AG-095 (11-14)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Aging and Adult Services

RESET

ARIZONA STANDARDIZED CLIENT ASSESSMENT PLAN (ASCAP)

☐ NEW ☐ REASSESSMENT ☐ CHANGE ☐ REVIEW ☐ CLOSE ☐ HOLD	ASSESSMENT DATE	DAARS ID NO.

PART I: INTAKE INFORMATION

A. Client Profile and Referral Information

FIRST NAME	LAST NAME	M.I.	SOC. SEC. NO.	DATE OF BIRTH

PHONE NO. 1	☐ HOME ☐ WORK ☐ CELL ☐ FAX ☐ CAR ☐ OTHER	PHONE NO. 2	☐ HOME ☐ WORK ☐ CELL ☐ FAX ☐ CAR ☐ OTHER

HOME OR RESIDENCE ADDRESS *(No., Street, Apt. No., City, State, ZIP)*	MAILING ADDRESS *(P.O. Box, Street, City, State, ZIP)*

VALID DATES From To	VALID DATES From To

E-MAIL ADDRESS 1 ☐ PERSONAL ☐ WORK ☐ OTHER	E-MAIL ADDRESS 2 ☐ PERSONAL ☐ WORK ☐ OTHER

☐ Yes ☐ No Needs emergency evacuation assistance *(based on responses in Part IV)*.	☐ Yes ☐ No Is a primary caregiver (informal) assisting you?

INFORMATION FOR INTERVIEW WAS OBTAINED FROM
☐ Self report ☐ Medical records ☐ Other *(specify)*

NAME OF REFERRAL SOURCE	REFERRAL SOURCE PHONE NO.	REFERRAL DATE

REFERRAL SOURCE ADDRESS *(No., Street, Apt. No., City, State, ZIP)*

REFERRAL SOURCE TYPE

☐ Self	☐ Hospital	☐ Senior center
☐ Family	☐ Agency	☐ AHCCCS health plan
☐ Friend	☐ Residential facility	☐ AHCCCS – ALTCS
☐ Physician	☐ APS	☐ Other

LOCATION AT TIME OF REFERRAL ☐ Hospital ☐ Emergency room ☐ Community ☐ LTC facility	ADMISSION DATE	DISCHARGE DATE

ELIGIBILITY CATEGORY
☐ 60 and over
☐ Spouse of client age 60 and over
☐ Under 60 with a disability
☐ Caregiver of eligible client

ELIGIBLE CLIENT *(associated with spouse or caregiver)*
NAME
SOC. SEC. NO.

B. Demographics

TYPE OF DISABILITY

☐ Physical	☐ Traumatic brain injury
☐ Intellectual disability/developmental disability (ID/DD)	☐ Dementia
☐ Mental illness	☐ Other *(specify)* _____
	☐ None

ETHNICITY
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Declined to state

RACE	RELATIONSHIP STATUS	LANGUAGE
☐ Asian	☐ Divorced	☐ English
☐ Black/African American	☐ Domestic partner	☐ American Indian (w/Eng)
☐ Native Hawaiian or other Pacific Islander	☐ Married	☐ American Indian (w/o Eng) *(specify)*:_____
☐ American Indian or Alaskan Native	☐ Separated	☐ Spanish (w/Eng)
☐ White	☐ Single	☐ Spanish (w/o Eng)
☐ Other	☐ Widowed	☐ Other *(specify)*: _____
☐ Declined to state	☐ Declined to state	☐ Declined to state

ENGLISH FLUENCY	EDUCATION
☐ Fluent	☐ Grade school or less
☐ Limited	☐ Some high school
☐ Needs translation	☐ High school graduate
☐ Declined to state	☐ Post high school
	☐ College degree
	☐ Declined to state

CLIENT'S NAME	DAARS ID NO.

RESIDENCE TYPE
- ☐ Apartment
- ☐ Assisted living facility
- ☐ Board and care
- ☐ DD group home
- ☐ Foster care
- ☐ House
- ☐ Mobile
- ☐ Nursing home
- ☐ Other (specify): _____
- ☐ Declined to state

LIVING ARRANGEMENT
- ☐ No pay
- ☐ Owns
- ☐ Rents
- ☐ Subsidized
- ☐ N/A
- ☐ Declined to state

NUMBER IN HOUSEHOLD

HOUSEHOLD COMPOSITION
- ☐ Institutionalized
- ☐ Lives alone
- ☐ With domestic partner
- ☐ With non-relative(s)
- ☐ With other relative(s)
- ☐ With parent(s)
- ☐ With spouse
- ☐ Other *(specify)*: _____
- ☐ Declined to state

LENGTH OF TIME AT PRESENT ADDRESS

_____ Years _____ Months

URBAN/RURAL
- ☐ Rural
- ☐ Urban
- ☐ Declined to state

SEX / GENDER
- ☐ Female
- ☐ Male
- ☐ Unknown

TRANSGENDER *(optional)*
- ☐ Yes
- ☐ No
- ☐ Declined to state

SEXUAL ORIENTATION *(optional)*
- ☐ Bisexual
- ☐ Gay
- ☐ Heterosexual
- ☐ Lesbian
- ☐ Declined to state

VETERAN
- ☐ No
- ☐ Child
- ☐ Spouse
- ☐ Veteran

Veteran #: _____
- ☐ Declined to state

LEGAL STATUS
- ☐ Independent
- ☐ Child
- ☐ Conservator
- ☐ DP7 payee
- ☐ Guardian
- ☐ LTC payee
- ☐ Other *(specify)*: _____
- ☐ Declined to state

C. Contacts

Close Contacts

EMERGENCY CONTACT	RELATIONSHIP	ADDRESS	PHONE	E-MAIL
NEXT OF KIN				
SIGNIFICANT OTHER/SPOUSE				
LIVES WITH				
USUAL CONTACT				
OTHER				
OTHER				

Medical Contacts *(if applicable)*

PRIMARY PHYSICIAN	FIELD	ADDRESS	PHONE	E-MAIL
SOCIAL WORKER				
HOMECARE AIDE				

Assessment Contacts *(if applicable)*

DP7 CONTACT	RELATIONSHIP	ADDRESS	PHONE	E-MAIL
DURABLE POWER OF ATTORNEY FOR HEALTHCARE (DPOAH)	RELATIONSHIP			
REFERRAL SOURCE				
HANDLING FINANCIAL MATTERS				
OTHER				

CLIENT'S NAME	DAARS ID NO.

D. Net Monthly Income Information

	CLIENT	SPOUSE/HOUSEHOLD	TOTAL
Earned income			
Retirement/pension			
Investment income			
Social Security			
Supplemental Security Income (SSI)			
Veterans compensation			
Veterans pension			
Veterans aid & attendance (A&A)			
Other			
Total monthly income	TOTAL CLIENT INCOME	TOTAL SPOUSE/HOUSEHOLD INCOME	COMBINED TOTAL INCOME

At or below 100% FPL ..... ☐ Yes ☐ No ☐ Declined to state income

E. Monthly Expenses

	CLIENT	SPOUSE/HOUSEHOLD	TOTAL
Housing			
Food			
Utilities			
Medical			
Insurance			
Private pay assistance			
Transportation			
Other			
Total monthly expenses	TOTAL CLIENT EXPENSES	TOTAL SPOUSE/HOUSEHOLD EXP	COMBINED TOTAL EXPENSES
		Subtract Total Expenses from Total Income above and enter the **Total net income after expenses**	

F. Insurance Information

MEDICARE NUMBER	ENROLLMENT DATE *(optional)*	QMB	SLMB
		☐ Yes ☐ No	☐ Yes ☐ No

MEDICARE PARTS
☐ A EFFECTIVE DATE: _____ ☐ B EFFECTIVE DATE: _____ ☐ D EFFECTIVE DATE: _____

AHCCCS / ALTCS NUMBER	AHCCCS PLAN NAME

COUNTY CODES *(OPTIONAL)*	INSURANCE/BENEFITS	VETERANS MEDICAL BENEFITS	HAS MEDICARE ADVANTAGE PLAN
		☐ Yes ☐ No	☐ Yes ☐ No

G. Legal Planning

DURABLE POWER OF ATTORNEY

Financial ..... ☐ Yes ☐ No
Health ..... ☐ Yes ☐ No
Mental health ..... ☐ Yes ☐ No

Living will ..... ☐ Yes ☐ No
DNR (Orange form) ..... ☐ Yes ☐ No
Burial arrangements, mortuary ..... ☐ Yes ☐ No

CLIENT'S NAME	DAARS ID NO.

NAME OF PERSON WHO WILL BE HANDLING YOUR FINANCIAL MATTERS	RELATIONSHIP	TYPE
		☐ Self ☐ Family ☐ DPOA ☐ Rep payee ☐ Other ☐ Conservator

PART II: CAREGIVER INFORMATION

Is there a primary caregiver (informal) assisting you? ..... ☐ Yes ☐ No *(if No, go to the next section of the assessment)*

CAREGIVER'S NAME *(Last, First, M.I.)*	PHONE NO.
ADDRESS *(No., Street, City, State, ZIP)*	E-MAIL ADDRESS

GENDER	RACE	ETHNICITY	URBAN/RURAL
☐ Male ☐ Female ☐ Declined to state	☐ Asian ☐ Black/African American ☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaskan Native ☐ White ☐ Other ☐ Declined to state	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to state	☐ Rural ☐ Urban ☐ Declined to state

RELATIONSHIP TO CARE RECIPIENT	LENGTH OF TIME PROVIDING CARE
☐ Husband ☐ Wife ☐ Domestic partner ☐ Daughter/daughter-in-law ☐ Son/son-in-law ☐ Grandparent ☐ Other relative ☐ Non-relative	☐ Less than one year ☐ 1-2 years ☐ 3-5 years ☐ 6-10 years ☐ 11 or more years

Does the caregiver reside with the recipient? ..... ☐ Yes ☐ No

Would the caregiver and care recipient be interested in more information about FCSP? ..... ☐ Yes ☐ No

PART III: NUTRITIONAL STATUS

Does the client have a special diet? ..... ☐ Yes ☐ No If Yes, specify: _____

Does the client have a food allergy? ..... ☐ Yes ☐ No If Yes, specify: _____

Nutritional Screening *(Check all that apply and total the score shown for each selected response.)*

- ☐ I have an illness or condition that made me change the kind and/or amount of food I eat. (2)
- ☐ I eat fewer than 2 meals per day. (3)
- ☐ I eat few fruits or vegetables or milk products. (2)
- ☐ I have 3 or more drinks of beer, liquor or wine almost every day. (2)
- ☐ I have tooth or mouth problems that make it hard for me to eat. (2)
- ☐ I don't always have enough money to buy the food I need. (4)
- ☐ I eat alone most of the time. (1)
- ☐ I take 3 or more different prescribed or over-the-counter drugs a day. (1)
- ☐ Without wanting to, I have lost or gained 10 pounds in the last 6 months. (2)
- ☐ I am not always physically able to shop, cook and/or feed myself. (2)

TOTAL SCORE *(0-2 is good, 3-5 is moderate nutritional risk, 6 or greater is high nutritional risk)*	HEIGHT *(Optional)*	WEIGHT *(Optional)*

COMMENTS

PART IV: BASIC FUNCTIONAL ASSESSMENT

A. Orientation *(Check appropriate answer. Consider last 90 days.)*

Orientation is defined as the client's awareness of his/her environment in relation to time, place and self.

Person (identification of self).

- ☐ Disoriented occasionally (3 times or less per month).
- ☐ Disoriented some of the time (more than 3 times per month but less than half the time).
- ☐ Disoriented at least half the time.
- ☐ No problems with orientation.

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Place (immediate environment, residence, city, state).

- ☐ Disoriented occasionally (3 times or less per month).
- ☐ Disoriented some of the time (more than 3 times per month but less than half the time).
- ☐ Disoriented at least half the time.
- ☐ No problems with orientation.

Time (day, month, year, time of day).

- ☐ Disoriented occasionally (3 times or less per month).
- ☐ Disoriented some of the time (more than 3 times per month but less than half the time).
- ☐ Disoriented at least half the time.
- ☐ No problems with orientation.

Recent memory recall.

- ☐ Minimally impaired function.
- ☐ Moderately impaired function.
- ☐ Severely impaired function and safety.
- ☐ No problem with memory recall.

COMMENTS

B. Communication/Sensory *(Check appropriate answer. Consider last 30 days.)*

Hearing – The ability to perceive sounds (with hearing appliance, if used).

- ☐ Minimal difficulty (e.g., understands conversation when face to face).
- ☐ Hears in special situations only (e.g., speaker has to adjust tonal quality and speak distinctly), will only understand loud conversation.
- ☐ Absence of useful hearing (e.g., will hear only very loud voice; totally deaf).
- ☐ Hears adequately (e.g., conversation, TV, phone).

Expressive Communication – The ability to express information and making self understood using any means (making self understood by others).

- ☐ Difficulty finding words, finishing thoughts, or enunciating.
- ☐ Ability is limited to making concrete requests.
- ☐ Rarely/never understood.
- ☐ Understood.

Vision – The ability to perceive visual stimuli (with corrective devices, if used).

- ☐ Difficulty with focus at close (reading) range. Sees large print and obstacles, but not details or has monocular vision.
- ☐ Unable to see large print, field of vision is severely limited (e.g., tunnel vision or central vision loss).
- ☐ No vision or appears to see only light, colors or shapes.
- ☐ Sees adequately (e.g., newsprint, TV, medication labels).

Smell – The ability to perceive odors/scents, especially odors indicating a danger (e.g., smoke).

- ☐ Impairs safety.
- ☐ Does not impair safety.

Touch – The ability to discriminate against temperature (e.g., hot, cold), dull and sharp, and pain (e.g., resulting from an open wound).

- ☐ Impairs safety.
- ☐ Does not impair safety.

COMMENTS

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C. Assessment of Daily Living Activities

For each activity, select the level of assistance needed, select the source of help, and select the qualifier, as needed.

Levels of Assistance

1. **Ind**ependent – Completes the task independently.
2. **Min**imum Assistance – Occasional assistance or supervision may be necessary.
3. **Mod**erate Assistance – Assistance or supervision is usually necessary.
4. **Max**imum Assistance – Totally dependent on others.

Qualifiers

C – Cognitive
I – Isolation
S – Safety

Source of Help

a. None
b AAA provided
c. Daughter
d. Friend
e. Other relative
f. Parent
g. Private paid help
h. Publicly funded help
i. Residential health care
j. Sibling
k. Son
l. Spouse/significant other
m. Volunteer

Activities of Daily Living

	1. Ind	2. Min	3. Mod	4. Max	Source of Help	Qualifiers	Comments
Bathing	☐	☐	☐	☐			
Dressing	☐	☐	☐	☐			
Eating	☐	☐	☐	☐			
Walking	☐	☐	☐	☐			
Transferring	☐	☐	☐	☐			
Toileting	☐	☐	☐	☐			

Instrumental Activities of Daily Living

	1. Ind	2. Min	3. Mod	4. Max	Source of Help	Qualifiers	Comments
Shopping for personal items	☐	☐	☐	☐			
Doing heavy housework	☐	☐	☐	☐			
Doing light housework	☐	☐	☐	☐			
Using the telephone	☐	☐	☐	☐			
Managing money	☐	☐	☐	☐			
Transportation ability	☐	☐	☐	☐			
Preparing meals	☐	☐	☐	☐			
Medication management	☐	☐	☐	☐			

COMMENTS

D. Assistive Devices

For the following devices, select *Has* or *Needs* the device. If client does not have or need any device, select None. **Restore List**

	Has	Needs		Has	Needs		Has	Needs
Cane	☐	☐	Hoyer lift	☐	☐	Mediset	☐	☐
Quad cane	☐	☐	Shower bench	☐	☐	Glucometer	☐	☐
Crutches	☐	☐	Shower chair	☐	☐	Test strips	☐	☐
Walker	☐	☐	Raised toilet seat	☐	☐	Dentures	☐	☐
Electric wheelchair	☐	☐	Commode chair	☐	☐	Hearing aids	☐	☐
Manual wheelchair	☐	☐	Hand-held shower	☐	☐	Eye glasses	☐	☐
Electric scooter	☐	☐	Geri-chair	☐	☐	Service dog	☐	☐
Hospital bed	☐	☐	Grab bars	☐	☐	Emergency notification	☐	☐
Egg crate mattress	☐	☐	Oxygen	☐	☐	Communication board	☐	☐
Hand rails	☐	☐	Oxygen mask	☐	☐	Companion animals	☐	☐
Side rails half	☐	☐	Nasal prongs/cannula	☐	☐	Assistive phone device	☐	☐
Side rails full	☐	☐	Concentrator	☐	☐	Other assistive device *(specify in comments)*	☐	☐
Trapeze	☐	☐	Portable oxygen	☐	☐			
Transfer board	☐	☐	Ventilator	☐	☐	None	☐	

CLIENT'S NAME	DAARS ID NO.

COMMENTS

E. Evacuation Needs Assessment

Evacuation Needs Assessment Instructions

1. Was the response to ASCAP Part I, Section B, question Household Composition identified as "Lives Alone"?
   - ☐ Yes (go to question #2)
   - ☐ No (go to question #3, select "No")
2. Which of the following items have been identified on the ASCAP? (Check the appropriate box(es).)
   - ☐ ASCAP Part IV, Sec. C, **Transportation** is identified as 3. Mod. Asst. OR 4. Max. Asst., OR the Qualifier "Cognitive" is identified.
   - ☐ ASCAP Part IV, Sec. C, **Transferring** is identified as 3. Mod. Asst. OR 4. Max. Asst., OR the Qualifier "Cognitive" is identified.
   - ☐ ASCAP Part IV, Sec. B, **Hearing** is identified as "Absence of useful hearing."
   - ☐ ASCAP Part IV, Sec. B, **Vision** is identified as "No vision or appears to see only light, colors or shapes."
   - ☐ ASCAP Part IV, Sec. A, **Person**, **Place**, **Time** and/or **Recent memory recall** are identified as "Disoriented at least half of the time" or "Severely impaired function and safety."
   - ☐ ASCAP Part IV, Sec. D, One or more of these items, **Cane, Quad Cane, Crutches, Walker, Electric wheelchair, Manual wheelchair, Electric scooter, Oxygen, Oxygen mask, Portable oxygen** or **Ventilator**, is identified as "Has."

   If one or more of these items are checked, go to question #3 and select "Yes".
   If no items are checked, go to question #3 and select "No".
3. In the event of a disaster/emergency where evacuation is required, would the individual be placed on a priority list for evacuation assistance?
   - ☐ **Yes** (Case Manager: If you are satisfied with this answer, go to question #4. If you feel that "No" would be a better answer, select the override box and provide an explanation.)
   - ☐ **No** (Case Manager: If you are satisfied with this answer, **STOP – Process Ends.** Go to Part I, Sec. A, Client Profile of this assessment and mark "No" to "Needs emergency evacuation assistance." If you feel that "Yes" would be a better answer, select the override box and provide an explanation.)
   - ☐ **Override:** Select this box if, in the judgment of the Case Manager, the answer to question #3 should be changed. Explain why an override of the automatic answer is warranted.

   If you selected the override, changing "Yes" to "No," **STOP – Process Ends.** Go to Part I, Sec. A, Client Profile of this assessment and mark "No" to "Needs emergency evacuation assistance."

   If you selected the override, changing "No" to "Yes", go to question **#4**.
4. In the judgment of the Case Manager, and if resources are available during a disaster/emergency requiring evacuation, describe what evacuation assistance would be required for the individual. Then go to Part I, Sec. A, Client Profile of this assessment and mark "Yes" to "Needs emergency evacuation assistance."

PART V: ADDITIONAL FUNCTIONAL ASSESSMENT

Required except for Tribal Services, HDM only, Respite, Supplemental Services and Case Management only.

A. Environmental Problems

Check all that apply.

☐ Accessibility	☐ Fire safety	☐ Plumbing/utilities	☐ Toilet
☐ Animals	☐ Furnishings	☐ Refrigerator/freezer	☐ Tub/shower
☐ Building structure	☐ Heating	☐ Security	☐ Unable to determine
☐ Cleanliness	☐ Hot water	☐ Stairs/handrail	☐ Other
☐ Dryer/washer	☐ Insects/rodents	☐ Stove/burner	☐ None
☐ Evaporative cooler/AC	☐ Microwave/convection oven	☐ Telephone	

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B. Continence *(Consider the last 30 days.)*

Bowel Continence – The ability to voluntarily control the discharge of body waste from the bowel.

- ☐ Incontinent episodes less than weekly.
- ☐ Incontinent episodes two or more times a week.
- ☐ Incontinent episodes daily and/or no voluntary control.
- ☐ Ostomy product.
- ☐ Continent. Complete voluntary control.

Bladder Continence – The ability to voluntarily control the discharge of body waste from the bladder.

- ☐ Incontinent episodes less than weekly.
- ☐ Incontinent episodes two or more times a week.
- ☐ Incontinent episodes daily and/or no voluntary control.
- ☐ Catheterized.
- ☐ Continent. Complete voluntary control.

Change in Bladder Continence *(In last 90 days; explain any change in condition.)*

- ☐ Improved
- ☐ Deteriorated
- ☐ No change

COMMENTS

C. Mental/Behavioral Health

Psychosocial Stressors (*Consider last 90 days. Select all that apply.)*

☐ Change of income	☐ Change in marital status	☐ Victim of assault/theft	☐ Grandparent raising grandchildren
☐ Financial concerns	☐ Illness in family	☐ Change in routine	☐ Other kinship care
☐ Change of residence	☐ Injury/accident	☐ Family concerns	☐ Unable to determine
☐ Death of friend/family	☐ Personal illness	☐ Care of child w/DD	☐ Other *(specify)* _____
☐ Death of pet	☐ Retirement	☐ Care of adult w/DD	☐ None

WHAT ARE YOU DOING TO COPE WITH THESE STRESSORS?

Anxiety – Do you find it difficult to control your worrying? If yes, how long has this feeling lasted?

- ☐ Yes, more than two weeks.
- ☐ Yes, less than two weeks.
- ☐ No

Anxiety – Have you been experiencing sudden, unexplained attacks of intense fear, anxiety, or panic for no apparent reason?

- ☐ Yes, more than once.
- ☐ Yes, once.
- ☐ No

Depression – Have you been feeling sad, depressed, and/or hopeless? If yes, how long has this feeling lasted?

- ☐ Yes, more than two weeks.
- ☐ Yes, less than two weeks.
- ☐ No

Depression – Have you lost interest in activities that you find enjoyable? If yes, how long has this feeling lasted?

- ☐ Yes, more than two weeks.
- ☐ Yes, less than two weeks.
- ☐ No

Suicidal Behavior – Have you had thoughts about ending your life?

- ☐ Yes
- ☐ No

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Suicidal Behavior – Have you threatened or attempted to end your life?

- ☐ Yes
- ☐ No

Counseling/Therapy Services – Are you currently participating in counseling/therapy services?

- ☐ Yes (List in Comments section below.)
- ☐ No (If no, select all the reasons below that apply.)
  - ☐ Health insurance
  - ☐ Transportation
  - ☐ Not available in area
  - ☐ Other: _____
- ☐ Not needed

Treatments – Have you had any previous inpatient/outpatient psychiatric and/or chemical dependency treatment episodes?

- ☐ Yes (List in Comments section below.)
- ☐ No (If no, select all the reasons below that apply.)
  - ☐ Health insurance
  - ☐ Transportation
  - ☐ Not available in area
  - ☐ Other: _____
- ☐ Not needed

COMMENTS

D. Behaviors *(Select the most appropriate answer. Consider the last 90 days.)*

Wandering – Moving about with no rational purpose, tendency to proceed beyond physical parameters of his/her environment in a manner than may jeopardize safety.

- ☐ Not a current problem.
- ☐ Occurs daily, posing a threat to safety, required constant supervision and/or intervention or a secured environment.
- ☐ Occurs predictably (in response to particular situations), poses a threat to safety of self or others; requires supervision and/or intervention weekly to every day.
- ☐ Requires additional supervision and/or intervention, but no safety problem.

Self-Injurious Behavior – Repeated biting, scratching, picking behaviors; putting inappropriate objects into ear, mouth or nose, head slapping or banging, etc. Also includes eating or drinking harmful substances. (Do NOT include lifestyle choices.)

- ☐ Not a current problem.
- ☐ Requires supervision and/or intervention less than weekly.
- ☐ Requires supervision and/or intervention weekly to every other day.
- ☐ Requires 24-hour awake supervision and/or physical intervention.

Aggression – Physically attacks others, including throwing objects, punching, biting, pushing, pinching, pulling hair, scratching, destroying property, threatening behavior. (Do not include self-injurious behaviors.)

- ☐ Not a current problem.
- ☐ Requires supervision and/or intervention less than weekly.
- ☐ Requires supervision and/or intervention weekly to every other day.
- ☐ Requires daily supervision and/or physical intervention.

Disruptive Behavior – Interferes with activities of others or own activities through behaviors, including but not limited to putting on or taking off clothing inappropriately, stubbornness, sexual behavior inappropriate to time, place or person, excessive whining or crying, screaming, persistent pestering or teasing, constant demand for attention, urinating in public.

- ☐ Not a current problem.
- ☐ Requires intervention less than weekly.
- ☐ Requires intervention weekly to every other day.
- ☐ Requires intervention daily.

Abusive Behavior	***Assaultive Behavior***	***Inappropriate Sexual Behavior***
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

CLIENT'S NAME | DAARS ID NO.

E. Medications/Treatments *(Select the most appropriate answer.)*

1. Are you taking your medications as prescribed?
   - ☐ Yes *(**Skip** question #2.)*
   - ☐ No *(**Ask** question #2.)*
   - ☐ No medications needed.
2. Are you able to buy the medications you need?
   - ☐ Yes
   - ☐ No (If no, select all the reasons below that apply.)
     - ☐ Income ☐ Health insurance ☐ Transportation ☐ Not available in area ☐ Other: _____

List medications below (If none, select None.): **Restore List**

Prescribed Medications	Over-the-Counter (OTC) Medications

Total number of Prescription Medications: _____ ☐ None ☐ Check if continuation sheet attached.

Total number of OTC Medications: _____ ☐ None

Information obtained from:
- ☐ Medical records
- ☐ Prescription bottles
- ☐ Self-report
- ☐ Other *(specify)*: _____

Drug allergies?
- ☐ Yes *(specify)*: _____
- ☐ No, no known allergies

COMMENTS

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F. Medical Conditions *(Check Acute, or current condition, and/or History, as appropriate. If no medical conditions, check* None. *)* **Restore**

Neurological	Acute	History
Polio	☐	☐
Seizure disorder	☐	☐
Cerebral palsy	☐	☐
Autism	☐	☐
Intellectual disability	☐	☐
Encephalopathy	☐	☐
Alzheimer's disease/organic brain syndrome/dementia	☐	☐
Parkinson's disease	☐	☐
Head trauma	☐	☐
Stroke	☐	☐
Multiple sclerosis	☐	☐
Amyotrophic lateral sclerosis (ALS)	☐	☐
Shingles	☐	☐

COMMENTS

Musculoskeletal	Acute	History
Amputation	☐	☐
Arthritis	☐	☐
Degenerative joint disease	☐	☐
Fractures	☐	☐
Joint replacement	☐	☐
Muscular dystrophy	☐	☐
Osteoporosis	☐	☐
Paralysis	☐	☐
Contracture	☐	☐
Curvature of spine	☐	☐

COMMENTS

Cardiovascular	Acute	History
Angina	☐	☐
Atherosclerotic heart disease (ASHD)	☐	☐
Congestive heart failure	☐	☐
Heart attack	☐	☐
Hypertension	☐	☐
Peripheral vascular disease	☐	☐
Phlebitis	☐	☐
Edema	☐	☐
Pacemaker/heartbeat problem	☐	☐

COMMENTS

Gastrointestinal	Acute	History
Ulcers	☐	☐
Hernia	☐	☐
Colitis	☐	☐
Irritable bowel syndrome (IBS)	☐	☐
Cirrhosis	☐	☐
Constipation	☐	☐
Intestinal obstruction	☐	☐

COMMENTS

Hematologic/Oncologic	Acute	History
Anemia	☐	☐
Cancer	☐	☐
Leukemia	☐	☐
HIV positive	☐	☐
AIDS	☐	☐
Hepatitis	☐	☐

COMMENTS

Respiratory	Acute	History
Asthma	☐	☐
Chronic obstructive pulmonary disease (COPD)	☐	☐
Bronchitis	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐
Emphysema	☐	☐

COMMENTS

Metabolic	Acute	History
Diabetes	☐	☐
Hypothyroidism	☐	☐
Hyperthyroidism	☐	☐
Electrolyte imbalance	☐	☐

COMMENTS

Genital/Urinary	Acute	History
Chronic urinary tract infection	☐	☐
Chronic renal failure/insufficiency	☐	☐
Urinary retention	☐	☐

COMMENTS

CLIENT'S NAME | DAARS ID NO.

Sight/Hearing	Acute	History
Blindness	☐	☐
Cataract	☐	☐
Glaucoma	☐	☐
Macular degeneration	☐	☐
Otitis media	☐	☐
Hearing deficit	☐	☐

COMMENTS

Other	Acute	History
Reduced physical stamina/frailty	☐	☐
Birth defect	☐	☐
Fibromyalgia	☐	☐
Dehydration	☐	☐
Other: _____	☐	☐
Other: _____	☐	☐

COMMENTS

Skin Conditions	Acute	History
Decubitus	☐	☐
Cellulitis	☐	☐

COMMENTS

Information provided by:

☐ Client
☐ Informal caregiver
☐ Other, specify: _____

None ☐

List the category and name of no more than 3 conditions that have a current effect on the client:

Category	Condition

G. Nursing Services and Treatment

For each service, select *S* for single/one-time or *C* for continuous. If the client currently receives the service from a Non-Area Agency on Aging Source, select the box below *Receives*. If no services are needed, select *None*.

	Frequency C	Frequency S	Receives	Comments
Insulin set up	☐	☐	☐	
Medication setup	☐	☐	☐	
Vital monitoring	☐	☐	☐	
Nursing assessment	☐	☐	☐	
Teaching by nurse	☐	☐	☐	
Medication management/monitoring	☐	☐	☐	
Wound care	☐	☐	☐	
Catheter colostomy care	☐	☐	☐	
None	☐			

H. Hospitalization/ER Visits/Falls

How many times have you been hospitalized in the past 6 months?	How many times have you been seen in the emergency room in the past 6 months?	How many times have you fallen in the past 6 months?
☐ None	☐ None	☐ None

CLIENT'S NAME | DAARS ID NO.

PART VI: UNMET NEEDS

Required except for Tribal Services and HDM only.

Select service(s) needed but not authorized through the Area Agency on Aging. For each service needed, indicate whether the service is not available or if there is a wait list, if applicable. Do not include services authorized by the Area Agency on Aging. If none, select "None." Restore

Non-area agency authorized services	Needed	Not Available	Waitlist	Referral made to	Date referred
Adaptive devices	☐	☐	☐		
Adult day health care	☐	☐	☐		
Adult Protective Services	☐	☐	☐		
ALTCS	☐	☐	☐		
Assisted living facility	☐	☐	☐		
Attendant care	☐	☐	☐		
Behavioral health services	☐	☐	☐		
Benefits counseling (SHIP)	☐	☐	☐		
Caregiver services	☐	☐	☐		
Commodities	☐	☐	☐		
Congregate meals	☐	☐	☐		
Dental	☐	☐	☐		
Emergency response system	☐	☐	☐		
Errand service	☐	☐	☐		
Financial services	☐	☐	☐		
Food stamps	☐	☐	☐		
Friendly visitor	☐	☐	☐		
Guardianship/conservatorship	☐	☐	☐		
Home repair/adaptation/renovation	☐	☐	☐		
Hospice	☐	☐	☐		
Hospital care	☐	☐	☐		
Housing	☐	☐	☐		
Interpretation	☐	☐	☐		
Kinship care	☐	☐	☐		
Laundry	☐	☐	☐		
Legal assistance	☐	☐	☐		
Medical care	☐	☐	☐		
Nutrition education	☐	☐	☐		
Occupational therapy	☐	☐	☐		
Ombudsman	☐	☐	☐		
Physical therapy	☐	☐	☐		
Public fiduciary	☐	☐	☐		
Recreation/socialization	☐	☐	☐		
Shopping	☐	☐	☐		
Speech therapy	☐	☐	☐		
Telephone reassurance	☐	☐	☐		
Transportation	☐	☐	☐		
Utility services	☐	☐	☐		
Yard work	☐	☐	☐		
Other: _____	☐	☐	☐		

None ☐

CLIENT'S NAME	DAARS ID NO.

PART VII: SERVICE ENROLLMENTS

☐ OPEN ☐ CHANGE ☐ CLOSE ☐ CONTINUE | PROVIDER / SUBCONTRACTOR | PROVIDER CODE

SCOPE OF WORK | PROGRAM | SERVICE DETAIL

ENROLLMENT STATUS ☐ Enrolled ☐ Disenrolled ☐ Waitlisted | CLOSURE REASON | LOCATION *(Optional)*

AUTHORIZATION PERIOD (mm/dd/yy) From: Through: | COST SHARE AMOUNT PER UNIT/MONTH | COST SHARE OPTION ☐ Total ☐ Rate

QUANTITY | UNITS | FREQUENCY/PERIOD ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:

COMMENTS

☐ OPEN ☐ CHANGE ☐ CLOSE ☐ CONTINUE | PROVIDER / SUBCONTRACTOR | PROVIDER CODE

SCOPE OF WORK | PROGRAM | SERVICE DETAIL

ENROLLMENT STATUS ☐ Enrolled ☐ Disenrolled ☐ Waitlisted | CLOSURE REASON | LOCATION *(Optional)*

AUTHORIZATION PERIOD (mm/dd/yy) From: Through: | COST SHARE AMOUNT PER UNIT/MONTH | COST SHARE OPTION ☐ Total ☐ Rate

QUANTITY | UNITS | FREQUENCY/PERIOD ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:

COMMENTS

☐ OPEN ☐ CHANGE ☐ CLOSE ☐ CONTINUE | PROVIDER / SUBCONTRACTOR | PROVIDER CODE

SCOPE OF WORK | PROGRAM | SERVICE DETAIL

ENROLLMENT STATUS ☐ Enrolled ☐ Disenrolled ☐ Waitlisted | CLOSURE REASON | LOCATION *(Optional)*

AUTHORIZATION PERIOD (mm/dd/yy) From: Through: | COST SHARE AMOUNT PER UNIT/MONTH | COST SHARE OPTION ☐ Total ☐ Rate

QUANTITY | UNITS | FREQUENCY/PERIOD ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:

COMMENTS

☐ OPEN ☐ CHANGE ☐ CLOSE ☐ CONTINUE | PROVIDER / SUBCONTRACTOR | PROVIDER CODE

SCOPE OF WORK | PROGRAM | SERVICE DETAIL

ENROLLMENT STATUS ☐ Enrolled ☐ Disenrolled ☐ Waitlisted | CLOSURE REASON | LOCATION *(Optional)*

AUTHORIZATION PERIOD (mm/dd/yy) From: Through: | COST SHARE AMOUNT PER UNIT/MONTH | COST SHARE OPTION ☐ Total ☐ Rate

QUANTITY | UNITS | FREQUENCY/PERIOD ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:

COMMENTS

☐ OPEN ☐ CHANGE ☐ CLOSE ☐ CONTINUE | PROVIDER / SUBCONTRACTOR | PROVIDER CODE

SCOPE OF WORK | PROGRAM | SERVICE DETAIL

ENROLLMENT STATUS ☐ Enrolled ☐ Disenrolled ☐ Waitlisted | CLOSURE REASON | LOCATION *(Optional)*

AUTHORIZATION PERIOD (mm/dd/yy) From: Through: | COST SHARE AMOUNT PER UNIT/MONTH | COST SHARE OPTION ☐ Total ☐ Rate

QUANTITY | UNITS | FREQUENCY/PERIOD ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:

COMMENTS

CLIENT'S NAME	DAARS ID NO.

PART VIII: AUTHORIZATION

Authorization / Autorización

_____ I have received a copy of the Client Rights and Responsibilities and I certify by my signature or mark that I understand my rights and responsibilities, and that the information provided on this form, as it relates to my request and eligibility, is true and correct.

He recibido una copia del folleto Derechos y Responsabilidades del Cliente y atestiguo por mi firma o marca que entiendo mis derechos y responsabilidades y que la información provista en este formulario como se relaciona a mi petición y mi elegibilidad es verdadera y correcta.

_____ The service plan has been discussed with me and I agree with the described services. I have received a copy of the grievance and appeals procedure, and I understand that if I disagree with any action taken in my case, I have the right to present a verbal or written request for a fair hearing.

Me han explicado el plan de servicios y estoy de acuerdo con los servicios descritos. He recibido una copia del procedimiento de quejas y entiendo que si no estoy de acuerdo con cualquiera acción tomado en mi caso, que yo tengo el derecho a presentar una solicitud verbal o por escrito de una audiencia imparcial.

_____ I was provided the opportunity to contribute voluntarily to the cost of services.

Se me proporcionó la oportunidad de contribuir de manera voluntaria al costo de los servicios.

Client's Signature or Mark / Firma o marca del cliente		Date / Fecha
Responsible Party's Signature / Firma del parte responsable	Relationship / Afinidad	Date / Fecha
Worker's Name / Nombre del trabajador	Worker's Signature / Firma del trabajador	Date / Fecha