<u>N</u> .	<u>AT</u>
1. INTRODUCTION	13b. Indicate Medicare recipient number
1.A. INDIVIDUAL'S IDENTIFICATION	14a. Does the individual have any other insurance?
Date of the face to face interview for Needs     Assessment Tool (NAT)	☐ No ☐ Yes
2. Individual's Last Name	Don't know  14b. Indicate other health insurance information
3. Individual's First Name	1.B. ASSESSMENT INFORMATION
4. Individual's Middle Initial	1. PSA number conducting assessment:
5. Individual's Name Suffix (If applicable)	01 02 03
6. Individual's Nickname/ Alias	04 05
7. Individual's Date of Birth (DOB)	☐ 06 ☐ 07 ☐ 08
8. Individual's Gender	09
Female	☐ 10 ☐ 11
Male	☐ 11 ☐ 12
9. Individual's Ethnicity (Check only one.)	13
Hispanic or Latino  Not Hispanic or Latino	<u> </u>
Unknown	☐ 15 ☐ 16
10. Individual's Race	☐ 16 ☐ 17
American Indian/ Native Alaskan	<u> </u>
Asian	<u> </u>
Black/ African American	20
Native Hawaiian/ Other Pacific Islander	<u> </u>
Non-Minority (White, non-Hispanic)	22
White-Hispanic	23
Unknown/ Unavailable Other-Document Details in Notes	☐ 24 ☐ 25
<u> </u>	25
11. Individual's Social Security Number (SSN)	27
	<u>28</u>
12a. Does the individual have a Medicaid number?	<u> </u>
□No	☐ 30 ☐ 31
Yes	☐ 31 ☐ 22
Pending	☐ 32 ☐ 33
12b. Indicate Medicaid recipient number	☐ 33 ☐ 34
120. Indicate riedicald recipient number	35
40 0 11 11 11 11 11 11	<u> </u>
13a. Does the individual have Medicare?	37
☐ No☐ Yes	□ 38
	☐ 39

1. PSA number conducting assessment:	1d. Complete address of legal guardian
<b>4</b> 0	
41	
<b>□</b> 42	1e. Primary phone number of legal guardian
☐ 43	
H 44	1f. Secondary phone number of legal guardian
	11. Secondary priorie flumber of legal guardian
<u></u> 45	
<u></u> 46	1g. E-mail address of legal guardian
<u></u> 47	
48	
<u>49</u>	2a. Does the individual have a Power of Attorney
☐ 50	(POA)?
<u> </u>	No-Skip to 1.D.1a
<u>□</u> 52	Yes
	2b. Proof of POA provided?
2. Indicate type of Needs Assessment Tool (NAT)	
Annual Care Plan	∐ No
DC-Domiciliary Care Annual	Yes
Initial	2c. Type of POA
Significant Change in Needs	Durable
Other-Document Details in Notes	Financial
Other-bocument betails in Notes	
3. Where was the individual interviewed?	Health
AL-Assisted Living	Other-Document Details in Notes
DC-Domiciliary Care	2d. Name of POA
Home	zui Rumo or i on
Home of Relative/ Caregiver	
	2e. Complete address of POA
Hospital	
PCH-Personal Care Home	
Other-Document Details in Notes	2f. Primary phone number of POA
4. Did the individual participate in the assessment?	
The the marriadal participate in the assessment.	2g. Secondary phone number of POA
No-Must complete 1.B.5	-g
Yes	
	2h. E-mail address of POA
5. If anyone else participated during the time of the	
needs assessment, please document the name and	1.D. INDIVIDUAL'S DEMOGRAPHICS
relationship in Notes.	
1 - Spouse/ Domestic Partner	1a. Is the individual homeless?
2 - Family-Other than Spouse	No-Skip to 1.D.2
3 - Legal Guardian	Yes
4 - Durable Power of Attorney (POA)	
5 - Friend	1b. Does the individual have a place to stay tonight?
6 - Other-Document Name and Relationship in Notes	_
	No-Document Details in Notes
1.C. POWER OF ATTORNEY (POA) / LEGAL GUARDIANSHIP	Yes
1a. Does the individual have a legal guardian?	1c. Does the individual have a place to stay long-term?
No-Skip to 1.C.2a	10. Does the mulviqual have a place to stay long-term?
	No-Document Details in Notes
Yes	
1b. Was proof of legal guardianship provided?	Yes
□ No	
Yes	
1c. Name of legal guardian	

1d. Explain homeless situation:	No-Skip to 1.D.7a
Cannot afford housing	Yes
Evicted	Unable to Determine
Housing not available	6b. What type of communication assistance is required?
Voluntary	,
Other-Document Details in Notes	Assistive Technology
2. Type of PERMANENT residence in which the	Interpreter
individual resides	Large Print
AL-Assisted Living	Picture Book
Apartment	Unable to Communicate
DC-Domiciliary Care	Unknown
Group Home	Other-Document Details in Notes
Nursing Home	7a. Does the individual use sign language as their
Own Home	PRIMARY language?
PCH-Personal Care Home	No-Skip to 1.D.8
Relative's Home	Yes
Specialized Rehab/ Rehab Facility	7b. What type of sign language is used?
State Institution  Other Decument Petails in Notes	American Sign Language
Other-Document Details in Notes	International Sign Language
3. What is the individual's PERMANENT living	Makaton
arrangement? (Include in the "Lives Alone" category	Manually Coded Language-English
individuals who live in an AL, DC or PCH, pay rent and have NO ROOMMATE.)	Manually Coded Language-Non-English
Lives Alone	Tactile Signing
Lives with Spouse Only	Other-Document Details in Notes
Lives with Child(ren) but not Spouse	8. What is the individual's PRIMARY language?
Lives with other Family Member(s)	English
Unknown	Russian
Other-Document Details in Notes	Spanish
	Spanish Other-Document Details in Notes
4. Individual's marital status	Other-Document Details in Notes
4. Individual's marital status Single	
4. Individual's marital status	Other-Document Details in Notes  1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED  1. Is the individual's postal/ mailing address exactly
4. Individual's marital status  Single Married Divorced	Other-Document Details in Notes  1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED  1. Is the individual's postal/ mailing address exactly the same as the residential address?
4. Individual's marital status Single Married	Other-Document Details in Notes  1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED  1. Is the individual's postal/ mailing address exactly
4. Individual's marital status  Single Married Divorced Legally Separated	Other-Document Details in Notes  1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED  1. Is the individual's postal/ mailing address exactly the same as the residential address?
4. Individual's marital status  Single Married Divorced Legally Separated Widowed Other-Document Details in Notes	Other-Document Details in Notes  1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED  1. Is the individual's postal/ mailing address exactly the same as the residential address?  No-Complete Section 1.E & F
4. Individual's marital status  Single  Married  Divorced  Legally Separated  Widowed  Other-Document Details in Notes  5a. Is the individual a Veteran?	Other-Document Details in Notes  1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED  1. Is the individual's postal/ mailing address exactly the same as the residential address?  No-Complete Section 1.E & F
4. Individual's marital status  Single Married Divorced Legally Separated Widowed Other-Document Details in Notes  5a. Is the individual a Veteran? No	Other-Document Details in Notes  1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED  1. Is the individual's postal/ mailing address exactly the same as the residential address?  No-Complete Section 1.E & F
4. Individual's marital status  Single Married Divorced Legally Separated Widowed Other-Document Details in Notes  5a. Is the individual a Veteran?  No Yes	Other-Document Details in Notes  1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED  1. Is the individual's postal/ mailing address exactly the same as the residential address?  No-Complete Section 1.E & F
4. Individual's marital status  Single Married Divorced Legally Separated Widowed Other-Document Details in Notes  5a. Is the individual a Veteran? No Yes Unable to Determine	Other-Document Details in Notes  1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED  1. Is the individual's postal/ mailing address exactly the same as the residential address?  No-Complete Section 1.E & F
4. Individual's marital status  Single Married Divorced Legally Separated Widowed Other-Document Details in Notes  5a. Is the individual a Veteran?  No Yes	Other-Document Details in Notes  1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED  1. Is the individual's postal/ mailing address exactly the same as the residential address?  No-Complete Section 1.E & F
4. Individual's marital status  Single Married Divorced Legally Separated Widowed Other-Document Details in Notes  5a. Is the individual a Veteran?  No Yes Unable to Determine  5b. Is the individual the spouse or child of a Veteran?	Other-Document Details in Notes  1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED  1. Is the individual's postal/ mailing address exactly the same as the residential address?  No-Complete Section 1.E & F
4. Individual's marital status  Single Married Divorced Legally Separated Widowed Other-Document Details in Notes  5a. Is the individual a Veteran? No Yes Unable to Determine  5b. Is the individual the spouse or child of a Veteran?	Other-Document Details in Notes  1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED  1. Is the individual's postal/ mailing address exactly the same as the residential address?  No-Complete Section 1.E & F
4. Individual's marital status  Single Married Divorced Legally Separated Widowed Other-Document Details in Notes  5a. Is the individual a Veteran? No Yes Unable to Determine  5b. Is the individual the spouse or child of a Veteran?	Other-Document Details in Notes  1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED  1. Is the individual's postal/ mailing address exactly the same as the residential address?  No-Complete Section 1.E & F
4. Individual's marital status  Single  Married  Divorced  Legally Separated  Widowed  Other-Document Details in Notes  5a. Is the individual a Veteran?  No  Yes  Unable to Determine  5b. Is the individual the spouse or child of a Veteran?  No  Yes  Unable to Determine	Other-Document Details in Notes  1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED  1. Is the individual's postal/ mailing address exactly the same as the residential address?  No-Complete Section 1.E & F
4. Individual's marital status  Single Married Divorced Legally Separated Widowed Other-Document Details in Notes  5a. Is the individual a Veteran? No Yes Unable to Determine  5b. Is the individual the spouse or child of a Veteran?  No Yes Unable to Determine  5c. Is the individual receiving Veteran's benefits?	Other-Document Details in Notes  1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED  1. Is the individual's postal/ mailing address exactly the same as the residential address?  No-Complete Section 1.E & F
4. Individual's marital status  Single Married Divorced Legally Separated Widowed Other-Document Details in Notes  5a. Is the individual a Veteran? No Yes Unable to Determine  5b. Is the individual the spouse or child of a Veteran?  No Yes Unable to Determine  5c. Is the individual receiving Veteran's benefits?  No	Other-Document Details in Notes  1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED  1. Is the individual's postal/ mailing address exactly the same as the residential address?  No-Complete Section 1.E & F
4. Individual's marital status  Single Married Divorced Legally Separated Widowed Other-Document Details in Notes  5a. Is the individual a Veteran? No Yes Unable to Determine  5b. Is the individual the spouse or child of a Veteran?  No Yes Unable to Determine  5c. Is the individual receiving Veteran's benefits?  No Yes	Other-Document Details in Notes  1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED  1. Is the individual's postal/ mailing address exactly the same as the residential address?  No-Complete Section 1.E & F
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assistance?

2a R	esidential County	Potter
2a. K	Adams	Schuylkill
H	Allegheny	Snyder
F	Armstrong	Somerset
<u> </u>	Beaver	Sullivan
H	Bedford	Susquehanna
H	Berks	Tioga
<u> </u>		
<u> </u>	Blair	Union
<u> </u>	Bradford	☐ Venango
<u> </u>	Bucks	Warren
<u> </u>	Butler	Washington
<u> </u>	Cambria	Wayne
<u> </u>	Cameron	Westmoreland
<u> </u>	Carbon	Wyoming
<u> </u>	Centre	☐ York
<u> </u>	Chester	Out of State
<u> </u>	Clarion	2b. Residential Street Address
<u> </u>	Clearfield	
F	Clinton .	2a Davidoutial Address Cossed Line (Aut on Doors #
<u> </u>	Columbia	2c. Residential Address Second Line (Apt or Room #, Building or Complex Name, etc.)
<u> </u>	Crawford	Danianing of Compress Hamiley Coory
Ļ	Cumberland	
<u> </u>	Dauphin	2d. Residential Municipality - REQUIRED (usually a
<u> </u>	Delaware	Township or Boro where individual votes, pays taxes)
<u> </u>	<u> </u> Elk	
<u> </u>	Erie .	
<u> </u>	Fayette	2e. Residential City/ Town
<u> </u>	Forest	
<u> </u>	Franklin	2f. Residential State
<u> </u>	Fulton	
<u> </u>	Greene	
<u> </u>	Huntingdon	2g. Residential Zip Code
<u> </u>	Indiana	
<u> </u>	Jefferson	3. Directions to the individual's home
<u> </u>	Juniata	
<u> </u>	Lackawanna	4. Does individual reside in a rural area?
<u> </u>	Lancaster	No
<u> </u>	Lawrence	Yes
<u> </u>	Lebanon	
<u> </u>	Lehigh	5a. Primary Phone Number
<u> </u>	Luzerne	
<u> </u>	Lycoming	5b. Mobile Phone Number
<u> </u>	McKean	SSI FISSILE FISHE NUMBER
<u>_</u>	Mercer	
<u>_</u>	Mifflin	5c. Other Phone Number (Enter number where
<u> </u>	Monroe	individual can be reached.)
<u> </u>	Montgomery	
	Montour	5d. E-mail Address
	Northampton	
	Northumberland -	
	Perry	
	Philadelphia	
	Pike	

6. What was the outcome when the individual was offered a voter registration form? REQUIRED  AAA will submit completed voter registration  Does not meet voter requirements (i.e. citizenship, etc.).  Individual declined application  Individual declined-already registered  Individual will submit completed voter registration  No Response  1.F. INDIVIDUAL'S POSTAL/MAILING ADDRESS INFORMATION	5. The approximate number of times the individual was an inpatient in a PSYCHIATRIC Facility in the LAST 24 MONTHS. Document Details in Notes  6. The number of times the individual has had outpatient surgery in the LAST 12 MONTHS:
1a. Postal Street Address	
	☐ 3 ☐ 4
1b. Postal Address Line 2 (optional)	Other-Document Details in Notes  2.B. PRIMARY PHYSICIAN INFORMATION
1c. Postal City/ Town	2.D. PRIMART PRISICIAN INFORMATION
Ic. Postal City/ Town	<ol> <li>Does the individual have a PRIMARY care physician?</li> </ol>
1d. Postal State	No Yes
1e. Postal Zip Code	2. PRIMARY Physician's Name
1.G. EMERGENCY CONTACT	3. PRIMARY Physician's Street Address
Name of Emergency Contact	4. PRIMARY Physician's City or Town
2. Relationship of Emergency Contact	5. PRIMARY Physician's State
3. Telephone Number of Emergency Contact	6. PRIMARY Physician's Zip Code
4. Work Telephone Number of Emergency Contact	7. PRIMARY Physician's Business Phone Number (Requires 10 digits to transfer to SAMS, optional 1-5
2. USE OF MEDICAL SERVICES	digit extension.)
2.A. HOSPITAL, NURSING FACILITY, ER, INPATIENT PSYCHIATRIC VISITS/STAYS	8. PRIMARY Physician's FAX Number
Has the individual stayed in the HOSPITAL in the	o. Transact injoinal of the Halling
LAST 12 MONTHS?  No-Skip to 2.A.3  Yes-Complete 2.A.2	9. PRIMARY Physician's E-MAIL ADDRESS
Unable to Determine-Document Details in Notes	10. Additional Physicians
2. The approximate number of times the individual has stayed overnight in the HOSPITAL in the LAST 12 MONTHS. Document Details in Notes	11. Does the individual receive alternative medical care from a practitioner?  No-Skip to 3.A.1
3. The approximate number of times the individual has visited the ER in the LAST 12 MONTHS and was NOT admitted.	Yes-Complete 2.B.12
4. The approximate number of times the individual was admitted to a NURSING FACILITY in the LAST 12 MONTHS. Document Details in Notes	

No-Document Details in Notes   and the time at ten minutes to eleven o'clock.    Yes	12. Select the type of alternative medical care-Document Details in Notes	2 - Incorrect (0) 3 - Unanswered (0)
Greek Polatic   Homocopathist   Greek Polatic   Greek Polati	Acupuncturist	Eh. How much do you have left?
Non-Document Details in Notes	Chiropractor	
Masseur   3 - Unanswered (0)	Herbalist	
Gasseur   Gass	Homoeopathist	
3. A. SLIMS PREPARATION  1. Determine if the individual is alert. Alert indicates that the individual is fully awake and able to focus.    Alert	Masseur	3 - Unanswered (0)
3. SAINT LOUIS UNIVERSITY MENTAL STATUS (SLUMS)  3. A. SLUMS PREPARATION  1. Determine if the individual is alert. Alert indicates that the individual is fully awake and able to focus.    Alert	Other-Document Details in Notes	6. Please name as many animals as you can in one
1. Determine if the individual is alert. Alert indicates that the individual is fully awake and able to focus.    Alert	3. SAINT LOUIS UNIVERSITY MENTAL STATUS (SLUMS)	
that the individual is fully awake and able to focus.    Alert	3.A. SLUMS PREPARATION	
confused   Distractible   Drowsy   Apple (1);   Tie (1)		
Distractible   Drowsy   Pen (1);   Pen (1);   Pen (1);   Tire (1);   Pen (1	Alert	7. What were the five objects I asked you to
Drowsy	Confused	remember? (1 point for each one correct.)
Drowsy   Inattentive   Preoccupied   Tile (1);   Tile (1);   Car (1);   Unanswered/ None Correct (0)	Distractible	Apple (1);
Inattentive		Pen (1);
House (1);   Car (1)		Tie (1);
Car (1);		House (1);
Unanswered/ None Correct (0)		
No	2. Do you have trouble with your memory?	
would like you to give them to me backwards. For example, if I say four-two, you would say two-four.    No	No	
a. May I ask you some questions about your memory?    No	Yes	
Yes	3. May I ask you some questions about your memory?	
Yes	□No	8-7 (78) (0);
Other-Document Details in Notes		
Unanswered/ None correct (0)		
4. Is the individual able to complete the SLUMS Exam?  No-Document Details in Notes  Yes  3.B. SLUMS QUESTIONNAIRE (Each score is beside the response.)  1. What DAY of the week is it?  1. Correct (1)  2. Incorrect (0)  2. What is the YEAR?  1. Correct (1)  2. Incorrect (0)  3. What is the name of the STATE we are in?  1. Correct (1)  2. Incorrect (0)  1. Lam going to tell you a story. Please listen carefully because afterwards, I'm going to ask you sor questions about it.  What was the female's name? (iiil) (2):		
No-Document Details in Notes   and the time at ten minutes to eleven o'clock.    Yes	4. Is the individual able to complete the SLUMS Exam?	orianswered/ Horie correct (0)
Hour markers correct (2);   Time correct (2);   Time correct (2);   Unanswered/ None Correct (0)		<ol><li>This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.</li></ol>
3.B. SLUMS QUESTIONNAIRE (Each score is beside the response.)  1. What DAY of the week is it?  1 - Correct (1)  2 - Incorrect (0)  1. Correct (1)  2 - Incorrect (1)  1. Correct (1)  2 - Incorrect (0)  1. Correct (1)  2 - Incorrect (0)  1. Correct (1)  2 - Incorrect (0)  1. Lam going to tell you a story. Please listen carefully because afterwards, I'm going to ask you sor questions about it.	res	Hour markers correct (2):
1. What DAY of the week is it?  1 - Correct (1) 2 - Incorrect (0)  2. What is the YEAR? 1 - Correct (1) 2 - Incorrect (0)  10a. Place an X in the triangle 1 - Correct (Triangle) (1) 2 - Incorrect (0)  10b. Which of the figures is the largest? 1 - Correct (Square) (1) 1 - Correct (Square) (1) 1 - Correct (0)  1 - Incorrect (0)  1 - Correct (1) 2 - Incorrect (0)  1 - Correct (Square) (1) 1 - Incorrect (0)  1 - Correct (0)  1 - Correct (O)  1 - Correct (Square) (1) 2 - Incorrect (0)  1 - Correct (0)  1 - Correct (O)  1 - Correct (Square) (1) 2 - Incorrect (0)	3.B. SLUMS QUESTIONNAIRE (Each score is beside the response.)	
1 - Correct (1) 2 - Incorrect (0)  1 - Correct (Triangle) (1) 2 - What is the YEAR? 1 - Correct (1) 2 - Incorrect (0)  1 - Correct (1) 2 - Incorrect (0)  1 - Correct (1) 2 - Incorrect (0)  1 - Correct (Square) (1) 2 - Incorrect (0)  1 - Correct (1) 2 - Incorrect (0)  1 - Correct (1) 2 - Incorrect (0)  1 - Correct (Square) (1) 2 - Incorrect (0)  1 - Correct (1) 2 - Incorrect (0)  1 - Correct (1) 2 - Incorrect (1) 2 - Incorrect (1) 2 - Incorrect (1) 3 - Correct (1) 4 - Correct (1) 3 - Correct (1) 3 - Correct (1) 4 - Correct (1) 3 - Correct (1) 4 - Correct (1) 3 - Correct (1) 4 - Correct (1) 3 - Correct (Square) (1) 4 - Correct (1) 3 - Correct (Square) (1) 4 - Correct (1) 3 - Correct (Square) (1) 4 - Correct (Square) (1) 4 - Correct (Square) (1) 4 - Correct (1) 5 - Correct (Square) (1) 5 - Correct (1) 5 -		<b>=</b>
2 - Incorrect (0)  2. What is the YEAR?  1 - Correct (1)  2 - Incorrect (0)  3. What is the name of the STATE we are in?  1 - Correct (1)  2 - Incorrect (0)  1 - Correct (Square) (1)  2 - Incorrect (0)  1 - Incorrect (0)		— Gridiswared, Note Correct (0)
2. What is the YEAR?  1 - Correct (1) 2 - Incorrect (0)  3. What is the name of the STATE we are in? 1 - Correct (1) 2 - Incorrect (0)  1. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you son questions about it.  What was the female's name? (1)(1)(2):		10a. Place an X in the triangle
1 - Correct (1) 2 - Incorrect (0)  3. What is the name of the STATE we are in? 1 - Correct (1) 2 - Incorrect (1) 2 - Incorrect (0)  1 - Correct (0)  1 - Correct (0)  1 - Incorrect (0)  1 - Correct (1) 2 - Incorrect (1) 2 - Incorrect (1) 3 - Incorrect (1) 4 - Incorrect (1) 3 - Incorrect (1) 4 - Incorrect (1) 3 - Incorrect (1) 4 - Incorrect (1) 4 - Incorrect (1) 5 - In	2 - Incorrect (0)	1 - Correct (Triangle) (1)
2 - Incorrect (0)  3. What is the name of the STATE we are in?  1 - Correct (1)  2 - Incorrect (0)  11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you son questions about it.  4. Please remember these five objects. I will ask you  What was the female's name? (1)(1)(2):	2. What is the YEAR?	2 - Incorrect (0)
2 - Incorrect (0)  3. What is the name of the STATE we are in?  1 - Correct (1)  2 - Incorrect (0)  11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you son questions about it.  4. Please remember these five objects. I will ask you  What was the female's name? (1)(1)(2):		10h Which of the figures is the largest?
3. What is the name of the STATE we are in?  1 - Correct (1) 2 - Incorrect (0)  1. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you son questions about it.  What was the female's name? (1ill) (2):		
1 - Correct (1) 2 - Incorrect (0)  1. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you son questions about it.  What was the female's name? (1)   (2)		
2 - Incorrect (0)  4. Please remember these five objects. I will ask you  The Tall going to tell you a story. Frease lister carefully because afterwards, I'm going to ask you sor questions about it.  What was the female's name? (lill) (2):		2 - Incorrect (0)
4. Please remember these five objects. I will ask you  questions about it.  What was the female's name? (lill) (2):		
4. Please remember these five objects. I will ask you What was the female's name? (1ill) (2)	2 - Incorrect (0)	
	4. Please remember these five objects. I will ask you	· <del>_</del>
what they are later. Apple, Pen, Tie, House, Car $\Longrightarrow$		
What state did she live in? (Illinois) (2);		
What work did she do? (Stockbroker) (2);		
	For Very have \$100 and year so to the store and have	When did she go back to work? (Kids were teenagers) (2)
5a. You have \$100 and you go to the store and buy a dozen apples for \$3 and a tricycle for \$20. How much		Unanswered/ None Correct (0)
did you spend?  3.C. SLUMS RESULTS		3.C. SLUMS RESULTS
1 - Correct (\$23) (1)	<u>·</u> ·	

1. SLUMS Total Score - This will be an INDICATOR	Emphysema Pulmonary Edema
2. Record the highest grade (1-12) the individual completed in school.	Respiratory Failure Other-Document Details in Notes
	2. Signs and symptoms of RESPIRATORY diagnoses:
3. Identify the highest educational degree that the	□ w
individual obtained.	None
High School Graduate/ or GED	Couch
Associate's Degree	Cough
Bachelor's Degree	Frequent Respiratory Infections Respiratory Failure
Graduate's Degree	Shortness of Breath
Doctoral's Degree	Wheezing
Other-Document Details in Notes	Other-Document Details in Notes
<ol><li>Care Manager's conclusion after completion of the individual's SLUMS Exam:</li></ol>	3. Current treatments for RESPIRATORY diagnoses:
Normal (HS 27+, Non HS 25+)	<u>_</u>
MNCD-Mild Neurocognitive Disorder (HS 21-26, Non HS 20-24)	None
	Medications-List in 9.D
Mild Dementia (HS 16-20, Non HS 15-19)	Oxygen
Moderate Dementia (HS 11-15, Non HS 11-14)	Respiratory Treatments (Nebulizers, Inhalants, etc.)
Severe Dementia (Any 10 or Less)	Suctioning
3.D. COGNITIVE FUNCTION	Tracheostomy/ Trach Care
1a. Does the individual exhibit any cognitive	Ventilator/ Vent Care
impairments?	Other-Document Details in Notes
No-Skip to 4.A.1	4. Do the RESPIRATORY diagnoses affect the
Yes-Complete 3.D	individual's ability to function?
	<u></u> No
1b. Does this impairment interfere with the individual's ability to function daily?	Yes-Document Details in Notes
No-Skip to 4.A.1	5. Who manages care of the RESPIRATORY
Yes-Document Details in Notes	condition(s)?
4 - Takka individual abla ta dinast/ annomica bia anno	Formal Support
1c. Is the individual able to direct/ supervise his own care with the impairment?	☐ Informal Support
No-Complete 3.D.1d	Primary Care Physician
Yes	Self
	Specialty Physician
1d. Does the individual have a representative who is able and willing to direct the individual's care because	Other-Document Details in Notes
of the impairment?	6. Does the individual need additional assistance in
∏ No	managing the care of the RESPIRATORY condition(s)?
Yes-Complete 3.D.1e	□No
1e. Document contact information (Name, Relationship,	Yes-Document Details in Notes
Phone Number, etc.) of the individual who is willing to	4.B. HEART/ CIRCULATORY SYSTEMS
supervise care. Additional space in Notes	4.B. HEART/ CIRCULATORT STSTEMS
4. DIAGNOSES	
4.A. RESPIRATORY	
1. Select all RESPIRATORY diagnoses:	
None-Skip to 4.B.1	
Asthma	
COPD-Chronic Obstructive Pulmonary Disease	

1. Select all HEART/ CIRCULATORY systems	4.C. GASTROINTESTINAL
diagnoses:	
None-Skip to 4.C.1	Select all GASTROINTESTINAL diagnoses:
A-Fib and other Dysrhythmia, Bradycardia, Tachycardia	None-Skip to 4.D.1
Anemia	Barrett's Esophagus
Ascites	Crohn's Disease
CAD-Coronary Artery Disease: including Angina, Myocardial	Diverticulitis
Infarction, ASHD	GERD
DVT-Deep Vein Thrombosis	Hernia
Heart Failure: including CHF, Pulmonary Edema	IBS-Irritable Bowel Syndrome
Hypertension	Laryngeal Reflux Disease
PE-Pulmonary Embolus	Other-Document Details in Notes
PVD/PAD (Peripheral Vascular or Artery Disease)	2. Signs and symptoms of GASTROINTESTIONAL
Other-Document Details in Notes	<ol><li>Signs and symptoms of GASTROINTESTIONAL diagnoses:</li></ol>
2. Signs and symptoms of the HEART/ CIRCULATORY	None
systems diagnoses:	Abdominal Pain
None	Bloated
Activity Intolerance	Constipation
Chest Pains	Diarrhea
Edema in Extremities	Flatulence
Fainting (Syncope)	Heartburn
Palpitations	Rectal Bleeding
Shortness of Breath	Other-Document Details in Notes
Skin Discoloration	Other-bocument betails in Notes
Weakness	3. Current treatments for GASTROINTESTINAL
Other-Document Details in Notes	diagnoses:
2 Comment to the control of the UEADT / CTDCUI ATODY	None
3. Current treatments for HEART/ CIRCULATORY systems diagnoses:	Aspiration Precautions
None	Feeding Tube-Document Type in Notes
Cardiac Rehabilitation	Medications-List in 9.D
Compression Device, TED Hose, Ace Bandage Wrap(s)	Ostomy-Document Type in Notes
Medications-List in 9.D	Speech Therapy
Pacemaker	TPN-Total Parenteral Nutrition
Special Diet	Other-Document Details in Notes
Other-Document Details in Notes	4. Do the GASTROINTESTINAL diagnoses affect the
Other-bocument betails in Notes	individual's ability to function?
4. Do the HEART/ CIRCULATORY systems diagnoses	☐ No
affect the individual's ability to function?	Yes-Document Details in Notes
□No	E Who manages care of the CASTROINTESTINAL
Yes-Document Details in Notes	5. Who manages care of the GASTROINTESTINAL condition(s)?
Tes-Document Details in Notes	Formal Support
5. Who manages care of the HEART/ CIRCULATORY	☐ Informal Support
systems condition(s)?	Primary Care Physician
Formal Support	Self
Informal Support	Specialty Physician
Primary Care Physician	Other-Document Details in Notes
Self	
Specialty Physician	6. Does the individual need additional assistance in
Other-Document Details in Notes	managing the care of the GASTROINTESTINAL
6. Does the individual need additional assistance in	condition(s)?
managing the care of the HEART/ CIRCULATORY	No
systems condition(s)?	Yes-Document Details in Notes
□ No	4.D. MUSCULOSKELETAL
Yes-Document Details in Notes	

1. MUSCULOSKELETAL diagnoses and/ or signs and	Incision (surgical)
symptoms of MUSCULOSKELETAL diagnoses:	Psoriasis
None-Skip to 4.E.1	Rash
Ambulatory Dysfunction	Ulcer
Arthritis-Document Type of Arthritis in Notes	Wound
Contracture(s)	Other-Document Details in Notes
Frequent Fractures	
Joint Deformity	2. Check ALL affected SKIN location(s):
Limited Range of Motion	Abdomen
Osteoporosis	Ankle(s)
Paraplegia	Arm(s)
Poor Balance	Back of Knee(s)
	Buttock(s)
Quadriplegia	Chest
Spasms	Face
Spinal Stenosis	Foot/ Feet
Weakness	Hip(s)
Other-Document Details in Notes	Leg(s)
2. Current treatments for MUSCULOSKELETAL	Lower Back
diagnoses::	Shoulder Blade(s)
None	Spine
Assistive Devices-Document Details in Notes	Tailbone
Brace(s)	
Cast	Other-Document Details in Notes
Elevate Legs	3. Identify the highest known ULCER STAGE.
Medication(s)-List in 9.D	0 - Unstageable
Physical/ Occupational therapy	1 - Stage 1 - Redness
Prosthesis(es)	2 - Stage 2 - Partial Skin Loss
Splint	3 - Stage 3 - Full Thickness
Traction	4 - Stage 4 - Muscle and/or Bone Exposed
Other-Document Details in Notes	5 - Unknown
Under-Document Details in Notes	
3. Do the MUSCULOSKELETAL diagnoses affect the	4. Signs and symptoms of the SKIN diagnoses:
individual's ability to function?	None
<u></u> No	Edema/ Swelling
	Edemay Swelling
Yes-Document Details in Notes	Excoriation
4. Who manages care of the MUSCULOSKELETAL	Excoriation
4. Who manages care of the MUSCULOSKELETAL condition(s)?	Excoriation Odor/ Drainage
4. Who manages care of the MUSCULOSKELETAL condition(s)?  Formal Support	Excoriation Odor/ Drainage Pain
4. Who manages care of the MUSCULOSKELETAL condition(s)?  Formal Support  Informal Support	Excoriation Odor/ Drainage Pain Redness/ Discoloration
4. Who manages care of the MUSCULOSKELETAL condition(s)?  Formal Support Informal Support Primary Care Physician	Excoriation Odor/ Drainage Pain Redness/ Discoloration Skin Tears Other-Document Details in Notes
4. Who manages care of the MUSCULOSKELETAL condition(s)?  Formal Support Informal Support Primary Care Physician Self	Excoriation Odor/ Drainage Pain Redness/ Discoloration Skin Tears Other-Document Details in Notes  Current treatments for SKIN diagnoses:
4. Who manages care of the MUSCULOSKELETAL condition(s)?  Formal Support Informal Support Primary Care Physician Self Specialty Physician	Excoriation Odor/ Drainage Pain Redness/ Discoloration Skin Tears Other-Document Details in Notes  Current treatments for SKIN diagnoses: None
4. Who manages care of the MUSCULOSKELETAL condition(s)?  Formal Support Informal Support Primary Care Physician Self	Excoriation Odor/ Drainage Pain Redness/ Discoloration Skin Tears Other-Document Details in Notes  5. Current treatments for SKIN diagnoses: None Debridement
4. Who manages care of the MUSCULOSKELETAL condition(s)?  Formal Support Informal Support Primary Care Physician Self Specialty Physician Other-Document Details in Notes  5. Does the individual need additional assistance in	Excoriation Odor/ Drainage Pain Redness/ Discoloration Skin Tears Other-Document Details in Notes  5. Current treatments for SKIN diagnoses: None Debridement Medications-List in 9.D
4. Who manages care of the MUSCULOSKELETAL condition(s)?  Formal Support Informal Support Primary Care Physician Self Specialty Physician Other-Document Details in Notes  5. Does the individual need additional assistance in managing the care of the MUSCULOSKELETAL	Excoriation Odor/ Drainage Pain Redness/ Discoloration Skin Tears Other-Document Details in Notes  5. Current treatments for SKIN diagnoses: None Debridement Medications-List in 9.D Pressure Relieving Devices
4. Who manages care of the MUSCULOSKELETAL condition(s)?  Formal Support Informal Support Primary Care Physician Self Specialty Physician Other-Document Details in Notes  5. Does the individual need additional assistance in managing the care of the MUSCULOSKELETAL condition(s)?	Excoriation Odor/ Drainage Pain Redness/ Discoloration Skin Tears Other-Document Details in Notes  5. Current treatments for SKIN diagnoses: None Debridement Medications-List in 9.D Pressure Relieving Devices Surgery
4. Who manages care of the MUSCULOSKELETAL condition(s)?  Formal Support Informal Support Primary Care Physician Self Specialty Physician Other-Document Details in Notes  5. Does the individual need additional assistance in managing the care of the MUSCULOSKELETAL condition(s)?  No	Excoriation Odor/ Drainage Pain Redness/ Discoloration Skin Tears Other-Document Details in Notes  5. Current treatments for SKIN diagnoses: None Debridement Medications-List in 9.D Pressure Relieving Devices Surgery Unna Boot(s)
4. Who manages care of the MUSCULOSKELETAL condition(s)?  Formal Support Informal Support Primary Care Physician Self Specialty Physician Other-Document Details in Notes  5. Does the individual need additional assistance in managing the care of the MUSCULOSKELETAL condition(s)?	Excoriation Odor/ Drainage Pain Redness/ Discoloration Skin Tears Other-Document Details in Notes  5. Current treatments for SKIN diagnoses: None Debridement Medications-List in 9.D Pressure Relieving Devices Surgery Unna Boot(s) Wound Dressing
4. Who manages care of the MUSCULOSKELETAL condition(s)?  Formal Support Informal Support Primary Care Physician Self Specialty Physician Other-Document Details in Notes  5. Does the individual need additional assistance in managing the care of the MUSCULOSKELETAL condition(s)?  No	Excoriation Odor/ Drainage Pain Redness/ Discoloration Skin Tears Other-Document Details in Notes  5. Current treatments for SKIN diagnoses: None Debridement Medications-List in 9.D Pressure Relieving Devices Surgery Unna Boot(s) Wound Dressing Wound Therapy
4. Who manages care of the MUSCULOSKELETAL condition(s)?  Formal Support Informal Support Primary Care Physician Self Specialty Physician Other-Document Details in Notes  5. Does the individual need additional assistance in managing the care of the MUSCULOSKELETAL condition(s)? No Yes-Document Details in Notes  4.E. SKIN	Excoriation Odor/ Drainage Pain Redness/ Discoloration Skin Tears Other-Document Details in Notes  5. Current treatments for SKIN diagnoses: None Debridement Medications-List in 9.D Pressure Relieving Devices Surgery Unna Boot(s) Wound Dressing
4. Who manages care of the MUSCULOSKELETAL condition(s)?    Formal Support   Informal Support   Primary Care Physician   Self   Specialty Physician   Other-Document Details in Notes  5. Does the individual need additional assistance in managing the care of the MUSCULOSKELETAL condition(s)?   No   Yes-Document Details in Notes  4.E. SKIN  1. Select all SKIN diagnoses:	Excoriation Odor/ Drainage Pain Redness/ Discoloration Skin Tears Other-Document Details in Notes  5. Current treatments for SKIN diagnoses: None Debridement Medications-List in 9.D Pressure Relieving Devices Surgery Unna Boot(s) Wound Dressing Wound Therapy
4. Who manages care of the MUSCULOSKELETAL condition(s)?  Formal Support Informal Support Primary Care Physician Self Specialty Physician Other-Document Details in Notes  5. Does the individual need additional assistance in managing the care of the MUSCULOSKELETAL condition(s)? No Yes-Document Details in Notes  4.E. SKIN	Excoriation Odor/ Drainage Pain Redness/ Discoloration Skin Tears Other-Document Details in Notes  5. Current treatments for SKIN diagnoses: None Debridement Medications-List in 9.D Pressure Relieving Devices Surgery Unna Boot(s) Wound Dressing Wound Therapy Wound VAC

6. Do the SKIN diagnoses affect the individual's ability to function?	No Yes-Document Details in Notes
No	
Yes-Document Details in Notes	5. Who manages care of the ENDOCRINE/ METABOLIC systems condition(s)?
7. Who manages care of the SKIN condition(s)?	Formal Support
Formal Support	Informal Support
Informal Support	Primary Care Physician
Primary Care Physician	Self
Self	Specialty Physician
Specialty Physician	Other-Document Details in Notes
Other-Document Details in Notes	
8. Does the individual need additional assistance in	6. Does the individual need additional assistance in managing the care of the ENDOCRINE/ METABOLIC
managing the care of the SKIN condition(s)?	systems condition(s)?
No	<u></u> No
Yes-Document Details in Notes	Yes-Document Details in Notes
4.F. ENDOCRINE/ METABOLIC SYSTEMS	4.G. GENITOURINARY
Select all ENDOCRINE/ METABOLIC systems	1. Select all GENITOURINARY diagnoses:
diagnoses:	None-Skip to 4.H.1
None-Skip to 4.G.1	Ascites
Ascites	Benign Prostatic Hypertrophy (BPH)
Cirrhosis	Bladder Disorders, including neurogenic or overactive bladder,
	urinary retention
Diabetes Mellitus (DM)-Insulin Dependent	Frequent Urinary Tract Infections (UTI)
Diabetes Mellitus (DM)-Non-Insulin Dependent	Renal Insufficiency/ Failure (ESRD)
Diabetic Neuropathy	Other-Document Details in Notes
Hypoglycemia	- Other Bottiment Bettins in Notes
Thyroid Disorder	2. Signs and symptoms of the GENITOURINARY
Other-Document Details in Notes	diagnoses:
2. Signs and symptoms of the ENDOCRINE/	None
METABOLIC systems diagnoses:	Abdominal Distention/ Bloated
None	☐ Bladder Spasms
Agitation	Frequent Urination
Anxiety	Incontinence
Blurred Vision	Low/ No Urine Output
Confusion	Painful/ Burning Urination
Frequent Urination	Urinary Retention
Increased Thirst	Other-Document Details in Notes
Lethargy	2 Current treatments for CENTTOLIBYARY 4:-
	3. Current treatments for GENITOURINARY diagnoses:
Slow Healing Sores	None
Sweating	
Other-Document Details in Notes	Catheter-Complete 4.G.4
3. Current treatments for ENDOCRINE/ METABOLIC	Dialysis
systems diagnoses:	Fluid Restrictions
None	Medications-List in 9.D
Blood Sugar Monitoring	Ostomy
Blood Transfusions	Other-Document Details in Notes
Medications-List in 9.D	_
Special Diet	
Other-Document Details in Notes	
outer bocament betails in notes	
4. Do the ENDOCRINE/ METABOLIC systems	

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diagnoses affect the individual's ability to function?

4. If the individual has a catheter, indicate the type.	Yes-Document Details in Notes
П. в. и и и и и и и и и и и и и и и и и и	5. Who manages care of the GYNECOLOGICAL
External/ Condom	condition(s)?
Indwelling	Formal Support
Straight Catheterization	Informal Support
Suprapubic	Primary Care Physician
Other-Document Details in Notes	Self
F. Do the CENTROLIDINARY discusses offert the	Specialty Physician
5. Do the GENITOURINARY diagnoses affect the individual's ability to function?	
No	Other-Document Details in Notes
	6. Does the individual need additional assistance in
Yes-Document Details in Notes	managing the care of the GYNECOLOGICAL
6. Who manages care of the GENITOURINARY	condition(s)?
condition(s)?	☐ No
Formal Support	Yes-Document Details in Notes
Informal Support	4.I. INFECTIONS/ IMMUNE SYSTEMS
Primary Care Physician	
Self	Select all INFECTION/ IMMUNE system diagnoses:
Specialty Physician	
Other-Document Details in Notes	None-Skip to 4.J.1
Other Bocument Betalls in Notes	AIDS Asymptomatic
7. Does the individual need additional assistance in	AIDS Symptomatic
managing the care of the GENITOURINARY	Hepatitis
condition(s)?	☐ HIV
∐ No	MRSA/ VRE/ C-Dif
Yes-Document Details in Notes	TB-Tuberculosis
4.H. GYNECOLOGICAL	Other-Document Details in Notes
	Other-bocument betails in Notes
Select all GYNECOLOGICAL diagnoses:	2. If HIV or AIDS is indicated in 4.I.1, has the
None-Skip to 4.I.1	individual ever had lab results of CD4 count under 400?
Abnormal Pap	□ Na
Abnormal Pap Breast Lumps	□ No
	Yes
Breast Lumps	
Breast Lumps  Diseases of the Uterus/ Cervix-Document Details in Notes	Yes Unknown
Breast Lumps  Diseases of the Uterus/ Cervix-Document Details in Notes  Prolapsed Uterus  Other-Document Details in Notes	Yes
Breast Lumps Diseases of the Uterus/ Cervix-Document Details in Notes Prolapsed Uterus Other-Document Details in Notes  2. Signs and symptoms of GYNECOLOGICAL	Yes Unknown  3. Signs and symptoms of the INFECTION/ IMMUNE
Breast Lumps Diseases of the Uterus/ Cervix-Document Details in Notes Prolapsed Uterus Other-Document Details in Notes  2. Signs and symptoms of GYNECOLOGICAL diagnoses:	Yes Unknown  3. Signs and symptoms of the INFECTION/ IMMUNE
Breast Lumps Diseases of the Uterus/ Cervix-Document Details in Notes Prolapsed Uterus Other-Document Details in Notes  2. Signs and symptoms of GYNECOLOGICAL diagnoses: None	Yes Unknown  3. Signs and symptoms of the INFECTION/ IMMUNE system conditions. Use Notes for additional text.
Breast Lumps Diseases of the Uterus/ Cervix-Document Details in Notes Prolapsed Uterus Other-Document Details in Notes  2. Signs and symptoms of GYNECOLOGICAL diagnoses: None Bleeding	Yes Unknown  3. Signs and symptoms of the INFECTION/ IMMUNE system conditions. Use Notes for additional text.  4. Current treatments for INFECTION/ IMMUNE
Breast Lumps Diseases of the Uterus/ Cervix-Document Details in Notes Prolapsed Uterus Other-Document Details in Notes  2. Signs and symptoms of GYNECOLOGICAL diagnoses: None Bleeding Bulging	Yes Unknown  3. Signs and symptoms of the INFECTION/ IMMUNE system conditions. Use Notes for additional text.
Breast Lumps Diseases of the Uterus/ Cervix-Document Details in Notes Prolapsed Uterus Other-Document Details in Notes  2. Signs and symptoms of GYNECOLOGICAL diagnoses: None Bleeding Bulging Discharge	Yes Unknown  3. Signs and symptoms of the INFECTION/ IMMUNE system conditions. Use Notes for additional text.  4. Current treatments for INFECTION/ IMMUNE system diagnoses:  None
Breast Lumps Diseases of the Uterus/ Cervix-Document Details in Notes Prolapsed Uterus Other-Document Details in Notes  2. Signs and symptoms of GYNECOLOGICAL diagnoses: None Bleeding Bulging Discharge Infection(s)	Yes Unknown  3. Signs and symptoms of the INFECTION/ IMMUNE system conditions. Use Notes for additional text.  4. Current treatments for INFECTION/ IMMUNE system diagnoses:  None Intravenous Therapy
Breast Lumps Diseases of the Uterus/ Cervix-Document Details in Notes Prolapsed Uterus Other-Document Details in Notes  2. Signs and symptoms of GYNECOLOGICAL diagnoses: None Bleeding Bulging Discharge Infection(s) Itching	Yes Unknown  3. Signs and symptoms of the INFECTION/ IMMUNE system conditions. Use Notes for additional text.  4. Current treatments for INFECTION/ IMMUNE system diagnoses:  None Intravenous Therapy Isolation
Breast Lumps Diseases of the Uterus/ Cervix-Document Details in Notes Prolapsed Uterus Other-Document Details in Notes  2. Signs and symptoms of GYNECOLOGICAL diagnoses: None Bleeding Bulging Discharge Infection(s) Itching Odor	Yes Unknown  3. Signs and symptoms of the INFECTION/ IMMUNE system conditions. Use Notes for additional text.  4. Current treatments for INFECTION/ IMMUNE system diagnoses: None Intravenous Therapy Isolation Laboratory result monitoring
Breast Lumps Diseases of the Uterus/ Cervix-Document Details in Notes Prolapsed Uterus Other-Document Details in Notes  2. Signs and symptoms of GYNECOLOGICAL diagnoses: None Bleeding Bulging Discharge Infection(s) Itching	Yes Unknown  3. Signs and symptoms of the INFECTION/ IMMUNE system conditions. Use Notes for additional text.  4. Current treatments for INFECTION/ IMMUNE system diagnoses: None Intravenous Therapy Isolation Laboratory result monitoring Medication(s)-List in 9.D
Breast Lumps Diseases of the Uterus/ Cervix-Document Details in Notes Prolapsed Uterus Other-Document Details in Notes  2. Signs and symptoms of GYNECOLOGICAL diagnoses: None Bleeding Bulging Discharge Infection(s) Itching Odor Other-Document Details in Notes	Yes Unknown  3. Signs and symptoms of the INFECTION/ IMMUNE system conditions. Use Notes for additional text.  4. Current treatments for INFECTION/ IMMUNE system diagnoses:  None Intravenous Therapy Isolation Laboratory result monitoring Medication(s)-List in 9.D Transfusion(s)
Breast Lumps Diseases of the Uterus/ Cervix-Document Details in Notes Prolapsed Uterus Other-Document Details in Notes  2. Signs and symptoms of GYNECOLOGICAL diagnoses: None Bleeding Bulging Discharge Infection(s) Itching Odor Other-Document Details in Notes	Yes Unknown  3. Signs and symptoms of the INFECTION/ IMMUNE system conditions. Use Notes for additional text.  4. Current treatments for INFECTION/ IMMUNE system diagnoses:  None Intravenous Therapy Isolation Laboratory result monitoring Medication(s)-List in 9.D Transfusion(s) Wound Therapy
Breast Lumps Diseases of the Uterus/ Cervix-Document Details in Notes Prolapsed Uterus Other-Document Details in Notes  2. Signs and symptoms of GYNECOLOGICAL diagnoses: None Bleeding Bulging Discharge Infection(s) Itching Odor Other-Document Details in Notes	Yes Unknown  3. Signs and symptoms of the INFECTION/ IMMUNE system conditions. Use Notes for additional text.  4. Current treatments for INFECTION/ IMMUNE system diagnoses:  None Intravenous Therapy Isolation Laboratory result monitoring Medication(s)-List in 9.D Transfusion(s)
Breast Lumps Diseases of the Uterus/ Cervix-Document Details in Notes Prolapsed Uterus Other-Document Details in Notes  2. Signs and symptoms of GYNECOLOGICAL diagnoses: None Bleeding Bulging Discharge Infection(s) Itching Odor Other-Document Details in Notes  3. Current treatments for GYNECOLOGICAL diagnoses:	Yes Unknown  3. Signs and symptoms of the INFECTION/ IMMUNE system conditions. Use Notes for additional text.  4. Current treatments for INFECTION/ IMMUNE system diagnoses:  None Intravenous Therapy Isolation Laboratory result monitoring Medication(s)-List in 9.D Transfusion(s) Wound Therapy
Breast Lumps Diseases of the Uterus/ Cervix-Document Details in Notes Prolapsed Uterus Other-Document Details in Notes  2. Signs and symptoms of GYNECOLOGICAL diagnoses: None Bleeding Bulging Discharge Infection(s) Itching Odor Other-Document Details in Notes  3. Current treatments for GYNECOLOGICAL diagnoses: None	Yes Unknown  3. Signs and symptoms of the INFECTION/ IMMUNE system conditions. Use Notes for additional text.  4. Current treatments for INFECTION/ IMMUNE system diagnoses:  None Intravenous Therapy Isolation Laboratory result monitoring Medication(s)-List in 9.D Transfusion(s) Wound Therapy Other-Document Details in Notes
Breast Lumps Diseases of the Uterus/ Cervix-Document Details in Notes Prolapsed Uterus Other-Document Details in Notes  2. Signs and symptoms of GYNECOLOGICAL diagnoses: None Bleeding Bulging Discharge Infection(s) Itching Odor Other-Document Details in Notes  3. Current treatments for GYNECOLOGICAL diagnoses: None Medications-List in 9.D	Yes
Breast Lumps   Diseases of the Uterus/ Cervix-Document Details in Notes   Prolapsed Uterus   Other-Document Details in Notes    2. Signs and symptoms of GYNECOLOGICAL diagnoses:   None   Bleeding   Bulging   Discharge   Infection(s)   Itching   Odor   Other-Document Details in Notes    3. Current treatments for GYNECOLOGICAL diagnoses:   None   Medications-List in 9.D   Sitz Bath   Other-Document Details in Notes	Yes
Breast Lumps Diseases of the Uterus/ Cervix-Document Details in Notes Prolapsed Uterus Other-Document Details in Notes  2. Signs and symptoms of GYNECOLOGICAL diagnoses: None Bleeding Bulging Discharge Infection(s) Itching Odor Other-Document Details in Notes  3. Current treatments for GYNECOLOGICAL diagnoses: None Medications-List in 9.D Sitz Bath Other-Document Details in Notes  4. Do the GYNECOLOGICAL diagnoses affect the	Yes
Breast Lumps Diseases of the Uterus/ Cervix-Document Details in Notes Prolapsed Uterus Other-Document Details in Notes  2. Signs and symptoms of GYNECOLOGICAL diagnoses: None Bleeding Bulging Discharge Infection(s) Itching Odor Other-Document Details in Notes  3. Current treatments for GYNECOLOGICAL diagnoses: None Medications-List in 9.D Sitz Bath Other-Document Details in Notes	Yes

6. Who manages care of the INFECTION/ IMMUNE	Sarcoma
system condition(s)?	Skin
Formal Support	Testicular
☐ Informal Support	Throat
Primary Care Physician	
Self	Thyroid
	Uterine
Specialty Physician	Vaginal
Other-Document Details in Notes	Other-Document Details in Notes
7. Does the individual need additional assistance in	4. Signs and symptoms of the CANCER diagnoses:
managing the care of the INFECTIONS/ IMMUNE	None
system condition(s)?	Abdominal distention
∐ No	Anemia
Yes-Document Details in Notes	Anorexia
4.J. CANCER	Anxiety
	Ascites
1. Does the individual have any current CANCER	Cachexia
diagnoses?	Confusion
No-Skip to 4.K.1	Constipation
Yes	Cough
2. If Yes, identify the STAGE of CANCER:	Diaphoresis
0 - Unstageable	
1 - Stage 1	Diarrhea
2 - Stage 2	Disorientation
3 - Stage 3	Dysphagia (choking)
4 - Stage 4	Dyspnea at rest
5 - Unknown	Dyspnea upon exertion
5 - OTIKNOWN	Edema
3. Select all current CANCER diagnoses:	Fatigue
Basal Cell	Hallucinations
Bile Duct	Hematuria
Bladder	Insomnia
Bone	Jaundice
Brain	Loss of appetite
Breast	Lymphedema
Cervical	Mental status changes
Colon	Nausea
Colorectal	Oral thrush
Endometrial	Pain
Esophageal	Special diet
Gallbladder	Terminal/ end stage dx
	Vomiting
Gastric	Weakness
Hodgkin's Disease	Weight loss
Kidney	
Leukemia	Other-Document Details in Notes
Liver	
Lung	
Lymphatic	
Multiple Myeloma	
Non-Hodgkin's Lymphoma	
Oral	
Ovarian	
Pancreatic	

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5. Current treatments for CANCER diagnoses:	Choking
None	Congestion
Aspiration Precautions	Difficulty Breathing
Bone Marrow Transplant	Difficulty Swallowing
Chemo/ Radiation Combination	Dizziness
Chemotherapy	Fullness/ Pressure in Head/ Sinuses
Hospice Care	Headaches
Indwelling Catheter/ Services	Hearing Loss
Maintenance/ Preventative Skin Care	Hoarseness
Medications-List in 9.D	Persistent Cough
Occupational Therapy	Other-Document Details in Notes
Ostomy/ Related Services	
Oxygen	3. Current treatments for ENT diagnoses:
Palliative Care	None
Physical Therapy	Esophageal Dilatation
Radiation	Feeding Tube
Respiratory Therapy	Hearing Aid
Restorative Care	Implants
Speech Therapy	Medications-List in 9.D
Suctioning	Tracheostomy
Surgery	Other-Document Details in Notes
Transfusion(s)	4. Do the ENT diagnoses affect the individual's ability
Tube Feedings/ TPN	to function?
Other-Document Details in Notes	☐ No
<u> </u>	Yes-Document Details in Notes
6. Do the CANCER diagnoses affect the individual's	5. Who manages care of the ENT condition(s)?
ability to function?	Formal Support
No	Informal Support
	Informal Support
Yes-Document Details in Notes	Primary Care Physician
7. Who manages care of the CANCER condition(s)?	Primary Care Physician
7. Who manages care of the CANCER condition(s)?	Self
7. Who manages care of the CANCER condition(s)?  Formal Support	Self Specialty Physician
7. Who manages care of the CANCER condition(s)?    Formal Support   Informal Support	Self Specialty Physician Other
7. Who manages care of the CANCER condition(s)?  Formal Support Informal Support Primary Care Physician	Self Specialty Physician Other  6. Does the individual need additional assistance in
7. Who manages care of the CANCER condition(s)?  Formal Support Informal Support Primary Care Physician Self	Self Specialty Physician Other  6. Does the individual need additional assistance in managing the care of the ENT condition(s)?
7. Who manages care of the CANCER condition(s)?  Formal Support Informal Support Primary Care Physician Self Specialty Physician	Self Specialty Physician Other  6. Does the individual need additional assistance in managing the care of the ENT condition(s)?  No
7. Who manages care of the CANCER condition(s)?  Formal Support Informal Support Primary Care Physician Self	Self Specialty Physician Other  6. Does the individual need additional assistance in managing the care of the ENT condition(s)?
7. Who manages care of the CANCER condition(s)?  Formal Support Informal Support Primary Care Physician Self Specialty Physician	Self Specialty Physician Other  6. Does the individual need additional assistance in managing the care of the ENT condition(s)?  No
7. Who manages care of the CANCER condition(s)?  Formal Support Informal Support Primary Care Physician Self Specialty Physician Other-Document Details in Notes	Self Specialty Physician Other  6. Does the individual need additional assistance in managing the care of the ENT condition(s)? No Yes-Document Details in Notes  4.L. EYES
7. Who manages care of the CANCER condition(s)?  Formal Support Informal Support Primary Care Physician Self Specialty Physician Other-Document Details in Notes  8. Does the individual need additional assistance in	Self Specialty Physician Other  6. Does the individual need additional assistance in managing the care of the ENT condition(s)? No Yes-Document Details in Notes  4.L. EYES  1. What EYE diagnoses/ disorders have been
7. Who manages care of the CANCER condition(s)?  Formal Support Informal Support Primary Care Physician Self Specialty Physician Other-Document Details in Notes  8. Does the individual need additional assistance in managing the care of the CANCER condition(s)?	Self Specialty Physician Other  6. Does the individual need additional assistance in managing the care of the ENT condition(s)? No Yes-Document Details in Notes  4.L. EYES
7. Who manages care of the CANCER condition(s)?    Formal Support   Informal Support   Primary Care Physician   Self   Specialty Physician   Other-Document Details in Notes  8. Does the individual need additional assistance in managing the care of the CANCER condition(s)?	Self Specialty Physician Other  6. Does the individual need additional assistance in managing the care of the ENT condition(s)? No Yes-Document Details in Notes  4.L. EYES  1. What EYE diagnoses/ disorders have been confirmed and documented by health/ medical
7. Who manages care of the CANCER condition(s)?    Formal Support   Informal Support   Primary Care Physician   Self   Specialty Physician   Other-Document Details in Notes  8. Does the individual need additional assistance in managing the care of the CANCER condition(s)?   No   Yes-Document Details in Notes	Self Specialty Physician Other  6. Does the individual need additional assistance in managing the care of the ENT condition(s)? No Yes-Document Details in Notes  4.L. EYES  1. What EYE diagnoses/ disorders have been confirmed and documented by health/ medical professionals?
7. Who manages care of the CANCER condition(s)?    Formal Support   Informal Support   Primary Care Physician   Self   Specialty Physician   Other-Document Details in Notes  8. Does the individual need additional assistance in managing the care of the CANCER condition(s)?   No   Yes-Document Details in Notes	Self Specialty Physician Other  6. Does the individual need additional assistance in managing the care of the ENT condition(s)?  No Yes-Document Details in Notes  4.L. EYES  1. What EYE diagnoses/ disorders have been confirmed and documented by health/ medical professionals?  None-Skip to 4.M.1
7. Who manages care of the CANCER condition(s)?    Formal Support   Informal Support   Primary Care Physician   Self   Specialty Physician   Other-Document Details in Notes  8. Does the individual need additional assistance in managing the care of the CANCER condition(s)?   No   Yes-Document Details in Notes  4.K. EARS, NOSE & THROAT (ENT)	Self Specialty Physician Other  6. Does the individual need additional assistance in managing the care of the ENT condition(s)? No Yes-Document Details in Notes  4.L. EYES  1. What EYE diagnoses/ disorders have been confirmed and documented by health/ medical professionals? None-Skip to 4.M.1 Blindness
7. Who manages care of the CANCER condition(s)?    Formal Support	Self Specialty Physician Other  6. Does the individual need additional assistance in managing the care of the ENT condition(s)? No Yes-Document Details in Notes  4.L. EYES  1. What EYE diagnoses/ disorders have been confirmed and documented by health/ medical professionals? None-Skip to 4.M.1 Blindness Cataracts  Cataracts
7. Who manages care of the CANCER condition(s)?    Formal Support	Self Specialty Physician Other  6. Does the individual need additional assistance in managing the care of the ENT condition(s)?  No Yes-Document Details in Notes  4.L. EYES  1. What EYE diagnoses/ disorders have been confirmed and documented by health/ medical professionals?  None-Skip to 4.M.1 Blindness Cataracts Glaucoma
7. Who manages care of the CANCER condition(s)?    Formal Support	Self Specialty Physician Other  6. Does the individual need additional assistance in managing the care of the ENT condition(s)?  No Yes-Document Details in Notes  4.L. EYES  1. What EYE diagnoses/ disorders have been confirmed and documented by health/ medical professionals?  None-Skip to 4.M.1 Blindness Cataracts Glaucoma Legally Blind
7. Who manages care of the CANCER condition(s)?    Formal Support   Informal Support   Primary Care Physician   Self   Specialty Physician   Other-Document Details in Notes  8. Does the individual need additional assistance in managing the care of the CANCER condition(s)?   No   Yes-Document Details in Notes  4.K. EARS, NOSE & THROAT (ENT)  1. Select all ENT diagnoses:   None-Skip to 4.L.1   Deafness   Deviated Septum	Self Specialty Physician Other  6. Does the individual need additional assistance in managing the care of the ENT condition(s)? No Yes-Document Details in Notes  4.L. EYES  1. What EYE diagnoses/ disorders have been confirmed and documented by health/ medical professionals? None-Skip to 4.M.1 Blindness Cataracts Glaucoma Legally Blind Macular Degeneration
7. Who manages care of the CANCER condition(s)?    Formal Support	Self Specialty Physician Other  6. Does the individual need additional assistance in managing the care of the ENT condition(s)? No Yes-Document Details in Notes  4.L. EYES  1. What EYE diagnoses/ disorders have been confirmed and documented by health/ medical professionals? None-Skip to 4.M.1 Blindness Cataracts Glaucoma Legally Blind Macular Degeneration Partially Sighted/ Low Vision
7. Who manages care of the CANCER condition(s)?    Formal Support	Self Specialty Physician Other  6. Does the individual need additional assistance in managing the care of the ENT condition(s)?  No Yes-Document Details in Notes  4.L. EYES  1. What EYE diagnoses/ disorders have been confirmed and documented by health/ medical professionals?  None-Skip to 4.M.1 Blindness Cataracts Glaucoma Legally Blind Macular Degeneration Partially Sighted/ Low Vision Retinal Detachment
7. Who manages care of the CANCER condition(s)?    Formal Support	Self Specialty Physician Other  6. Does the individual need additional assistance in managing the care of the ENT condition(s)?  No Yes-Document Details in Notes  4.L. EYES  1. What EYE diagnoses/ disorders have been confirmed and documented by health/ medical professionals?  None-Skip to 4.M.1 Blindness Cataracts Glaucoma Legally Blind Macular Degeneration Partially Sighted/ Low Vision Retinal Detachment

2. Signs and symptoms for EYE conditions and/ or diagnoses:	Thrush Other-Document Details in Notes
None	- Other Bocument Betalls in Notes
Double /Blurred Vision	4. Do the MOUTH diagnoses affect the individual's
Dry Eye	ability to function?
☐ Itching	No
Redness	Yes-Document Detail in Notes
Other-Document Details in Notes	5. Who manages care of the MOUTH condition(s)?
3. Current treatments for EYE conditions and/ or	Formal Support
diagnoses:	Informal Support
None	Primary Care Physician
Corrective Lenses	Self
Corrective Surgery	Specialty Physician
Medications-List in 9.D	Other-Document Detail in Notes
Other-Document Details in Notes	6. Does the individual need additional assistance in
4. Do the EYE diagnoses affect the individual's ability	managing the care of the MOUTH conditions?
to function?	∐ No
No	Yes-Document Details in Notes
Yes-Document Detail in Notes	5. NEUROLOGICAL (MANDATORY completion of Section 8 if Neurological diagnosis)
5. Who manages care of the EYE condition(s)?	5.A. NEUROLOGICAL
Formal Support	
☐ Informal Support	1. If there are NEUROLOGICAL diagnoses, select all
Primary Care Physician	types & completion of Section 8 (Behaviors) is
Self	MANDATORY.
Specialty Physician	None-Skip to 6.A.1
Other-Document Detail in Notes	ALS
	Alzheimer's Disease
6. Does the individual need additional assistance in	Autism
managing the care of the EYE condition(s)?	Cerebral Palsy
∐ No	CVA/ TIA/ Stroke
Yes-Document Details in Notes	Dementia (Include all Non-Alzheimer's Dementia)
4.M. MOUTH	Multiple Sclerosis
	Muscular Dystrophy
<ol> <li>Select all MOUTH conditions and/ or diagnoses:</li> </ol>	Parkinson's Disease
None-Skip to 5.A.1	Neuropathy
Dry Mouth	Seizure Disorder
Edentulous/ Toothless	
Gingivitis	☐ TBI-Traumatic Brain Injury
☐ Thrush	Other-Document Details in Notes
Ulcer(s)	2. What characteristics describe the individual's
Other-Document Details in Notes	COGNITIVE state?
Other-Document Details in Notes	Appears to be cognitively intact
2. Current treatments for MOUTH conditions and/ or	Executive functioning impaired-Document Details in Notes
diagnoses:	Inability to adapt to changes in routine or location
None	Inability to follow commands
Dental Hygiene	Non-communicative
Medications-List in 9.D	Poor long term memory
Other-Document Details in Notes	
	Poor short term memory
3. Signs and symptoms of MOUTH conditions and/ or	Slow response to questions
diagnoses:	Other-Document Details in Notes
None	
Halitosis	
Pain	
Swelling	

3. Signs and symptoms of NEUROLOGICAL diagnoses:	2. Is the individual able to self-manage care of the
	IDD condition?
None	No
Ambulation Dysfunction	Yes
Aphasia	Unable to Determine
Fatigue	3. Does the IDD diagnosis affect the individual's
Muscle Spasticity/ Stiffness	ability to function?
Pain	No
Poor Balance	Yes
Rigidity	Unable to Determine
Shuffling Gait	7. MENTAL HEALTH (MANDATORY completion of Section 8 if
Spasms	Psychiatric diagnosis)
Tremors/ Twitches	7.A. PSYCHIATRIC
Other-Document Details in Notes	
4. Current treatments for NEUROLOGICAL diagnoses:	<ol> <li>If there are PSYCHIATRIC diagnoses, select all types &amp; completion of Section 8 (Behaviors) is</li> </ol>
None	MANDATORY.
Braces	None-Skip to 7.B.1
Cervical Collar	Anxiety Disorders
Cognitive/ Behavioral Therapy	Bipolar Disorders
Electrical Stimulation Device	Depressive Disorders
Medications-List in 9.D	Disruptive Impulse Control/ Conduct Disorders
Seizure Precautions	Eating Disorders
Therapy-Document Details in Notes	Obsessive Compulsive Disorders
Traction	Personality Disorders
Other-Document Details in Notes	Schizophrenia/ Other Psychotic Disorders
Outer Bocument Betails in Notes	Sleep/ Wake disorders
5. Do the NEUROLOGICAL diagnoses affect the	Somatic Symptom/ Related Disorders
individual's ability to function?	Trauma/ Stress/ Related Disorders
□ No	Other-Document Details in Notes
Yes-Document Detail in Notes	2. Signs and Symptoms of PSYCHIATRIC conditions:
6. Who manages care of the NEUROLOGICAL	•
condition(s)?	None
Formal Support	Exhibits Other Unusual Behavior-Document Details in Notes
Informal Support	Experiences Sleep Disturbances
Primary Care Physician	Experiencing Hallucinations/ Delusions
Self	Fearful/ Suspicious
Specialty Physician	Feels Depressed, Sad or Hopeless
Other-Document Detail in Notes	Feels Lonely
7. Does the individual need additional assistance in	☐ Irritable/ Easily Upset
managing the care of the NEUROLOGICAL condition(s)?	Physically/ Verbally Abusive
_	Withdrawn/ Lethargic
<u></u> No	Worried/ Anxious
Yes-Document Details in Notes	Other-Document Details in Notes
. INTELLECTUAL DEVELOPMENTAL DISABILITY (IDD) MANDATORY completion of Section 8 if IDD diagnosis)	3. Current treatments for PSYCHIATRIC diagnoses:
6.A. INTELLECTUAL DEVELOPMENTAL DISABILITY (IDD)	None
	ECT-Electroconvulsive Therapy
Does the individual have a diagnosis of Intellectual  Burdenment   Directific (TDD) from birth to 22 december	Medications-List in 9.D
Developmental Disability (IDD) from birth to 22nd birthday or known to the ID system?	Outpatient Psychiatric Care
bit and y or another to the 10 system:	Other-Document Details in Notes
No-Skip to 7.A.1	
Vec-Completion of Section & (Rehaviors) is MANDATORY	

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4. Do the PSYCHIATRIC diagnoses affect the	Hair pulling
individual's ability to function?	Hitting
☐ No	Kicking
Yes-Document Detail in Notes	Picking
- CH POVOUTATRIO	Scratching
<ol><li>Who manages care of the PSYCHIATRIC condition(s)?</li></ol>	Sexual acting out/ behavior
<u> </u>	
Formal Support	Spitting  Other Decument Petrile in Notes
Informal Support	Other-Document Details in Notes
Primary Care Physician	2c. Does the aggressive PHYSICAL behavior toward
Self	OTHERS interfere with the individual's ability to
Specialty Physician	function daily?
Other-Document Detail in Notes	No-Document in Notes why the behavior does NOT interfere.
6. Does the individual need additional assistance in	Yes-Document in Notes how it interferes.
managing the care of the PSYCHIATRIC condition(s)?	22. Doos the individual exhibit aggressive PHYSICAL
managing the care of the Forest Managing	3a. Does the individual exhibit aggressive PHYSICAL behavioral symptoms towards SELF?
□No	No-Skip to 8.A.4a
Yes-Document Details in Notes	Yes-Complete 8.A.3b-c
	Tes-complete 8.A.3b-c
7.B. SUICIDE SCREENING	3b. Specify ALL types of aggressive PHYSICAL behavior
4. Have you they also the bout bout in a converte or taking	towards SELF (If not listed, document in Notes.)
<ol> <li>Have you thought about hurting yourself or taking your life in the PAST 30 DAYS?</li> </ol>	_
No	Biting
	Hair pulling
Yes-Complete Aging Suicide Risk Assessment	Hitting
Individual Refused to Answer	Kicking
2. When did you have these thoughts, and do you have	Picking
a plan to take your life?	Scratching
No	Spitting
Yes-Document Details in Notes	Other-Document Details in Notes
Individual Refused to Answer	- Other Document Details in Motes
	3c. Does the aggressive PHYSICAL behavior toward
3. Have you ever had a suicide attempt?	SELF interfere with the individual's ability to function
<u></u> No	daily?
Yes-Document Details in Notes	No-Document in Notes why the behavior does NOT interfere.
Individual Refused to Answer	Yes-Document in Notes how it interferes.
8. BEHAVIORS - MANDATORY if Neurological, IDD or Psychiatric	4a. Does the individual exhibit aggressive VERBAL
Diagnosis	behavior symptoms toward OTHERS?
8.A. BEHAVIORS	No-Skip to 8.A.5a
	Yes-Complete 8.A.4b-c
1. Does the individual present with any BEHAVIORAL	
signs/ symptoms? This Section is REQUIRED if any	4b. Specify ALL types of aggressive VERBAL behavior
Neurologic, IDD or Psychiatric Diagnoses were noted in	towards OTHERS (If not listed, document in Notes.)
Section 5, 6 or 7.	Curcing
No-Skip to 8.B.1	Cursing
Yes-Completion of Section 8-Behaviors is MANDATORY.	Screaming
Unable to Determine-Completion of Section 8-Behaviors is	Threatening
MANDATORY.	Other-Document Details in Notes
2a. Does the individual exhibit PHYSICAL behavioral	4c. Does the aggressive VERBAL behavior toward
symptoms toward OTHERS?	OTHERS interfere with the individual's ability to
No-Skip to 8.A.3a	function daily?
Yes-Complete 8.A.2b-c	No-Document in Notes why the behavior does NOT interfere.
	Yes-Document in Notes how it interferes.
2b. Specify ALL types of aggressive PHYSICAL behavior	
toward OTHERS (If not listed, document in Notes.)	
□ paine	
Biting	

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5a. Does the individual exhibit any GENERAL aggressive VERBAL behavior symptoms not specifically directed toward self or others?  No-Skip to 8.A.6a Yes-Complete 8.A.5b-c	5. Do you drink or use other substances alone? (Do you live alone? Feel lonely?)  No Yes-Document Details in Notes
5b. Select ALL GENERAL aggressive VERBAL behaviors (If not listed, document in Notes.)  Disruptive sounds Yelling out Other-Document Details in Notes	<ul> <li>6. Have you ever felt remorse (regret) after you've drank or used other substance?  No Yes-Document Details in Notes</li> <li>7. Do you believe that your drinking or use of other</li> </ul>
5c. Does the GENERAL aggressive VERBAL behavior interfere with the individual's ability to function daily?  No-Document in Notes why the behavior does NOT interfere.  Yes-Document in Notes how it interferes.	substances is causing a financial burden or decline?  No Yes-Document Details in Notes  8. Do you find your ambition (effort to get up and do things each day) has declined since drinking or using
6a. Does the individual exhibit any OTHER behavioral symptoms?  No-Skip to 8.B.1 Yes-Complete 8.A.6b-c	other substances?  No Yes-Document Details in Notes  9. Do you find yourself replacing meals with either an
6b. Specify ALL OTHER types of behaviors reported (If not listed, document in Notes.)  Fecal Smearing Hoarding Pacing Public Disrobing Rummaging	alcoholic drink or another substance?  No Yes-Document Details in Notes  10. Does drinking or use of other substances cause you to have difficulty sleeping?  No Yes-Document Details in Notes
Sundowner's Syndrome Other-Document Details in Notes  6c. Do the OTHER types of behaviors interfere with the individual's ability to function daily?  No-Document in Notes why the behavior does NOT interfere. Yes-Document in Notes how it interferes.	11. Do you drink to escape (getaway from) worries or troubles?  No Yes-Document Details in Notes  12. Do you find yourself more depressed since drinking
1. Has anyone ever expressed concern about your use of alcohol or drugs?  No- Skip to Section 9.A.1	or using other substances?  No Yes-Document Details in Notes  13. Are you having memory problems due to drinking or use of other substances?
Yes-Document Details in Notes and Complete Section 8.8  2. Do you find yourself missing work, family events, activities that you once participated in due to over use of a substance?  No Yes-Document Details in Notes	No Yes-Document Details in Notes  14. Have you spoken to your doctor about drinking or use of other substances?  No Yes-Document Details in Notes
<ul> <li>3. Is drinking or use of other substances making your home life unhappy?  No Yes-Document Details in Notes</li> <li>4. Do you find yourself reaching for an alcoholic drink</li> </ul>	15. Have you ever been treated in a hospital, rehabilitation center or by a doctor for drinking or other substance use?  No Yes-Document Details in Notes
or other substance to get you through an event or interaction with certain people?  No Yes-Document Details in Notes	9. OTHER MEDICAL INFORMATION  9.A. INFORMATION

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1. Has the individual exhibited ELOPEMENT behavior in the LAST 6 MONTHS? If so, indicate the	6. Frailty Score indicator WILL go here
FREQUENCY.	9.C. DEPRESSION /LIFE SATISFACTION
Never	5.C. DEFRESSION / LITE SATISTACTION
Less than once a month	Are you basically satisfied with your life?
Once a month	□ No
Several times a month	Yes
Several times a week	
Daily	2. Do you often get bored?
Other-Document Details in Notes	□ No
2. Does the individual require supervision?	Yes
No-Skip to 9.A.4	3. Do you often feel hopeless?
Yes-Complete 9.A	No
	Yes
2a. How long can the individual be routinely left alone?	
	4. Do you prefer to stay at home, rather than going out and doing new things?
Indefinitely	
Entire day and overnight	Yes
Eight (8) hours or more - day or night	
Eight (8) hours or more - daytime only	5. Do you ever have feelings of worthlessness?
Four (4) hours or more - day or night	☐ No
Four (4) hours or more - daytime only	Yes
Less than four (4) hours	6. Depression/ Life Satisfaction indicator WILL go
Cannot be left alone	here
3. Why does the individual require supervision?	
Cognitive diagnosis	9.D. MEDICATION MANAGEMENT
Environmental issue	, , , , , , , , , , , , , , , , , , ,
General physical condition	Does the individual take any PRESCRIBED
Other-Document Details in Notes	Medications?
	No-Skip to 9.D.6
4. Can the individual evacuate their home in the event of a fire?	Yes
No-See Section 17 Emergency Information	2. Does the individual have a central venous line?
Yes	□ No
	Yes-Document Type & Details in Notes
9.B. FRAILTY SCORE	
1. Are you tired?	
□ No	
Yes	
<u> </u>	
2. Can you walk up a flight of stairs?	
No	
Yes	
3. Can you walk a city block (250-350 feet)?	
No	
Yes	
4. Do you have more than 5 illnesses?	
<u></u> No	
Yes	
5. Have you lost more than 5% of your weight in the	
last year?	
No	
Yes	

3. List all PRESCRIBED medications taken by the	8. What is the individual's ability level to manage
individual:	medication?
<b>a. Name and Dose:</b> Record the name of the medication and dose ordered.	1 - Independent-Skip to 9.D.11
<b>b. Form:</b> Code the route of administration using the following list:	2 - Limited Assistance
1 = by mounth (PO) $7 = topical$ $2 = sub lingual (SL)$ $8 = inhalation$	3 - Total Assistance
3 = intramuscular (IM) 9 = enteral tube 4 = intravenous (IV) 10 = other 5 = subcutaneous (SQ) 11 = eye drop 6 = rectal (R) 12 = transdermal	9. If Limited Assistance, indicate ALL types needed for MEDICATION MANAGEMENT:
d. Frequency: Code the number of times per period the med is administered using the following list:	Assistance with Self-Injections/ Independent with Oral Medications
	Coaxing
PR = (PRN) as necessary $OO = $ every other day $1H = (QH)$ every hour $1W = (Q  week)$ once each week	Medication Dispenser
2H = (Q2H) every 2 hours $2W = 2$ times every week $3H = (Q3H)$ every 3 hours $3W = 3$ times every week	Set-up/ Prepackaged
4H = (Q4H) every 4 hours $4W = 4$ times each week $6H = (Q6H)$ every 6 hours $5W = 5$ times each week	Verbal Reminders
8H = (Q8H) every eight hours $6W = 6$ times each week $1D = (QD  or HS)$ once daily $1M = (Q  month)$ once/mo.	Other-Document Details in Notes
2D = (BID) two times daily 2M = twice every month  (includes every 12 hours) C = Continuous  3D = (TID) 3 times daily O = Other  4D = (QID) four times daily	10. Who assists the individual with medication administration?
(4-7-1-1-1-1)	Formal Support-Document Details in Notes
a. Name and Dose b. Form c. # Taken d. Freq e. Comments	Informal Support-Document Details in Notes
<u> </u>	Other-Document Details in Notes
4. Does the individual take all medications as	11. Does the individual use herbs or other remedies?
prescribed?	□No
No-Document Details in Notes	Yes-Document Details in Notes.
Yes	12. Pharmacy Information (Name, Phone, etc.)
5. Does the individual know what medication they take and why? Document Details in Notes  No Yes Unable to Determine	9.E. HEIGHT/WEIGHT  1. What is the individual's height?
6. List all OVER THE COUNTER (OTC) medications taken by the individual:  a. Name and Dose: Record the name of the medication and dose ordered.	2. What is the individual's weight?
1 = by mounth (PO) 2 = sub lingual (SL) 3 = intramuscular (IM) 4 = intravenous (IV) 5 = subcutaneous (SQ) 6 = rectal (R) 7 = topical 8 = inhalation 9 = enteral tube 10 = other 11 = eye drop 12 = transdermal	3. Has the individual lost or gained at least 10 pounds or more in the LAST 6 MONTHS? Document Details in Notes  No-Skip to 9.E.6  Yes, gained 10 pounds or more
<b>d. Frequency:</b> Code the number of times per period the med is administered using the following list:	Yes, lost 10 pounds or more
PR = (PRN) as necessary  1H = (QH) every hour  2H = (Q2H) every 2 hours  3H = (Q3H) every 3 hours  4H = (Q4H) every 4 hours  6H = (Q6H) every 6 hours  8H = (Q8H) every eight hours  1D = (QD or HS) once daily  2D = (BID) two times daily  (Includes every 12 hours)  3D = (TID) 3 times daily  4D = (QID) four times daily  4D = (QID) four times daily  OO = every other day  1W = (Q week) once each week  2W = 2 times every week  3W = 3 times every week  5W = 5 times each week  6W = 6 times each week  1M = (Q month) once/mo.  2M = twice every month  C = Continuous  O = Other	Don't know  4. Reason(s) for weight gain or loss:  Diet/ Intentional Fluid Loss Fluid Retention Increased Appetite Poor Appetite Unable to Determine
a. Name and Dose b. Form c. # Taken d. Freq e. Comments	Other
-	
7. Does the individual have any allergies or adverse reactions to any medication?  No Yes-Document Details in Notes	5. Is physician aware of the weight change?  No Yes

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6. What is the individual's weight type?	Massage
Normal-height/ weight appropriate	Medications-List in 9.D
Morbidly Obese	Pain Management Center
Obese	Physical Therapy
Overweight	Other-Document Details in Notes
Underweight	6. PAIN Management
PAIN	No pain treatment
	Treated, full relief
. Does the individual report PAIN?	Treated, partial relief
No-Skip to 10.A.1a	Treated, no or minimal relief
Yes	— Treated, no or minima relief
Unable to determine-Skip to 10.A.1a	7. Does PAIN affect the individual's ability to function
. Location(s) of PAIN site(s)	No
Back	Yes-Document Detail in Notes
Bone	
Chest	8. Who manages care of the PAIN condition(s)?
Head	Formal Support
Hip	Informal Support
Incision site	Primary Care Physician
Knee	Self
Soft tissue (muscle)	Specialty Physician
Stomach	Other-Document Detail in Notes
Other Joint-Document Details in Notes	9. Does the Individual need additional assistance in
Other-Document Details in Notes	managing PAIN?
	managing i Aziv.
sing a scale from 0-10 (0=no pain, 10=severe pain)	No Yes-Document Details in Notes  10. ACTIVITIES OF DAILY LIVING (ADLs)
	No Yes-Document Details in Notes
sing a scale from 0-10 (0=no pain, 10=severe pain)  0=No pain	No Yes-Document Details in Notes  10. ACTIVITIES OF DAILY LIVING (ADLs)  10.A. ADLs
sing a scale from 0-10 (0=no pain, 10=severe pain)  0=No pain  1	No Yes-Document Details in Notes  10. ACTIVITIES OF DAILY LIVING (ADLs)  10.A. ADLs  1a. BATHING: Ability to prepare a bath and wash
sing a scale from 0-10 (0=no pain, 10=severe pain)  0=No pain  1  2	No Yes-Document Details in Notes  10. ACTIVITIES OF DAILY LIVING (ADLs)  10.A. ADLs
0=No pain	No Yes-Document Details in Notes  10. ACTIVITIES OF DAILY LIVING (ADLs)  10.A. ADLs  1a. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating
sing a scale from 0-10 (0=no pain, 10=severe pain)  0=No pain 1 2 3 4	No Yes-Document Details in Notes  10. ACTIVITIES OF DAILY LIVING (ADLs)  10.A. ADLs  1a. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.
sing a scale from 0-10 (0=no pain, 10=severe pain)  0=No pain 1 2 3 4 5	No Yes-Document Details in Notes  10. ACTIVITIES OF DAILY LIVING (ADLs)  10.A. ADLs  1a. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.  1 - Independent-Skip to 10.A.2a
0=No pain	No Yes-Document Details in Notes  10. ACTIVITIES OF DAILY LIVING (ADLs)  10.A. ADLs  1a. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.  1 - Independent-Skip to 10.A.2a 2 - Limited Assistance 3 - Total Assistance
0=No pain	No Yes-Document Details in Notes  10. ACTIVITIES OF DAILY LIVING (ADLs)  10.A. ADLs  1a. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.  1 - Independent-Skip to 10.A.2a 2 - Limited Assistance 3 - Total Assistance  1b. If Limited Assistance, indicate ALL types needed for the state of the s
sing a scale from 0-10 (0=no pain, 10=severe pain)    0=No pain	No Yes-Document Details in Notes  10. ACTIVITIES OF DAILY LIVING (ADLs)  1a. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.  1 - Independent-Skip to 10.A.2a 2 - Limited Assistance 3 - Total Assistance  1b. If Limited Assistance, indicate ALL types needed for BATHING:
0=No pain	No Yes-Document Details in Notes  10. ACTIVITIES OF DAILY LIVING (ADLs)  10.A. ADLs  1a. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.  1 - Independent-Skip to 10.A.2a 2 - Limited Assistance 3 - Total Assistance  1b. If Limited Assistance, indicate ALL types needed for BATHING:  Assistance with the use of equipment/ assistive devices
sing a scale from 0-10 (0=no pain, 10=severe pain)    0=No pain	No Yes-Document Details in Notes  10. ACTIVITIES OF DAILY LIVING (ADLs)  10.A. ADLs  1a. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.  1 - Independent-Skip to 10.A.2a 2 - Limited Assistance 3 - Total Assistance  1b. If Limited Assistance, indicate ALL types needed for BATHING: Assistance with the use of equipment/ assistive devices Encouragement, cueing, or coaxing
sing a scale from 0-10 (0=no pain, 10=severe pain)    0=No pain	No Yes-Document Details in Notes  10. ACTIVITIES OF DAILY LIVING (ADLs)  10.A. ADLs  1a. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.  1 - Independent-Skip to 10.A.2a 2 - Limited Assistance 3 - Total Assistance  1b. If Limited Assistance, indicate ALL types needed for BATHING:  Assistance with the use of equipment/ assistive devices
o=No pain  0=No pain  1  2  3  4  5  6  7  8  9  10=Severe pain  Indicate the frequency the individual reports the PAIN  Less than Daily	No   Yes-Document Details in Notes   10. ACTIVITIES OF DAILY LIVING (ADLs)   10.A. ADLs   1a. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.   1 - Independent-Skip to 10.A.2a   2 - Limited Assistance   3 - Total Assistance   3 - Total Assistance   Assistance   Assistance with the use of equipment/ assistive devices   Encouragement, cueing, or coaxing   Guided maneuvering of limbs   Set-up
o=No pain  0=No pain  1  2  3  4  5  6  7  8  9  10=Severe pain	No   Yes-Document Details in Notes   10. ACTIVITIES OF DAILY LIVING (ADLs)   10.A. ADLs   1a. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.   1 - Independent-Skip to 10.A.2a   2 - Limited Assistance   3 - Total Assistance   3 - Total Assistance   BATHING:   Assistance with the use of equipment/ assistive devices   Encouragement, cueing, or coaxing   Guided maneuvering of limbs   Set-up   Supervision
o=No pain  0=No pain  1  2  3  4  5  6  7  8  9  10=Severe pain  Indicate the frequency the individual reports the AIN  Less than Daily  Daily-One Episode	No   Yes-Document Details in Notes   10. ACTIVITIES OF DAILY LIVING (ADLs)   10.A. ADLs   1a. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.   1 - Independent-Skip to 10.A.2a   2 - Limited Assistance   3 - Total Assistance   3 - Total Assistance   3 - Total Assistance   Assistance with the use of equipment/ assistive devices   Encouragement, cueing, or coaxing   Guided maneuvering of limbs   Set-up   Supervision   Other-Document Details in Notes
sing a scale from 0-10 (0=no pain, 10=severe pain)    0=No pain	No   Yes-Document Details in Notes   10. ACTIVITIES OF DAILY LIVING (ADLs)   10.A. ADLs   1a. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.   1 - Independent-Skip to 10.A.2a   2 - Limited Assistance   3 - Total Assistance   3 - Total Assistance   3 - Total Assistance   Assistance with the use of equipment/ assistive devices   Encouragement, cueing, or coaxing   Guided maneuvering of limbs   Set-up   Supervision   Other-Document Details in Notes
O=No pain   O=No	No Yes-Document Details in Notes  10. ACTIVITIES OF DAILY LIVING (ADLs)  10.A. ADLs  1a. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.  1 - Independent-Skip to 10.A.2a 2 - Limited Assistance 3 - Total Assistance  1b. If Limited Assistance  1b. If Limited Assistance  Assistance with the use of equipment/ assistive devices Encouragement, cueing, or coaxing Guided maneuvering of limbs Set-up Supervision Other-Document Details in Notes  1c. BATHING: Assistance currently provided by wha INFORMAL supports? Document Details in Notes
O=No pain   O=No	No   Yes-Document Details in Notes   10. ACTIVITIES OF DAILY LIVING (ADLs)   10.A. ADLs   10.A
O=No pain   1   2   3   4   5   5   6   7   8   9   10=Severe pain	No   Yes-Document Details in Notes   10. ACTIVITIES OF DAILY LIVING (ADLs)   10.A. ADLs   1a. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.   1 - Independent-Skip to 10.A.2a   2 - Limited Assistance   3 - Total Assistance   3 - Total Assistance   BATHING:   Assistance with the use of equipment/ assistive devices   Encouragement, cueing, or coaxing   Guided maneuvering of limbs   Set-up   Supervision   Other-Document Details in Notes   None   Family   None   Family
O=No pain   1   2   3   4   5   5   6   7   8   9   10=Severe pain	No   Yes-Document Details in Notes   10. ACTIVITIES OF DAILY LIVING (ADLs)   10.A. ADLs   1a. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.   1 - Independent-Skip to 10.A.2a   2 - Limited Assistance   3 - Total Assistance   3 - Total Assistance   Assistance   Encouragement, cueing, or coaxing   Guided maneuvering of limbs   Set-up   Supervision   Other-Document Details in Notes   Information Notes   None   Family   Friend   Family   Friend
1 2 3 4 5 6 6 7 7 8 9 9 10=Severe pain  D. Indicate the frequency the individual reports the PAIN	No   Yes-Document Details in Notes   10. ACTIVITIES OF DAILY LIVING (ADLs)   10.A. ADLs   1a. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.   1 - Independent-Skip to 10.A.2a   2 - Limited Assistance   3 - Total Assistance   3 - Total Assistance   BATHING:   Assistance with the use of equipment/ assistive devices   Encouragement, cueing, or coaxing   Guided maneuvering of limbs   Set-up   Supervision   Other-Document Details in Notes   None   Family   None   Family

1d. BATHING: Assistance currently provided by what FORMAL supports? Document Details in Notes	2c. DRESSING: Assistance currently provided by what INFORMAL supports? Document Details in Notes
None Medicaid Medicare Hospice Private Pay Insurance	None Family Friend Neighbor Other-Document Details in Notes
Other-Document Details in Notes  1e. How often is BATHING support available?  Document Details in Notes  Daily	2d. DRESSING: Assistance currently provided by what FORMAL supports? Document Details in Notes  None Medicaid
Weekly	Medicare Hospice Private Pay Insurance Other-Document Details in Notes
Partial Shower Sponge bath Tub Other-Document Details in Notes	2e. How often is DRESSING support available?  Document Details in Notes  Daily Weekly
1g. Assistive devices/ adaptive equipment used for BATHING? Document Details in Notes  None Bathtub bench Grab bar/ tub rail Handheld shower Hydraulic lift Shower bench Transfer bench	Monthly Other-Document Details in Notes  2f. Assistive devices/ adaptive equipment used for DRESSING? Document Details in Notes  None Buttonhole helper Shoe horn Sock cup Other-Document Details in Notes
1h. Does the individual need additional assistance in BATHING?	2g. Does the individual need additional assistance in managing DRESSING?  No Yes-Document Details in Notes
2a. DRESSING: Ability to remove clothes from a closet/ drawer; application of clothing, including shoes/ socks (regular/ TEDS); orthotics; prostheses; removal/ storage of items; managing fasteners; and to use any needed assistive devices.  1 - Independent-Skip to 10.A.3a 2 - Limited Assistance 3 - Total Assistance	3a. GROOMING/ PERSONAL HYGIENE: Ability to comb/ brush hair; brush teeth; care for/ inset dentures; shave; apply make-up (if worn); apply deodorant, etc.  1 - Independent-Skip to 10.A.4a 2 - Limited Assistance 3 - Total Assistance 3b. If Limited Assistance, indicate ALL types needed for GROOMING/ PERSONAL HYGIENE:
2b. If Limited Assistance, indicate ALL types needed for DRESSING:  Assistance with the use of equipment/ assistive device Encouragement, cueing, or coaxing Guided maneuvering of limbs Set-up Supervision Other-Document Details in Notes	Assistance with the use of equipment/ assistive devices  Encouragement, cueing, or coaxing  Guided maneuvering of limbs  Set-up  Supervision  Other-Document Details in Notes

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3c. GROOMING/ PERSONAL HYGIENE: Assistance	Tube Feeding
currently provided by what INFORMAL supports?	Other-Document Details in Notes
Document Details in Notes	
None	4d. EATING: Assistance currently provided by what
Family	INFORMAL supports? Document Details in Notes
Friend	None
Neighbor	Family
Other-Document Details in Notes	Friend
U other-bocument betails in Notes	Neighbor
3d. GROOMING/ PERSONAL HYGIENE: Assistance	Other-Document Details in Notes
currently provided by what FORMAL supports?	
None	4e. EATING: Assistance currently provided by what
Medicaid	FORMAL supports?
Medicare	None
Hospice	Medicaid
	Medicare
Private Pay Insurance	Hospice
Other-Document Details in Notes	Private Pay Insurance
3e. How often is GROOMING/ PERSONAL HYGIENE	Other-Document Details in Notes
support available? Document Details in Notes	Other-Document Details in Notes
Daily	4f. How often is EATING support available? Document
Weekly	Details in Notes
	Daily
Monthly	Weekly
Other-Document Details in Notes	Monthly
3f. Are assistive devices/ adaptive equipment used for	Other-Document Details in Notes
GROOMING/ PERSONAL HYGIENE? Document Details	Other-Document Details in Notes
in Notes	4g. Assistive devices/ adaptive equipment used for
□No	EATING? Document Details in Notes
Yes	Adaptive cup
	Adaptive plate
3g. Does the individual need additional assistance in	Adaptive utensils
GROOMING/ PERSONAL HYGIENE?	Dentures
☐ No	
Yes-Document Details in Notes	Hand split/ braces
	Infusion pump
4a. EATING: Ability to eat/ drink; cut, chew, swallow food; and to use any needed assistive devices	Special utensil/ plate
tood; and to use any needed assistive devices	Other-Document Details in Notes
1 Tadasandant Clin to 10 A Fa	Ah Doos the individual need additional assistance in
1 - Independent-Skip to 10.A.5a	4h. Does the individual need additional assistance in managing EATING?
2 - Limited Assistance	
3 - Total Assistance	
4 - Does not eat-Skip to 10.A.4c	Yes-Document Details in Notes
4b. If Limited Assistance, indicate ALL types needed for	5a. TRANSFER: Ability to move between surfaces,
EATING:	including to/ from bed, chair, wheelchair, or to a
Assistance with the use of equipment/ assistive devices	standing position; onto or off a commode; and to
	manage/ use any needed assistive devices.
Encouragement, cueing or coaxing	1 - Independent-Skip to 10.A.6a
Guided maneuvering of limbs	2 - Limited Assistance
Set-up	3 - Total Assistance
Supervision	
Other-Document in Notes	
4c. If response to 10.A.4a is "4-Does not eat", indicate	
type of nutritional intake. Check ALL that apply:	
IV Fluids	
NPO (nothing by mouth)	
Parenteral Nutrition	

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TRANSFER:  Assistance with the use of equipment/ assistive devices   Groundegement, cuerce, or coasing	5b. If Limited Assistance, indicate ALL types needed for	3 - Total Assistance
Groundegement, cueing, or cassing   Guided maneuvering of limbs   Set-up   Supervision   Set-up   Supervision   Supervision   Set-up   Supervision   Supervision   Set-up   Set-up   Supervision   Set-up   Supervision   Set-up   Supervision   Set-up   Set-up   Supervision   Set-up	TRANSFER:	4 - Self management of indwelling catheter/ ostomy
Guided maneuvering of limbs	Assistance with the use of equipment/ assistive devices	Ch. 761 in the distance in disease All Lance and disease
Guided maneuvering of limbs   Assistance with incontinent products   Assistance with incontinent products   Assistance with the use of equipment/ assistive devices   Clothing maneuvery adjustment   Encouragement, cueing, or coaving   Clother Document Details in Notes   Clothing maneuvery adjustment   Encouragement, cueing, or coaving   Clother Document Details in Notes   Clothing maneuvery adjustment   Encouragement, cueing, or coaving   Clother Document Details in Notes   Clothing maneuvery adjustment   Encouragement, cueing, or coaving   Clother Document Details in Notes   Clother Document Detai	Encouragement, cueing, or coaxing	
Set-up Supervision Other-Document Details in Notes  Sc. TRANSFER: Assistance currently provided by what INFORMAL supports? Document Details in Notes    None	Guided maneuvering of limbs	
Supervision   Clothing maneuvers/ adjustment   Encouragement, cueing, or cooxing   Encouragement, cueing, or cooxing   Encouragement, cueing, or cooxing   Encouragement, cueing, or cooxing   Supervision   Personal hygiere post tolieting   Secure   Supervision   Other-Document Details in Notes   Other-Document Details in Note	Set-up	
Other-Document Details in Notes	Supervision	
Guided mareuvering of limbs   Personal hygiene post toileting   Sepup   Supervision   Other-Document Details in Notes   Personal hygiene post toileting   Sepup   Supervision   Other-Document Details in Notes	Other-Document Details in Notes	
INFORMAL supports? Document Details in Notes    None   Setup   Other-Document Details in Notes   Setup   Other-Document Details in Notes   Setup   Other-Document Details in Notes   Other-Document Details in Not		
None		
None	INFORMAL supports? Document Details in Notes	Personal hygiene post toileting
Family	Mono	Setup
Friend   Reighbor   Cher-Document Details in Notes		Supervision
Neighbor   Other-Document Details in Notes   Sd. TRANSFER: Assistance currently provided by what INFORMAL supports? Document Details in Notes   Smiles   S		Other-Document Details in Notes
Other-Document Details in Notes   None   Family   None   Family   Friend   Neighbor   None   FoRMAL supports?   Other-Document Details in Notes   Formal   None   Family   Friend   Neighbor   Other-Document Details in Notes   Other-Document De		6c TOTI ETING: Assistance currently provided by wha
None   Family   Friend   None   Medicare   Hospice   Private Pay Insurance   Other-Document Details in Notes   Gd. TOILETING: Assistance currently provided by whate   FORMAL supports?   None   Medicare   Private Pay Insurance   Other-Document Details in Notes   Other-Document Details		
FORMAL supports?   None   Friend   Friend   Notes   Friend   Notes   Private Pay Insurance   Medicare   Private Pay Insurance   Private Pay Insurance	Other-Document Details in Notes	In on the supports. Secument Secument Notes
FORMAL supports?   None   Friend   Friend   Notes   Friend   Notes   Private Pay Insurance   Medicare   Private Pay Insurance   Private Pay Insurance	5d. TRANSFER: Assistance currently provided by what	None
None     Friend   Neighbor   Neighbor   Neighbor   Neighbor   Neighbor   Neighbor   Neighbor   None   Neighbor   None   Neighbor   None   None   None   None   None   None   None   None   Neighbor   None		
Medicaid   Medicare   Hospice   Other-Document Details in Notes   Other-	<u> </u>	
Medicare   Hospice   Other-Document Details in Notes		
Hospice   Private Pay Insurance   Other-Document Details in Notes   Medicare   PortMAL supports?   Medicare   Medicare   Private Pay Insurance   Other-Document Details in Notes   Medicare   Private Pay Insurance   Medicare   Private Pay Insurance   Other-Document Details in Notes   Medicare   Private Pay Insurance   Other-Document Details in Notes   Daily   Weekly   Monthly   Other-Document Details in Notes   Daily   Weekly   Monthly   Other-Document Details in Notes   Ostomy   Other-Document Details in Notes   Ostomy   Ostomy   Pads for incontinence   Raised toilet seat   Other-Document Details in Notes   Ostomy   Os	Medicare	
Private Pay Insurance		Other-bocument betails in Notes
Other-Document Details in Notes   None   Medicarid   Medicarid   Medicare   Hospice   Private Pay Insurance   Other-Document Details in Notes   Medicare   Hospice   Private Pay Insurance   Other-Document Details in Notes   Other-Document Deta		6d. TOILETING: Assistance currently provided by what
Se. How often is support available for TRANSFER?  Document Details in Notes    Daily   Weekly   Hospice   Private Pay Insurance   Other-Document Details in Notes    Sf. Assistive devices/ adaptive equipment used for TRANSFER? Document Details in Notes    Se. How often is support available for TOILETING?   Other-Document Details in Notes    Se. How often is support available for TOILETING?   Document Details in Notes    Daily   Weekly   Document Details in Notes    Daily   Weekly   Document Details in Notes    Cane   Electric lift chair   Other-Document Details in Notes    Lifted menually   Dided mechanically   Document Details in Notes    Silde board   Catheter   Commode   Grab bars   Ostomy   Pads for incontinence   Raised toilet seat   Other-Document Details in Notes    Sp. Does the individual need additional assistance in managing TRANSFERS?   Other-Document Details in Notes    So. TOILETING: Ability to manage bowel and bladder elimination.   1 - Independent-Skip to 10.A.7a		FORMAL supports?
Document Details in Notes	Under-Document Details in Notes	None
Daily   Hospice   Private Pay Insurance   Other-Document Details in Notes	5e. How often is support available for TRANSFER?	Medicaid
Weekly	Document Details in Notes	Medicare
Monthly	☐ Daily	Hospice
Other-Document Details in Notes   Ge. How often is support available for TOILETING?   Document Details in Notes   Daily   Weekly   Weekly   Monthly   Other-Document Details in Notes   Other-Document Details i	Weekly	Private Pay Insurance
Other-Document Details in Notes   Ge. How often is support available for TOILETING?   Document Details in Notes   Daily   Weekly   Monthly   Weekly   Monthly   Other-Document Details in Notes   Other-Documen	Monthly	Other-Document Details in Notes
5f. Assistive devices/ adaptive equipment used for TRANSFER? Document Details in Notes     Doally       None     Weekly       Bed rails     Monthly       Cane     Other-Document Details in Notes       Electric lift chair     6f. Assistive devices/ adaptive equipment used for TOILETING? Document Details in Notes       Hospital bed     None       Lifted manually     Bed pan/ urinal       Slide board     Catheter       Trapeze     Grab bars       Walker     Ostomy       Other-Document Details in Notes     Pads for incontinence       5g. Does the individual need additional assistance in managing TRANSFERS?     Other-Document Details in Notes       6g. TOILETING: Ability to manage bowel and bladder elimination.     Mo       1 - Independent-Skip to 10.A.7a     Yes-Document Details in Notes	Other-Document Details in Notes	
TRANSFER? Document Details in Notes  None Bed rails Bedfast all or most of time Cane Electric lift chair Hospital bed Lifted manually Lifted mechanically Slide board Trapeze Walker Other-Document Details in Notes  5g. Does the individual need additional assistance in managing TRANSFERS? No Yes-Document Details in Notes  6g. ToileTING: Ability to manage bowel and bladder elimination.  Daily Weekly Weekly Monthly Monthly Other-Document Details in Notes  6f. Assistive devices/ adaptive equipment used for TOILETING? Document Details in Notes  6f. Assistive devices/ adaptive equipment used for TOILETING? Document Details in Notes  6f. Assistive devices/ adaptive equipment used for TOILETING? Document Details in Notes  6g. Dosement Details in Notes  6g. Dose the individual need additional assistance in managing TOILETING?  6g. Dose the individual need additional assistance in managing TOILETING?  No Yes-Document Details in Notes		
None		
Bed rails Bedfast all or most of time Cane Electric lift chair Hospital bed Lifted manually Lifted mechanically Slide board Trapeze Walker Other-Document Details in Notes   5g. Does the individual need additional assistance in managing TRANSFERS? No Yes-Document Details in Notes  6g. Does the individual need additional assistance in managing TRANSFERS? No Yes-Document Details in Notes  6g. Does the individual need additional assistance in managing TOILETING: Ability to manage bowel and bladder elimination.  1 - Independent-Skip to 10.A.7a		
Bedfast all or most of time  Cane  Electric lift chair  Hospital bed  Lifted manually  Lifted mechanically  Slide board  Trapeze  Walker  Other-Document Details in Notes   Grab bars  Grab bars  Ostomy  Other-Document Details in Notes   5g. Does the individual need additional assistance in managing TRANSFERS?  No  Yes-Document Details in Notes  6g. Does the individual need additional assistance in managing TOILETING:  Ability to manage bowel and bladder elimination.  1 - Independent-Skip to 10.A.7a		
Cane		Monthly
Electric lift chair	Bedfast all or most of time	Other-Document Details in Notes
TOILETING? Document Details in Notes    Hospital bed		6f Assistive devices / adaptive equipment used for
Lifted manually Lifted mechanically Slide board Trapeze Walker Other-Document Details in Notes  5g. Does the individual need additional assistance in managing TRANSFERS? No Yes-Document Details in Notes  6a. TOILETING: Ability to manage bowel and bladder elimination.  1 - Independent-Skip to 10.A.7a  Bed pan/ urinal Catheter Commode Grab bars Ostomy Pads for incontinence Raised toilet seat Other-Document Details in Notes  6g. Does the individual need additional assistance in managing TOILETING? No Yes-Document Details in Notes	Electric lift chair	
Lifted mechanically Slide board Trapeze Walker Other-Document Details in Notes  5g. Does the individual need additional assistance in managing TRANSFERS? No Yes-Document Details in Notes  6a. TOILETING: Ability to manage bowel and bladder elimination.  1 - Independent-Skip to 10.A.7a    Catheter     Commode     Grab bars     Ostomy     Pads for incontinence     Raised toilet seat     Other-Document Details in Notes     Other-Document Details in Notes     No     Yes-Document Details in Notes     No     Yes-Document Details in Notes     Yes-Document Details in Notes     No     Yes-Document Details in Notes     Yes-Document Details in Notes     No     Yes-Document Details in Notes     No     Yes-Document Details in Notes	Hospital bed	None
Lifted mechanically  Slide board  Trapeze  Walker  Other-Document Details in Notes   5g. Does the individual need additional assistance in managing TRANSFERS?  No  Yes-Document Details in Notes  6a. TOILETING: Ability to manage bowel and bladder elimination.  1 - Independent-Skip to 10.A.7a  Catheter  Commode  Grab bars  Ostomy  Pads for incontinence  Raised toilet seat  Other-Document Details in Notes  6g. Does the individual need additional assistance in managing TOILETING?  No  Yes-Document Details in Notes	Lifted manually	Bed pan/ urinal
Slide board Trapeze Walker Other-Document Details in Notes  Sg. Does the individual need additional assistance in managing TRANSFERS? No Yes-Document Details in Notes  Ga. TOILETING: Ability to manage bowel and bladder elimination.  1 - Independent-Skip to 10.A.7a  Commode Grab bars Ostomy Pads for incontinence Raised toilet seat Other-Document Details in Notes  Gg. Does the individual need additional assistance in managing TOILETING? No Yes-Document Details in Notes	Lifted mechanically	
Trapeze Walker Other-Document Details in Notes  5g. Does the individual need additional assistance in managing TRANSFERS? No Yes-Document Details in Notes  6a. TOILETING: Ability to manage bowel and bladder elimination. 1 - Independent-Skip to 10.A.7a  Grab bars Ostomy Pads for incontinence Raised toilet seat Other-Document Details in Notes  6g. Does the individual need additional assistance in managing TOILETING? No Yes-Document Details in Notes	Slide board	
Walker	Trapeze	
Other-Document Details in Notes  Fads for incontinence  Raised toilet seat Other-Document Details in Notes  Raised toilet seat Other-Document Details in Notes  Geg. Does the individual need additional assistance in managing TOILETING?  Ga. TOILETING: Ability to manage bowel and bladder elimination.  1 - Independent-Skip to 10.A.7a	Walker	
5g. Does the individual need additional assistance in managing TRANSFERS?  No Yes-Document Details in Notes  6a. TOILETING: Ability to manage bowel and bladder elimination.  1 - Independent-Skip to 10.A.7a  Pads for incontinence Raised toilet seat Other-Document Details in Notes  6g. Does the individual need additional assistance in managing TOILETING?  No Yes-Document Details in Notes	Other-Document Details in Notes	
managing TRANSFERS?  No Yes-Document Details in Notes  Ga. TOILETING: Ability to manage bowel and bladder elimination.  1 - Independent-Skip to 10.A.7a  Other-Document Details in Notes  Gg. Does the individual need additional assistance in managing TOILETING?  No Yes-Document Details in Notes		
No Yes-Document Details in Notes  6a. TOILETING: Ability to manage bowel and bladder elimination.  1 - Independent-Skip to 10.A.7a  6g. Does the individual need additional assistance in managing TOILETING?  No Yes-Document Details in Notes		
Yes-Document Details in Notes  6g. Does the individual need additional assistance in managing TOILETING?  No Yes-Document Details in Notes  1 - Independent-Skip to 10.A.7a		Other-Document Details in Notes
6a. TOILETING: Ability to manage bowel and bladder elimination.  1 - Independent-Skip to 10.A.7a  managing TOILETING?  No Yes-Document Details in Notes		6a. Does the individual need additional assistance in
6a. TOILETING: Ability to manage bowel and bladder elimination.  \[ \begin{array}{cccccccccccccccccccccccccccccccccccc	Yes-Document Details in Notes	
elimination.  Yes-Document Details in Notes  1 - Independent-Skip to 10.A.7a	6a. TOILETING: Ability to manage howel and bladder	
1 - Independent-Skip to 10.A.7a		

7a. BLADDER CONTINENCE: Indicate the description that best describes the individual's BLADDER function.	Yes-Skip to 12.A.1 Unable to Determine
1 - Continent - Complete control, no type of catheter or urinary collection device	2a. INDOOR MOBILITY: Ability of movement within INTERIOR environment:
2 - Usually Continent - Incontinence episodes once a week or less	1 - Independent-Skip to 11.A.3a
3 - Incontinent - Inadequate control, multiple daily episodes	2 - Limited Assistance 3 - Total Assistance
4 - Self management of indwelling catheter or ostomy	2b. If Limited Assistance, indicate ALL types needed for
7b. Does the individual need additional assistance in managing BLADDER CONTINENCE?	INDOOR MOBILITY:
No	Assistance with the use of equipment/ assistive devices
Yes-Document Details in Notes	Encouragement, cueing, or coaxing Guided maneuvering of limbs
7. DOMEL CONTINENCE: Indicate the description	Set-up
7c. BOWEL CONTINENCE: Indicate the description that best describes the individual's BOWEL function.	Supervision
1 - Continent - Complete control, no ostomy device	Other-Document Details in Notes
2 - Usually Continent - Incontinence episodes once a week or less	2c. Assistive devices needed for INDOOR MOBILITY. Document Details in Notes
3 - Incontinent - Inadequate control, multiple daily episodes	None
4 - Continent - with ostomy	Cane
74 Baratha tudisthad and additional automorphis	Hand rails
7d. Does the individual need additional assistance in managing BOWEL CONTINENCE?	Prosthesis-Document Type in Notes
	Quad cane
Yes-Document Details in Notes	Scooter
Tes bocument betails in Notes	Stair glide
7e. Does the individual use incontinency products?	Walker
No	Wheelchair (manual)
Yes-Document Details in Notes	Wheelchair (motorized)
8a. WALKING: Ability to safely walk to/ from one area to another; manage/ use any needed ambulation devices.	2d. Does the individual need additional assistance in
1 - Independent-Skip to 11.A.1	managing INDOOR MOBILITY?
2 - Limited Assistance	
3 - Total Assistance	Yes-Document Details in Notes
8b. If Limited Assistance, indicate ALL types needed for	3a. OUTDOOR MOBILITY: Ability of movement OUTSIDE living arrangement:
WALKING:	1 - Independent-Skip to 11.A.4a
Assistance with the use of equipment/ assistive devices	2 - Limited Assistance
Encouragement, cueing, or coaxing	3 - Extensive/ Total Assistance
Guided maneuvering of limbs	3b. If Limited Assistance, indicate ALL types needed for
☐ Set-up	OUTDOOR MOBILITY:
Supervision	Assistance with the use of equipment/ assistive devices
Other-Document Details in Notes	Encouragement, cueing, or coaxing
8c. Does the individual need additional assistance in	Guided maneuvering of limbs
managing WALKING?	Set-up
No	Supervision
Yes-Document Details in Notes	Other-Document Details in Notes
1. MOBILITY	_ <del>_</del>
11.A. INDIVIDUAL'S MOBILITY	
1. BEDBOUND: Is the individual bedbound?	
Indicate in Notes any comments or relevant	
information.	
No	

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3c. Assistive devices needed for OUTDOOR MOBILITY.	Shuffling Gait
Document Details in Notes	Spasms
None	Tremors/ Twitches
Cane	Other-Document Details in Notes
Hand rails	11.B. FALLS
Hold furniture/ walls	II.B. FALLS
Prosthesis-Document Type in Notes	1 To the individual at rick of falling?
Quad cane	1. Is the individual at risk of falling?
Scooter	∐ No
	Yes
Stair glide	Unable to Determine
Walker	2. Select the number of times the individual has fallen
Wheelchair (manual)	in the LAST 6 MONTHS.
Wheelchair (motorized)	None-Skip to 12.A.1
Other-Document Details in Notes	$\Pi_1$
3d. Does the individual need additional assistance in	$\Pi_2$
managing OUTDOOR MOBILITY?	3 or More
□ No	
Yes-Document Details in Notes	3. Reasons for falls-Document Details in Notes
Tes bocament betails in Notes	Accidental
4a. STAIR MOBILITY: Movement safely up and down	Environmental
STEPS:	Medical
1 - Independent-Skip to 11.A.5	Other-Document Details in Notes
2 - Limited Assistance	
3 - Extensive/ Total Assistance	12. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)
4b. If Limited Assistance, indicate ALL types needed for STAIR MOBILITY:	12.A. IADLs  1. MEAL PREPARATION: Ability to plan/ prepare
Assistance with the use of equipment/ assistive devices	1. MEAL PREPARATION: Ability to plan/ prepare
	meals, use of kitchen annliances, heat meals. List any
Encouragement, cueing, or coaxing	meals, use of kitchen appliances, heat meals. List any needed adaptive equipment/ assistive devices in Notes.
Encouragement, cueing, or coaxing Guided maneuvering of limbs	meals, use of kitchen appliances, heat meals. List any needed adaptive equipment/ assistive devices in Notes.
Encouragement, cueing, or coaxing	
Encouragement, cueing, or coaxing Guided maneuvering of limbs	needed adaptive equipment/ assistive devices in Notes.
Encouragement, cueing, or coaxing Guided maneuvering of limbs Independent	needed adaptive equipment/ assistive devices in Notes.  1 - Independent-Skip to 12.A.2
Encouragement, cueing, or coaxing Guided maneuvering of limbs Independent Set-up	needed adaptive equipment/ assistive devices in Notes.  1 - Independent-Skip to 12.A.2 2 - Limited Assistance 3 - Total Assistance
Encouragement, cueing, or coaxing Guided maneuvering of limbs Independent Set-up Supervision	needed adaptive equipment/ assistive devices in Notes.  1 - Independent-Skip to 12.A.2  2 - Limited Assistance
Encouragement, cueing, or coaxing Guided maneuvering of limbs Independent Set-up Supervision Other-Document Details in Notes  4c. Does the individual need additional assistance in	needed adaptive equipment/ assistive devices in Notes.  1 - Independent-Skip to 12.A.2 2 - Limited Assistance 3 - Total Assistance  1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document
Encouragement, cueing, or coaxing Guided maneuvering of limbs Independent Set-up Supervision Other-Document Details in Notes  4c. Does the individual need additional assistance in managing STAIR MOBILITY?	needed adaptive equipment/ assistive devices in Notes.  1 - Independent-Skip to 12.A.2 2 - Limited Assistance 3 - Total Assistance  1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes  None
Encouragement, cueing, or coaxing Guided maneuvering of limbs Independent Set-up Supervision Other-Document Details in Notes  4c. Does the individual need additional assistance in managing STAIR MOBILITY? No Yes-Document Details in Notes	needed adaptive equipment/ assistive devices in Notes.  1 - Independent-Skip to 12.A.2 2 - Limited Assistance 3 - Total Assistance  1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes  None Family
Encouragement, cueing, or coaxing Guided maneuvering of limbs Independent Set-up Supervision Other-Document Details in Notes  4c. Does the individual need additional assistance in managing STAIR MOBILITY? No	needed adaptive equipment/ assistive devices in Notes.  1 - Independent-Skip to 12.A.2 2 - Limited Assistance 3 - Total Assistance  1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes  None Family Friend
Encouragement, cueing, or coaxing Guided maneuvering of limbs Independent Set-up Supervision Other-Document Details in Notes  4c. Does the individual need additional assistance in managing STAIR MOBILITY? No Yes-Document Details in Notes	needed adaptive equipment/ assistive devices in Notes.  1 - Independent-Skip to 12.A.2 2 - Limited Assistance 3 - Total Assistance  1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes None Family Friend Neighbor
Encouragement, cueing, or coaxing Guided maneuvering of limbs Independent Set-up Supervision Other-Document Details in Notes  4c. Does the individual need additional assistance in managing STAIR MOBILITY? No Yes-Document Details in Notes  5. What is the individual's weight bearing status?	needed adaptive equipment/ assistive devices in Notes.  1 - Independent-Skip to 12.A.2 2 - Limited Assistance 3 - Total Assistance  1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes  None Family Friend
Encouragement, cueing, or coaxing Guided maneuvering of limbs Independent Set-up Supervision Other-Document Details in Notes  4c. Does the individual need additional assistance in managing STAIR MOBILITY? No Yes-Document Details in Notes  5. What is the individual's weight bearing status? Full weight bearing	needed adaptive equipment/ assistive devices in Notes.  1 - Independent-Skip to 12.A.2 2 - Limited Assistance 3 - Total Assistance  1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes None Family Friend Neighbor
Encouragement, cueing, or coaxing Guided maneuvering of limbs Independent Set-up Supervision Other-Document Details in Notes  4c. Does the individual need additional assistance in managing STAIR MOBILITY? No Yes-Document Details in Notes  5. What is the individual's weight bearing status? Full weight bearing Partial weight bearing	needed adaptive equipment/ assistive devices in Notes.  1 - Independent-Skip to 12.A.2 2 - Limited Assistance 3 - Total Assistance  1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes None Family Friend Neighbor Other-Document Details in Notes  1b. MEAL PREPARATION: Assistance is currently provided by what FORMAL supports? Document
Encouragement, cueing, or coaxing Guided maneuvering of limbs Independent Set-up Supervision Other-Document Details in Notes  4c. Does the individual need additional assistance in managing STAIR MOBILITY? No Yes-Document Details in Notes  5. What is the individual's weight bearing status? Full weight bearing Partial weight bearing Toe touch weight bearing	needed adaptive equipment/ assistive devices in Notes.  1 - Independent-Skip to 12.A.2 2 - Limited Assistance 3 - Total Assistance  1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes  None Family Friend Neighbor Other-Document Details in Notes  1b. MEAL PREPARATION: Assistance is currently
Encouragement, cueing, or coaxing Guided maneuvering of limbs Independent Set-up Supervision Other-Document Details in Notes  4c. Does the individual need additional assistance in managing STAIR MOBILITY? No Yes-Document Details in Notes  5. What is the individual's weight bearing status? Full weight bearing Partial weight bearing Toe touch weight bearing Non-weight bearing Unable to Determine	needed adaptive equipment/ assistive devices in Notes.  1 - Independent-Skip to 12.A.2 2 - Limited Assistance 3 - Total Assistance  1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes None Family Friend Neighbor Other-Document Details in Notes  1b. MEAL PREPARATION: Assistance is currently provided by what FORMAL supports? Document
Encouragement, cueing, or coaxing Guided maneuvering of limbs Independent Set-up Supervision Other-Document Details in Notes  4c. Does the individual need additional assistance in managing STAIR MOBILITY? No Yes-Document Details in Notes  5. What is the individual's weight bearing status? Full weight bearing Partial weight bearing Toe touch weight bearing Non-weight bearing	needed adaptive equipment/ assistive devices in Notes.  1 - Independent-Skip to 12.A.2 2 - Limited Assistance 3 - Total Assistance  1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes None Family Friend Neighbor Other-Document Details in Notes  1b. MEAL PREPARATION: Assistance is currently provided by what FORMAL supports? Document Details in Notes
Encouragement, cueing, or coaxing Guided maneuvering of limbs Independent Set-up Supervision Other-Document Details in Notes  4c. Does the individual need additional assistance in managing STAIR MOBILITY? No Yes-Document Details in Notes  5. What is the individual's weight bearing status? Full weight bearing Partial weight bearing Partial weight bearing Non-weight bearing Unable to Determine  6. Select all that affect the individual's MOBILITY: None	needed adaptive equipment/ assistive devices in Notes.    1 - Independent-Skip to 12.A.2   2 - Limited Assistance   3 - Total Assistance     1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes   None   Family   Friend   Neighbor   Other-Document Details in Notes     1b. MEAL PREPARATION: Assistance is currently provided by what FORMAL supports? Document Details in Notes   None   None   None
Encouragement, cueing, or coaxing   Guided maneuvering of limbs   Independent   Set-up   Supervision   Other-Document Details in Notes    4c. Does the individual need additional assistance in managing STAIR MOBILITY?   No   Yes-Document Details in Notes    5. What is the individual's weight bearing status?   Full weight bearing   Partial weight bearing   Toe touch weight bearing   Non-weight bearing   Unable to Determine    6. Select all that affect the individual's MOBILITY:	needed adaptive equipment/ assistive devices in Notes.    1 - Independent-Skip to 12.A.2   2 - Limited Assistance   3 - Total Assistance   3 - Total Assistance   1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes   None   Family   Friend   Neighbor   Other-Document Details in Notes    1b. MEAL PREPARATION: Assistance is currently provided by what FORMAL supports? Document Details in Notes   None   None   Medicaid
Encouragement, cueing, or coaxing Guided maneuvering of limbs Independent Set-up Supervision Other-Document Details in Notes  4c. Does the individual need additional assistance in managing STAIR MOBILITY? No Yes-Document Details in Notes  5. What is the individual's weight bearing status? Full weight bearing Partial weight bearing Partial weight bearing Non-weight bearing Unable to Determine  6. Select all that affect the individual's MOBILITY: None	needed adaptive equipment/ assistive devices in Notes.    1 - Independent-Skip to 12.A.2   2 - Limited Assistance   3 - Total Assistance   3 - Total Assistance   1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes   None   Family   Friend   Neighbor   Other-Document Details in Notes   1b. MEAL PREPARATION: Assistance is currently provided by what FORMAL supports? Document Details in Notes   None   Medicaid   Medicaid   Medicare
Encouragement, cueing, or coaxing   Guided maneuvering of limbs   Independent   Set-up   Supervision   Other-Document Details in Notes    4c. Does the individual need additional assistance in managing STAIR MOBILITY?   No   Yes-Document Details in Notes    5. What is the individual's weight bearing status?   Full weight bearing   Partial weight bearing   Partial weight bearing   Non-weight bearing   Unable to Determine    6. Select all that affect the individual's MOBILITY:   None   Ambulation Dysfunction	needed adaptive equipment/ assistive devices in Notes.    1 - Independent-Skip to 12.A.2   2 - Limited Assistance   3 - Total Assistance   3 - Total Assistance   1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes   None   Family   Friend   Neighbor   Other-Document Details in Notes   1b. MEAL PREPARATION: Assistance is currently provided by what FORMAL supports? Document Details in Notes   None   Medicaid   Medicare   Hospice   Private Pay Insurance
Encouragement, cueing, or coaxing   Guided maneuvering of limbs   Independent   Set-up   Supervision   Other-Document Details in Notes    4c. Does the individual need additional assistance in managing STAIR MOBILITY?   No   Yes-Document Details in Notes    5. What is the individual's weight bearing status?   Full weight bearing   Partial weight bearing   Partial weight bearing   Non-weight bearing   Unable to Determine    6. Select all that affect the individual's MOBILITY:   None   Ambulation Dysfunction   Aphasia	needed adaptive equipment/ assistive devices in Notes.    1 - Independent-Skip to 12.A.2   2 - Limited Assistance   3 - Total Assistance   3 - Total Assistance   1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes   None   Family   Friend   Neighbor   Other-Document Details in Notes   1b. MEAL PREPARATION: Assistance is currently provided by what FORMAL supports? Document Details in Notes   None   Medicaid   Medicare   Hospice
Encouragement, cueing, or coaxing Guided maneuvering of limbs Independent Set-up Supervision Other-Document Details in Notes  4c. Does the individual need additional assistance in managing STAIR MOBILITY? No Yes-Document Details in Notes  5. What is the individual's weight bearing status? Full weight bearing Partial weight bearing Partial weight bearing Non-weight bearing Unable to Determine  6. Select all that affect the individual's MOBILITY: None Ambulation Dysfunction Aphasia Fatigues Easily	needed adaptive equipment/ assistive devices in Notes.    1 - Independent-Skip to 12.A.2   2 - Limited Assistance   3 - Total Assistance   3 - Total Assistance   1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes   None   Family   Friend   Neighbor   Other-Document Details in Notes   1b. MEAL PREPARATION: Assistance is currently provided by what FORMAL supports? Document Details in Notes   None   Medicaid   Medicare   Hospice   Private Pay Insurance
Encouragement, cueing, or coaxing   Guided maneuvering of limbs   Independent   Set-up   Supervision   Other-Document Details in Notes    4c. Does the individual need additional assistance in managing STAIR MOBILITY?   No   Yes-Document Details in Notes    5. What is the individual's weight bearing status?   Full weight bearing   Partial weight bearing   Toe touch weight bearing   Non-weight bearing   Unable to Determine    6. Select all that affect the individual's MOBILITY:   None   Ambulation Dysfunction   Aphasia   Fatigues Easily   Muscle Stiffness   Pain	needed adaptive equipment/ assistive devices in Notes.    1 - Independent-Skip to 12.A.2   2 - Limited Assistance   3 - Total Assistance   3 - Total Assistance   1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes   None   Family   Friend   Neighbor   Other-Document Details in Notes   1b. MEAL PREPARATION: Assistance is currently provided by what FORMAL supports? Document Details in Notes   None   Medicaid   Medicare   Hospice   Private Pay Insurance
Encouragement, cueing, or coaxing   Guided maneuvering of limbs   Independent   Set-up   Supervision   Other-Document Details in Notes    4c. Does the individual need additional assistance in managing STAIR MOBILITY?   No   Yes-Document Details in Notes    5. What is the individual's weight bearing status?   Full weight bearing   Partial weight bearing   Toe touch weight bearing   Non-weight bearing   Unable to Determine    6. Select all that affect the individual's MOBILITY:   None   Ambulation Dysfunction   Aphasia   Fatigues Easily   Muscle Stiffness	needed adaptive equipment/ assistive devices in Notes.    1 - Independent-Skip to 12.A.2   2 - Limited Assistance   3 - Total Assistance     1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes   None   Family   Friend   Neighbor   Other-Document Details in Notes     1b. MEAL PREPARATION: Assistance is currently provided by what FORMAL supports? Document Details in Notes   None   Medicaid   Medicare   Hospice   Private Pay Insurance

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1c. How often is support available for MEAL PREPARATION? Document Details in Notes	3b. LAUNDRY: Assistance is currently provided by
	what FORMAL supports? Document Details in Notes
☐ Daily	None
Weekly	Medicaid
Monthly	Medicare
Other-Document Details in Notes	
2. HOUSEWORK: Ability to maintain living space,	Hospice
includes tasks such as dishwashing, making the bed,	Private Pay Insurance
dusting, running the vacuum or sweeping an area. List	Other-Document Details in Notes
any needed adaptive equipment/ assistive devices in	3c. How often is support available for LAUNDRY?
Notes.	Document Details in Notes
1 - Independent-Skip to 12.A.3	Daily
2 - Limited assistance	Weekly
3 - Total Assistance	Monthly
2a. HOUSEWORK: Assistance is currently provided by	Other-Document Details in Notes
what INFORMAL supports? Document Details in Notes	
	4. SHOPPING: Ability to go to the store and purchase
None	needed items, including groceries and other items. List any needed adaptive equipment/ assistive devices in
Family	Notes.
Friend	1 - Independent-Skip to 12.A.5
Neighbor	2 - Limited assistance
Other-Document Details in Notes	3 - Total Assistance
2b. HOUSEWORK: Assistance is currently provided by what FORMAL supports? Document Details in Notes	4a. SHOPPING: Assistance is currently provided by what INFORMAL supports? Document Details in Notes
□ Name	
None	None
☐ Medicaid	Family
Medicare	Friend
Hospice	Neighbor
Private Pay Insurance	Other-Document Details in Notes
Other-Document Details in Notes	4b. SHOPPING: Assistance is currently provided by
2c. How often is support available for HOUSEWORK?	what FORMAL supports? Document Details in Notes
Document Details in Notes	
Daily	None
Weekly	Medicaid
Monthly	Medicare
Other-Document Details in Notes	Hospice
<u> </u>	Private Pay Insurance
3. LAUNDRY: Ability to gather clothes, place clothes	Other-Document Details in Notes
in washing machine, turn on appliance, remove clothes and place in dryer, or hand wash items and hang to dry.	
List any needed adaptive equipment/ assistive devices	4c. How often is support available for SHOPPING?
in Notes.	Document Details in Notes
1 - Independent-Skip to 12.A.4	☐ Daily
2 - Limited Assistance	Weekly
3 - Total Assistance	Monthly
	Other-Document Details in Notes
3a. LAUNDRY: Assistance is currently provided by what INFORMAL supports? Document Details in Notes	5. TRANSPORTATION: Ability to travel on public transportation or drive a car. List any needed adaptive equipment/ assistive devices in Notes.
None	1 - Independent-Skip to 12.A.6
Family	2 - Limited Assistance
Friend	
Neighbor	3 - Total Assistance
Other-Document Details in Notes	

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5a. TRANSPORTATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes  None Family Friend Neighbor Other-Document Details in Notes	7. TELEPHONE: Ability to obtain phone numbers, dial the telephone and communicate with person on the other end. List any needed adaptive equipment/assistive devices in Notes.  1 - Independent-Skip to 12.A.8 2 - Limited Assistance 3 - Total Assistance
5b. TRANSPORTATION: Assistance is currently provided by what FORMAL supports? Document Details in Notes  None Medicaid Medicare Hospice Private Pay Insurance Other-Document Details in Notes	7a. TELEPHONE: Assistance is currently provided by what INFORMAL supports? Document Details in Notes  None Family Friend Neighbor Other-Document Details in Notes  7b. TELEPHONE: Assistance is currently provided by what FORMAL supports? Document Details in Notes
5c. How often is support available for TRANSPORTATION? Document Details in Notes  Daily Weekly Monthly Other-Document Details in Notes  6. MONEY MANAGEMENT: Ability to manage financial matters, writing checks, paying bills, going to the bank. List any needed adaptive equipment/ assistive devices in Notes.  1 - Independent-Skip to 12.A.7 2 - Limited assistance 3 - Total Assistance	None Medicaid Medicare Hospice Private Pay Insurance Other-Document Details in Notes  7c. How often is support available for TELEPHONE? Document Details in Notes  Daily Weekly Monthly
6a. MONEY MANAGEMENT: Assistance is currently provided by what INFORMAL supports? Document Details in Notes  None Family Friend Neighbor Other-Document Details in Notes  6b. MONEY MANAGEMENT: Assistance is currently provided by what FORMAL supports? Document Details in Notes  None Medicaid Medicare Hospice Private Pay Insurance	8. HOME MANAGEMENT: Ability to perform heavier household tasks such as taking out the trash, completing minor repairs around the living space, yard work and/ or snow removal. List any needed adaptive equipment/ assistive devices in Notes.  1 - Independent-Skip to 13.A.1 2 - Limited Assistance 3 - Total Assistance  8a. HOME MANAGEMENT: Assistance is currently provided by what INFORMAL supports? Document Details in Notes  None Family Friend Neighbor
Other-Document Details in Notes  6c. How often is support available for MONEY MANAGEMENT? Document Details in Notes  Daily Weekly Monthly Other-Document Details in Notes	Other-Document Details in Notes

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8b. HOME MANAGEMENT: Assistance is currently provided by what FORMAL supports? Document	Yes-Document Details in Notes
Details in Notes	4. Does the individual eat fewer than 5 servings (1/2 cup each) of fruits or vegetables every day?
None	No
Medicaid Medicaid	Yes-Document Details in Notes
Medicare Medicare	Tes Bocument Becaus in Notes
Hospice	5. Does the individual have trouble eating due to
Private Pay Insurance	problems with chewing/ swallowing?
Other-Document Details in Notes	∐ No
8c. How often is support available for HOME MANAGEMENT? Document Details in Notes	Yes-Document Details in Notes  6. Does the individual have enough money to buy
Daily	food?
Weekly	No-Document Details in Notes
Monthly	Yes
Other-Document Details in Notes	7. Does the individual eat alone most of the time?
13. NUTRITION	No Yes-Document Details in Notes
13.A. DIETARY ISSUES	Tes-Document Details in Notes
Does the individual generally have a good appetite?	8. Does the individual take 3 or more prescribed or over-the-counter drugs (OTC) per day?
	No
No-Document Details in Notes	Yes-Document Details in Notes
Yes	9. Nutritional Risk Score Indicator WILL go here
Other-Document Details in Notes	5
2. Does the individual use a dietary supplement?	14. INFORMAL SUPPORTS
∐ No	14 A INFORMAL HELDER(C) INFORMATION
Yes-Document Details in Notes	14.A. INFORMAL HELPER(S) INFORMATION
3. Does the individual have any food allergies?	Does the individual have any NON-PAID helpers
No	that provide care or assistance on a regular basis?
Yes-Document Details in Notes	No-Skip to 14.C.1
4. Does the individual have a special diet for medical	Yes-Complete Section 14
reasons?	2. List names, phone numbers and email addresses of
No	the non-paid helpers. Use the Note section if more
Yes-Document Details in Notes	room is needed.
F. D. alle indiction have a market distance with indiction of	
5. Does the individual have a special diet for religious/ cultural reasons?	3. Do any of the non-paid helpers reside in the
□ No	individual's home?
Yes-Document Details in Notes	No
	Yes-Document Details in Notes
13.B. NUTRITIONAL RISK ASSESSMENT	4. Calcat the valetionaking of the individually non-naid
Has there been a change in lifelong eating habits	<ol><li>Select the relationships of the individual's non-paid helpers:</li></ol>
because of health problems?	Child/ Child-in-Law
No	Friend
Yes-Document Details in Notes	Neighbor
2. Doos the individual ant forwards and 2 months and 4 months	Parent
2. Does the individual eat fewer than 2 meals per day?	Spouse/ Domestic Partner
□No	Other-Document Details in Notes
Yes-Document Details in Notes	
	14.B. CONCERNS ABOUT THE HELPING RELATIONSHIPS
3. Does the individual eat fewer than 2 servings of	
dairy products (such as milk, yogurt, or cheese) every day?	
□ No	

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What concerns does the individual have about any	Yes
of the non-paid helpers? Document Details in Notes	3. Does the individual need a safe place to stay?
None	∏ No
Cognition	Yes-Completion of Section 15 is required
Doesn't feel safe	4. Nata and dangers. Description Details in Natas
Drug/ alcohol abuse	4. Note any dangers - Document Details in Notes.  None/ Not Reported
Mental health	Gang Activity
Physical health	History of Violent Behavior in Home
Regrets actions toward helper when upset	Known Drug Activity
Strained relationship	Neighborhood Dangers
Stressed/ overwhelmed	Pets
Theft of belongings/ money/ assets	Weapons
Understanding and managing the behavior of the care recipient	Unknown
Understanding and managing the care recipient's health needs.	Other-Document Details in Notes
_	5. Is a referral to protective services indicated?
Other-Document Details in Notes	No
2. Care Manager's observations or concerns about the	Yes-Document Details in Notes
non-paid helpers-Document Details in Notes	15.B. ACCESS TO SERVICES
None	
Cares for others	1. Does the individual have an issue with access to
Displays behaviors that pose a risk to the individual's well-being	needed services or supports?
Family or other responsibilities	∐ No
Not reliable/ unwilling to provide care	Yes-Document Details in Notes
Not trustworthy	2. If the individual does not have access to the needed
Poor physical health, disabled or frail	services or supports, what assistance is needed?
Poor relationship/ communication	
Possible alcohol/ drug abuse	
Possible mental health issues	16. PHYSICAL ENVIRONMENT
Other-Document Details in Notes	16.A. CURRENT DWELLING UNIT
14.C. ADDITIONAL INFORMAL SUPPORTS	
	1. Does the individual own his/ her current residence?
Is the individual involved with any informal	
supports in the community that are or may be willing to	No-Document Details in Notes
provide help and support (i.e., church, social or community organizations)?	Yes
No-Skip to 15.A.1	2. Is the individual able to remain in his/ her current
Yes-Complete 14.C.2	residence?
	No-Document Details in Notes
<ol><li>Document the name of the community support(s), type of help and frequency of help that could be or is</li></ol>	Yes
provided.	Uncertain-Document Details in Notes
•	
L5. PROTECTIVE SERVICES (PS)	
is. Profective services (FS)	
15.A. PROTECTIVE SERVICES (PS) Questions 1-3 are MANDATORY	
Does the individual feel afraid in his/ her current	
living situation?	
∐ No	
Yes-Completion of Section 15 is required	
2. Is the individual safe to stay in his/ her home environment?	
No-Completion of Section 15 is required	

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3. What conditions of the home environment cause	2. Does the individual have any of the following
health and safety risks to the individual? Document in	special medical needs during a public emergency?
notes what and where are the problems.	None
П	Dialysis
None	Insulin
Appliances	Life sustaining equipment or treatment
Clutter	Nasal/ gastrointestinal tubes/ suctioning
Cooling system	Oxygen
Environmental pests	Respirator
Furnishings	Special medications & management needs
Hallways	
Heating system	Specialized transportation
Lack of electricity	Supervision
Lack of fire safety devices	Other-Document Details in Notes
Lack of refrigeration	3. Select ALL types of Emergency Response Systems
Lack of toilet	(ERS) with which the individual is currently utilizing:
Lack of water	_
Lighting	None
	ERS /w 24 hour family notification
Pets	ERS /w 24 hour response for elopement
Poor flooring	ERS /w medical information
Shower	ERS /w special emergency arrangements
Stairs	Other-Document Details in Notes
Structural issues	
Other-Document Details in Notes	4. Is the consumer enrolled in a community response program?
4. What areas of the home environment impact	□ No
accessibility? Document in Notes, what and where	Yes-Document Details in Notes
problems exist.	Tes bocument betails in Notes
Bathroom	18. INDIVIDUAL/ SPOUSE/ HOUSEHOLD FINANCIAL DATA
Bedroom	18.A. CONSUMER'S INCOME
Hallways	16.A. CONSUMER S INCOME
Home entryways	Refused to provide financial information?
Kitchen	□ No
Laundry	☐ Yes
Stairs	
Other-Document Details in Notes	2. Does the individual have direct deposit?
7 EMERGENCY INFORMATION	☐ No
.7. EMERGENCY INFORMATION	Yes-Document Details in Notes
17.A. EMERGENCY INFORMATION	3. Individual's monthly Social Security (SS) income:
	5. Individual's monthly Social Security (33) mediae.
1. What are the individual's physical limitations that	
would prevent individual leaving the home alone in an	
emergency?	4. Individual's monthly Supplemental Social Security
None	Income (SSI):
Bed bound/ immobile	
Dementia (May be reluctant to leave.)	5. Individual's monthly retirement/ pension income:
Hearing impaired (May need special warnings.)	-
Intellectual disabilities (Supervision needed.)	
Lives alone (May be reluctant to leave.)	6. Individual's monthly interest/ dividends income:
Morbid Obesity	o. Individual 5 monthly interest, dividends intollie.
Visually impaired (Guide dogs may become disoriented in a disaster.)	
Wheelchair bound (Special transportation needed.)	
Wheelerian bound (Special Carisportation Reduct.)	7. Individual's monthly public assistance:

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**Individual's monthly VA benefit income:** Monthly Social Security (SS) income of spouse **RESIDING** with the individual: Individual's monthly black lung income: Do not Monthly SSI of spouse RESIDING with the consider this as income for CSP determination. individual: 10. Individual's monthly wage/ salary/ earnings income: Monthly retirement/ pension income of spouse **RESIDING** with the individual: 11. Individual's monthly rental income: Monthly interest/ dividend income of spouse **RESIDING** with the individual: 12. Individual's railroad retirement benefit income: Monthly public assistance income of spouse **RESIDING** with the individual: 13. Individual's annuity, trust, estate income: Monthly VA benefits income of spouse RESIDING 14. Reverse mortgage monthly income: with the individual: 15. Individual's other monthly income-Document the source of income in Notes. Monthly Black Lung income of spouse RESIDING with the individual: 16. Individual's Total Monthly Income indicator WILL Monthly wage/ salary/ earnings income of spouse go here **RESIDING** with the individual: **18.B. CONSUMER'S ASSETS** Monthly NON-residential rental income of spouse **RESIDING** with the individual: Individual's primary savings account balance: 10. Other monthly income of spouse RESIDING with Individual's primary checking account balance: the individual-Document the source of income in Notes. 3. Individual's certificates/ other retirement accounts: 11. Residing Spouse's Total Monthly Income indicator WILL go here 4. Individual's NON-residential real estate assets value: 18.D. HOUSEHOLD INCOME 5. Cash surrender value of the individual's primary life insurance policy: Individual's stocks and bonds account balances: 7. Individual's other account(s) balance(s)-Document type of account(s) in Notes. 8. Individual's Total Assets' Value indicator WILL go

18.C. SPOUSE'S INCOME (Residing with individual)

here

1. Financial Resources Score - Only required for	3. What referral is recommended based on the LCD &
individuals served in community.	NAT?
Individual Alone Annual \$34,470 and Above; W/ Spouse \$46,530 and Above	☐ None
Individual Alone Annual \$33,033-\$34,469; W/ Spouse	CSP-Caregiver Support Program  DC-Domiciliary Care Program
<u>\$44,591-\$46,529</u>	DPW Program
Individual Alone Annual \$31,596-\$33,032; W/ Spouse \$42,652-\$44,590	Nursing Home
Individual Alone Annual \$30,160-\$31,595; W/ Spouse	OPTIONS Program
\$40,713-\$42,651	PCH-Personal Care Home
Individual Alone Annual \$28,724-\$30,159; W/ Spouse \$38,774-\$40,712	Other-Document Details in Notes  19.B. NEEDS ASSESSMENT OUTCOME AND AUTHENTICATION
Individual Alone Annual \$27,288-\$28,723; W/ Spouse \$36,835-\$38,773	19.B. NEEDS ASSESSMENT OUTCOME AND AUTHENTICATION
Individual Alone Annual \$25,852-\$27,287; W/ Spouse \$34,896-\$36,834	<ol> <li>Name of Care Manager (CM)/ Service Coordinator (SC) completing this Needs Assessment Tool</li> </ol>
Individual Alone Annual \$24,416-\$25,851; W/Spouse \$32,957-\$34,895	
Individual Alone Annual \$22,980-\$24,415; W/ Spouse \$31,018-\$32,956	2. Date of Care Manager (CM)/ Service Coordinator
Individual Alone Annual \$21,544-\$22,979; W/ Spouse \$29,079-\$31,017	(SC) Signature
Individual Alone Annual \$20,108-\$21,543; W/ Spouse \$27,141-\$29,078	3. Name of Registered Nurse reviewing the Needs Assessment Tool (if reviewed)
Individual Alone Annual \$18,672-\$20,107; W/ Spouse \$25,203-\$27,140	
Individual Alone Annual \$17,236-\$18,671; W/ Spouse \$23,265-\$25,202	4. Date of Registered Nurse review (if reviewed)
Consumer Alone Annual \$15,800-\$17,235; W/ Spouse \$21,327-\$23,264	5. Name of Supervisor reviewing this Needs
Consumer Alone Annual \$14,364-\$15,799; W/ Spouse \$19,389-\$21,326	Assessment Tool
Consumer Alone Annual \$0-\$14,363; W/ Spouse \$0-\$19,388	6. Date Supervisor approved the Needs Assessment
E. BENEFIT PROGRAMS	Tool
Check all benefits the individual is currently     RECEIVING:	
Food Stamps	
LIHEAP	
Medicaid	
PACE	
Section 8	
Subsidized Transit	
Tax and Rent Rebates	
Weatherization	
Other-Document Details in Notes	
NEEDS ASSESSMENT SUMMARY	
9.A. LCD & NAT OUTCOME	
What is the most recent Level of Care     Determination (LCD) for this individual?	
NFCE-Nursing Facility Clinically Eligible	
NFI-Nursing Facility Ineligible	
2. Has the individual had a change in condition that	
warrants a new LOC determination?	
∐ No	
Yes-Document Details in Notes	

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