

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.: _____

Date of Birth: _____

Phone No. 1 _____ Home Work Cell FAX Car Other

Home, Residence or Physical Address (No., Street, Apt. No., City, State, ZIP):

Valid Dates: From: _____ To: _____

E-Mail Address 1: _____ Personal Work Other

Needs emergency evacuation assistance (based on responses in Part IV). Yes No

Phone No. 2 _____ Home Work Cell FAX Car Other

Mailing Address (P.O. Box, Street, City, State, ZIP):

Valid Dates: From: _____ To: _____

E-Mail Address 2: _____ Personal Work Other

Is a primary caregiver (informal) assisting you? Yes No

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: _____

Client's Name: _____ DAARS ID No.: _____

Eligibility Category:

60 and Over Spouse of Client Age 60 and Over Under 60 with A Disability
Caregiver of Eligible Client

Eligible Client Name (associated with spouse or caregiver): _____

B. Demographics

Type of Disability:

Physical Traumatic Brain Injury Intellectual Disability/Developmental Disability (ID/DD)
Dementia Mental Health Other (specify): _____ None

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to State

Race:

Asian Black/African American Native Hawaiian or other Pacific Islander
American Indian or Alaskan Native White Other Declined to State

Relationship Status:

Divorced Domestic Partner Married Separated Single Widowed
Declined to State

Language:

English American Indian (w/Eng) American Indian (w/o Eng) (specify): _____
Spanish (w/Eng) Spanish (w/o Eng) Other (specify): _____
Declined to State

English Fluency:

Fluent Limited Needs Translation Declined to State

Education:

Grade School or Less Some High School High School Graduate
Post High School College Degree Declined to State

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: _____

Client's Name: _____ DAARS ID No.: _____

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				
	Relationship	Address	Phone	E-Mail
Emergency Contact				
Next of Kin				
Significant Other/Spouse				
Lives With				
Usual Contact				
Other				
Other				

Client's Name: _____ DAARS ID No.: _____

Medical Contacts (if applicable)				
	Field	Address	Phone	E-Mail
Primary Physician				
Social Worker				
Homecare Aide				

Assessment Contacts (if applicable)				
	Relationship	Address	Phone	E-Mail
DP7 Contact				
Durable Power of Attorney for Healthcare (DPOAH)				
Referral Source				
Handling Financial Matters				
Other				

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

Client's Name: _____ DAARS ID No.: _____

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 Yes No SLMB 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: Yes No Has Medicare Advantage Plan: Yes No

G. Legal Planning

Durable Power of Attorney:

Financial Yes No

Living will Yes No

Health Yes No

DNR (Orange form) Yes No

Mental health Yes No

Burial arrangements, mortuary Yes No

Name of Person Who Will Be Handling Your Financial Matters:

Relationship: _____

Type: Self Family DPOA Rep Payee Other Conservator

Client's Name: _____ DAARS ID No.: _____

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:
Male Female Declined to state

Race:
Asian Black/African American Native Hawaiian or other Pacific Islander
American Indian or Alaskan Native White Other Declined to state

Ethnicity:
Hispanic or Latino Not Hispanic or Latino Declined to state

Urban/Rural:
Rural Urban Declined to state

Relationship to Care Recipient:
Husband Wife Domestic partner Daughter/daughter-in-law Son/son-in-law
Grandparent Other relative Non-relative

Length of Time Providing Care:
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: _____

Client's Name: _____ DAARS ID No.: _____

Section 1

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:

Section 2

Malnutrition Screening

1. Have you recently lost weight without trying? Yes No

If Yes, how much weight have you lost?

2-13 lbs. (1) 14-23 lbs. (2) 24-33 lbs. (3) 34 lbs. or more (4) Unsure (1)

Weight loss score: _____

2. Have you been eating poorly because of a decreased appetite? Yes (1) No(0)

Appetite Score: _____

Section 3

Food Insecurity Questions

A response of "often true" or "sometimes true" to either question = a positive screen for Food Insecurity

1. "We worried whether our food would run out before we got more money to buy more."

Often True Sometimes True Never True

2. "The food that we bought just didn't last, and we didn't have money to get more."

Often True Sometimes True Never True

Client's Name: _____ DAARS ID No.: _____

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.

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).*

Client's Name: _____ DAARS ID No.: _____

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:

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. **Independent** – Completes the task independently.
2. **Minimum Assistance** – Occasional assistance or supervision may be necessary.
3. **Moderate Assistance** – Assistance or supervision is usually necessary.
4. **Maximum Assistance** – Totally dependent on others.

Qualifiers:

- C– Cognitive
- I– Isolation
- S– Safety

Client's Name: _____ DAARS ID No.: _____

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:

Client's Name: _____ DAARS ID No.: _____

D. Assistive Devices

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

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

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")

Client's Name: _____ DAARS ID 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."

Client's Name: _____ DAARS ID No.: _____

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

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

Client's Name: _____ DAARS ID No.: _____

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

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:

Client's Name: _____ DAARS ID No.: _____

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 Yes No

Assaultive Behavior Yes No

Inappropriate Sexual Behavior Yes 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.

Client's Name: _____ DAARS ID No.: _____

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

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:		

Client's Name: _____ DAARS ID No.: _____

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

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

Skin Conditions	Acute	History
Decubitus		
Cellulitis		
Comments:		

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

None

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

Category	Condition

Information provided by:

Client Informal caregiver Other, specify: _____

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

Client's Name: _____ DAARS ID No.: _____

H. Hospitalization/ER Visits/Falls

How many times have you been hospitalized in the past 6 months? _____ None

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

How many times have you fallen in the past 6 months? _____ None

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."

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					

Client's Name: _____ DAARS ID No.: _____

Non-Area Agency Authorized Services	Needed	Not Available	Waitlist	Referral Made To	Date Referred
Occupational therapy					
Ombudsman					
Physical therapy					
Public fiduciary					
Recreation/socialization					
Shopping					
Speech therapy					
Telephone reassurance					
Transportation					
Utility services					
Yard work					
Other:					

None

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: _____

Client's Name: _____ DAARS ID No.: _____

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 _____

Client's Name: _____ DAARS ID No.: _____

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:

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.

Client's Name: _____ DAARS ID No.: _____

_____ 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: _____

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Aging and Adult Services at 602-542-4446; TTY/TDD Services 7-1-1 • Disponible en español en línea o en la oficina local

Programa y Empleador con Igualdad de Oportunidades • Servicios y ayudantes auxiliares para personas con discapacidades están disponibles a petición • Para obtener este documento en otro formato u obtener información adicional sobre esta política, comuníquese con el División de Servicios para Adultos y Personas de la Tercera Edad al 602-542-4446; Servicios de TTY/TDD: 7-1-1 • Available in English online or at the local office