NAT-E 12-3-18

1. INTRODUCTION

1.A. INDIVIDUAL'S IDENTIFICATION

1. Date of the face to face interview for Needs Assessment Tool (NAT)

_____/_____/_____

2. Individual's Last Name

_____

3. Individual's First Name

_____

4. Individual's Middle Initial

_____

5. Individual's Name Suffix (If applicable)

_____

6. Individual's Nickname/ Alias

_____

_____

_____

_____

7. Individual's Date of Birth (DOB)

_____/_____/_____

8. Individual's Gender

- ☐ Female
- ☐ Male

9. Individual's Ethnicity (Check only one.)

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

10. Individual's Race

- ☐ American Indian/ Native Alaskan
- ☐ Asian
- ☐ Black/ African American
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ Non-Minority (White, non-Hispanic)
- ☐ White-Hispanic
- ☐ Unknown/ Unavailable
- ☐ Other-Document Details in Notes

11. Individual's Social Security Number (SSN)

_____-_____-_____

12. Is the individual's annual income less than 100% of the current Federal Poverty Income Guidelines (FPIG)?

- ☐ Yes
- ☐ No
- ☐ Unknown

13a. Does the individual have a Medicaid number?

- ☐ No
- ☐ Yes
- ☐ Pending

13b. Indicate Medicaid recipient number

_____

14a. Does the individual have Medicare?

- ☐ No
- ☐ Yes

14b. Indicate Medicare recipient number

_____

15a. Does the individual have any other insurance?

- ☐ No
- ☐ Yes
- ☐ Don't know

15b. Indicate other health insurance information

_____

16. 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

1.B. NAT-E INFORMATION

1. PSA Number:

- [ ] 01
- [ ] 02
- [ ] 03
- [ ] 04
- [ ] 05
- [ ] 06
- [ ] 07
- [ ] 08
- [ ] 09
- [ ] 10
- [ ] 11
- [ ] 12
- [ ] 13
- [ ] 14
- [ ] 15
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- [ ] 44
- [ ] 45
- [ ] 46
- [ ] 47
- [ ] 48
- [ ] 49
- [ ] 50
- [ ] 51
- [ ] 52

2. If NAT-E was completed for specific SERVICE(S), document ALL that apply.

- [ ] Congregate Meal Nutrition Screen
- [ ] Home Delivered Meals Nutrition Screen
- [ ] Other-Document Details in Notes

3. Where was the individual interviewed?

- [ ] AAA-Area Agency on Aging
- [ ] AL-Assisted Living
- [ ] DC-Domiciliary Care
- [ ] Home
- [ ] Home of Relative/ Caregiver
- [ ] Hospital
- [ ] PCH-Personal Care Home
- [ ] Senior Center Site
- [ ] Other-Document Details in Notes

4. Did the individual participate in the NAT-E?

- [ ] No-Must complete 1.B.5
- [ ] Yes

5. If anyone else participated during the time of the needs assessment, please document the name and relationship in Notes.

- [ ] 1 - Spouse/ Domestic Partner
- [ ] 2 - Family/ Other than Spouse
- [ ] 3 - Legal Guardian
- [ ] 4 - Durable Power of Attorney (POA)
- [ ] 5 - Friend
- [ ] 6 - Other-Document Name and Relationship in Notes

1.C. INDIVIDUAL'S DEMOGRAPHICS

1a. Is the individual homeless?

- [ ] No-Skip to 1.C.2
- [ ] Yes

1b. Does the individual have a place to stay tonight?

- [ ] No-Document Details in Notes
- [ ] Yes

1c. Does the individual have a place to stay long-term?

- [ ] No-Document Details in Notes
- [ ] Yes

1d. Explain homeless situation:

- [ ] Cannot afford housing
- [ ] Evicted
- [ ] Housing not available
- [ ] Voluntary
- [ ] Other-Document Details in Notes

2. Type of PERMANENT residence in which the individual resides

- [ ] AL-Assisted Living
- [ ] Apartment
- [ ] DC-Domiciliary Care
- [ ] Group Home
- [ ] Nursing Home
- [ ] Own Home
- [ ] PCH-Personal Care Home
- [ ] Relative's Home
- [ ] Specialized Rehab/ Rehab Facility
- [ ] State Institution
- [ ] Other-Document Details in Notes

3. What is the individual's PERMANENT living arrangement? (Include in the "Lives Alone" category individuals who live in an AL, DC or PCH, pay rent and have NO ROOMMATE.)

- [ ] Lives Alone
- [ ] Lives with Spouse Only
- [ ] Lives with Child(ren) but not Spouse
- [ ] Lives with other Family Member(s)
- [ ] Unknown
- [ ] Other-Document Details in Notes

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/ widow or dependent child of a Veteran?

- [ ] No
- [ ] Yes
- [ ] Unable to Determine

5c. Is the individual receiving Veteran's benefits?

- [ ] No
- [ ] Yes
- [ ] Unable to Determine

6a. Does the individual require communication assistance?

- [ ] No-Skip to 1.C.7a
- [ ] Yes
- [ ] Unable to Determine

6b. What type of communication assistance is required?

- [ ] Assistive Technology
- [ ] Interpreter
- [ ] Large Print
- [ ] Picture Book
- [ ] Unable to Communicate
- [ ] Unknown
- [ ] Other-Document Details in Notes

7a. Does the individual use sign language as their PRIMARY language?

- [ ] No-Skip to 1.C.8
- [ ] Yes

7b. What type of sign language is used?

- [ ] American Sign Language
- [ ] International Sign Language
- [ ] Makaton
- [ ] Manually Coded Language-English
- [ ] Manually Coded Language-Non-English
- [ ] Tactile Signing
- [ ] Other-Document Details in Notes

8. What is the individual's PRIMARY language?

- [ ] English
- [ ] Russian
- [ ] Spanish
- [ ] Other-Document Details in Notes

9. Is the consumer disabled?

- [ ] No
- [ ] Not Collected
- [ ] Yes

1.D. 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.D & E
- [ ] Yes

2a. Residential County

- [ ] Adams
- [ ] Allegheny
- [ ] Armstrong
- [ ] Beaver
- [ ] Bedford
- [ ] Berks
- [ ] Blair
- [ ] Bradford
- [ ] Bucks
- [ ] Butler
- [ ] Cambria
- [ ] Cameron
- [ ] Carbon
- [ ] Centre
- [ ] Chester
- [ ] Clarion
- [ ] Clearfield
- [ ] Clinton
- [ ] Columbia
- [ ] Crawford
- [ ] Cumberland
- [ ] Dauphin
- [ ] Delaware
- [ ] Elk
- [ ] Erie
- [ ] Fayette
- [ ] Forest
- [ ] Franklin
- [ ] Fulton
- [ ] Greene
- [ ] Huntingdon
- [ ] Indiana
- [ ] Jefferson
- [ ] Juniata
- [ ] Lackawanna
- [ ] Lancaster
- [ ] Lawrence
- [ ] Lebanon
- [ ] Lehigh
- [ ] Luzerne
- [ ] Lycoming
- [ ] McKean
- [ ] Mercer
- [ ] Mifflin
- [ ] Monroe
- [ ] Montgomery
- [ ] Montour
- [ ] Northampton
- [ ] Northumberland
- [ ] Perry
- [ ] Philadelphia
- [ ] Pike
- [ ] Potter
- [ ] Schuylkill
- [ ] Snyder
- [ ] Somerset
- [ ] Sullivan
- [ ] Susquehanna
- [ ] Tioga
- [ ] Union
- [ ] Venango
- [ ] Warren
- [ ] Washington
- [ ] Wayne
- [ ] Westmoreland
- [ ] Wyoming
- [ ] York
- [ ] Out of State

2b. Residential Street Address

_____

2c. Residential Address Second Line (Apt or Room #, Building or Complex Name, etc.)

_____

2d. Residential Municipality - REQUIRED (usually a Township or Boro where individual votes, pays taxes)

_____

2e. Residential City/ Town

_____

2f. Residential State

_____

2g. Residential Zip Code

_____

3. Directions to the individual's home

4. Does individual reside in a rural area?

- ☐ No
- ☐ Yes

5a. Primary Phone Number

5b. Mobile Phone Number

5c. Other Phone Number (Enter number where individual can be reached.)

5d. E-mail Address

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.E. INDIVIDUAL'S POSTAL/MAILING ADDRESS INFORMATION

1a. Postal Street Address

1b. Postal Address Line 2 (optional)

1c. Postal City/ Town

1d. Postal State

1e. Postal Zip Code

1.F. EMERGENCY CONTACT

1. Name of Emergency Contact

2. Relationship of Emergency Contact

3. Telephone Number of Emergency Contact

4. Work Telephone Number of Emergency Contact

2. NUTRITION (Only Section 1 & 2 are required for Congregate Meals)

2.A. DIETARY ISSUES

1. Does the individual generally have a good appetite?

- [ ] No-Document Details in Notes
- [ ] Yes
- [ ] Other-Document Details in Notes

2. Does the individual use a dietary supplement?

- [ ] No
- [ ] Yes-Document Details in Notes

3. Does the individual have any food allergies?

- [ ] No
- [ ] Yes-Document Details in Notes

4. Does the individual have a special diet for medical reasons?

- [ ] No
- [ ] Yes-Document Details in Notes

5. Does the individual have a special diet for religious/ cultural reasons?

- [ ] No
- [ ] Yes-Document Details in Notes

2.B. NUTRITIONAL RISK ASSESSMENT

1. Has there been a change in lifelong eating habits because of health problems?

- [ ] No
- [ ] Yes-Document Details in Notes

2. Does the individual eat fewer than 2 meals per day?

- [ ] No
- [ ] Yes-Document Details in Notes

3. Does the individual eat fewer than 2 servings of dairy products (such as milk, yogurt, or cheese) every day?

- [ ] No
- [ ] Yes-Document Details in Notes

4. Does the individual eat fewer than 5 servings (1/2 cup each) of fruits or vegetables every day?

- [ ] No
- [ ] Yes-Document Details in Notes

5. Does the individual have 3 or more drinks of beer, liquor or wine almost every day?

- [ ] No
- [ ] Yes-Document Details in Notes

6. Does the individual have trouble eating due to problems with chewing/ swallowing?

- [ ] No
- [ ] Yes-Document Details in Notes

7. Individual does not have enough money to buy food needed?

- [ ] No
- [ ] Yes-Document Details in Notes

8. Does the individual eat alone most of the time?

- [ ] No
- [ ] Yes-Document Details in Notes

9. Does the individual take 3 or more prescribed or over-the-counter drugs (OTC) per day?

- [ ] No
- [ ] Yes-Document Details in Notes

10. Has the individual lost or gained at least 10 pounds or more in the LAST 6 MONTHS? Document Details in Notes

- [ ] No
- [ ] Yes, gained 10 pounds or more
- [ ] Yes, lost 10 pounds or more
- [ ] Don't know

11. Is the individual not always physically able to shop, cook and/or feed themselves (or to get someone to do it for them)?

- [ ] No
- [ ] Yes-Document Details in Notes

12. Calculates the consumer's Nutritional Risk Score based upon the responses to 2.A. 1-11.

3. USE OF MEDICAL SERVICES

3.A. HOSPITAL, NURSING FACILITY, ER, INPATIENT PSYCHIATRIC VISITS/STAYS

1. Has the individual stayed in the HOSPITAL in the LAST 12 MONTHS?

- ☐ No-Skip to 3.A.3
- ☐ Yes-Complete 3.A.2
- ☐ Unable to Determine-Document Details in Notes

2. The approximate number of times the individual has stayed overnight in the HOSPITAL in the LAST 12 MONTHS. Document Details in Notes

3. The approximate number of times the individual has visited the ER in the LAST 12 MONTHS and was NOT admitted.

4. The approximate number of times the individual was admitted to a NURSING FACILITY in the LAST 12 MONTHS. Document Details in Notes

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:

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ Other-Document Details in Notes

3.B. PRIMARY PHYSICIAN INFORMATION

1. Does the individual have a PRIMARY care physician?

- ☐ No
- ☐ Yes

2. PRIMARY Physician's Name

3. PRIMARY Physician's Street Address

4. PRIMARY Physician's City or Town

5. PRIMARY Physician's State

6. PRIMARY Physician's Zip Code

7. PRIMARY Physician's Business Phone Number (Requires 10 digits to transfer to SAMS, optional 1-5 digit extension.)

8. PRIMARY Physician's FAX Number

9. PRIMARY Physician's E-MAIL ADDRESS

10. Additional Physicians

11. Does the individual receive alternative medical care from a practitioner?

- ☐ No-Skip to 4.A.1
- ☐ Yes-Complete 3.B.12

12. Select the type of alternative medical care-Document Details in Notes

- ☐ Acupuncturist
- ☐ Chiropractor
- ☐ Herbalist
- ☐ Homoeopathist
- ☐ Masseur
- ☐ Other-Document Details in Notes

4. DIAGNOSES

4.A. HEART/ CIRCULATORY SYSTEMS

1. Select all HEART/ CIRCULATORY systems diagnoses:

- [ ] None-Skip to 4.B.1
- [ ] A-Fib and other Dysrhythmia, Bradycardia, Tachycardia
- [ ] Anemia
- [ ] Ascites
- [ ] CAD-Coronary Artery Disease: including Angina, Myocardial Infarction, ASHD
- [ ] DVT-Deep Vein Thrombosis
- [ ] Heart Failure: including CHF, Pulmonary Edema
- [ ] Hypertension
- [ ] PE-Pulmonary Embolus
- [ ] PVD/PAD (Peripheral Vascular or Artery Disease)
- [ ] Other-Document Details in Notes

2. Signs and symptoms of the HEART/ CIRCULATORY systems diagnoses:

- [ ] None
- [ ] Activity Intolerance
- [ ] Chest Pains
- [ ] Edema in Extremities
- [ ] Fainting (Syncope)
- [ ] Palpitations
- [ ] Shortness of Breath
- [ ] Skin Discoloration
- [ ] Weakness
- [ ] Other-Document Details in Notes

4.B. GASTROINTESTINAL

1. Select all GASTROINTESTINAL diagnoses:

- [ ] None-Skip to 4.C.1
- [ ] Barrett's Esophagus
- [ ] Crohn's Disease
- [ ] Diverticulitis
- [ ] GERD
- [ ] Hernia
- [ ] IBS-Irritable Bowel Syndrome
- [ ] Laryngeal Reflux Disease
- [ ] Other-Document Details in Notes

2. Signs and symptoms of GASTROINTESTIONAL diagnoses:

- [ ] None
- [ ] Abdominal Pain
- [ ] Bloated
- [ ] Constipation
- [ ] Diarrhea
- [ ] Flatulence
- [ ] Heartburn
- [ ] Rectal Bleeding
- [ ] Other-Document Details in Notes

4.C. SKIN

1. Select all SKIN diagnoses:

- [ ] None-Skip to 4.D.1
- [ ] Dry Skin
- [ ] Incision (surgical)
- [ ] Psoriasis
- [ ] Rash
- [ ] Ulcer
- [ ] Wound
- [ ] Other-Document Details in Notes

2. Check ALL affected SKIN location(s):

- [ ] Abdomen
- [ ] Ankle(s)
- [ ] Arm(s)
- [ ] Back of Knee(s)
- [ ] Buttock(s)
- [ ] Chest
- [ ] Face
- [ ] Foot/ Feet
- [ ] Hip(s)
- [ ] Leg(s)
- [ ] Lower Back
- [ ] Shoulder Blade(s)
- [ ] Spine
- [ ] Tailbone
- [ ] Other-Document Details in Notes

3. Signs and symptoms of the SKIN diagnoses:

- [ ] None
- [ ] Edema/ Swelling
- [ ] Excoriation
- [ ] Odor/ Drainage
- [ ] Pain
- [ ] Redness/ Discoloration
- [ ] Skin Tears
- [ ] Other-Document Details in Notes

4.D. ENDOCRINE/ METABOLIC SYSTEMS

1. Select all ENDOCRINE/ METABOLIC systems diagnoses:

- [ ] None-Skip to 4.E.1
- [ ] Ascites
- [ ] Cirrhosis
- [ ] Diabetes Mellitus (DM)-Insulin Dependent
- [ ] Diabetes Mellitus (DM)-Non-Insulin Dependent
- [ ] Diabetic Neuropathy
- [ ] Hypoglycemia
- [ ] Thyroid Disorder
- [ ] Other-Document Details in Notes

2. Signs and symptoms of the ENDOCRINE/ METABOLIC systems diagnoses:

- [ ] None
- [ ] Agitation
- [ ] Anxiety
- [ ] Blurred Vision
- [ ] Confusion
- [ ] Frequent Urination
- [ ] Increased Thirst
- [ ] Lethargy
- [ ] Slow Healing Sores
- [ ] Sweating
- [ ] Other-Document Details in Notes

4.E. NEUROLOGICAL

1. If there are NEUROLOGICAL diagnoses, select all types:

- [ ] None-Skip to 4.F.1
- [ ] ALS
- [ ] Alzheimer's Disease
- [ ] Autism
- [ ] Cerebral Palsy
- [ ] CVA/ TIA/ Stroke
- [ ] Dementia (Include all Non-Alzheimer's Dementia)
- [ ] Multiple Sclerosis
- [ ] Muscular Dystrophy
- [ ] Neuropathy
- [ ] Parkinson's Disease
- [ ] Seizure Disorder
- [ ] TBI-Traumatic Brain Injury
- [ ] Other-Document Details in Notes

4.F. CANCER

1. Does the individual have any current CANCER diagnoses?

- [ ] No-Skip to 4.G.1
- [ ] Yes

2. Select all current CANCER diagnoses:

- [ ] Basal Cell
- [ ] Bile Duct
- [ ] Bladder
- [ ] Bone
- [ ] Brain
- [ ] Breast
- [ ] Cervical
- [ ] Colon
- [ ] Colorectal
- [ ] Endometrial
- [ ] Esophageal
- [ ] Gallbladder
- [ ] Gastric
- [ ] Hodgkin's Disease
- [ ] Kidney
- [ ] Leukemia
- [ ] Liver
- [ ] Lung
- [ ] Lymphatic
- [ ] Multiple Myeloma
- [ ] Non-Hodgkin's Lymphoma
- [ ] Oral
- [ ] Ovarian
- [ ] Pancreatic
- [ ] Prostate
- [ ] Sarcoma
- [ ] Skin
- [ ] Testicular
- [ ] Throat
- [ ] Thyroid
- [ ] Uterine
- [ ] Vaginal
- [ ] Other-Document Details in Notes

4.G. EARS, NOSE & THROAT (ENT)

1. Select all ENT diagnoses:

- [ ] None-Skip to 4.H.1
- [ ] Deafness
- [ ] Deviated Septum
- [ ] Rhinitis
- [ ] Sinusitis
- [ ] Tinnitus
- [ ] Other-Document Details in Notes

2. Signs and symptoms of the ENT diagnoses:

- [ ] None
- [ ] Choking
- [ ] Congestion
- [ ] Difficulty Breathing
- [ ] Difficulty Swallowing
- [ ] Dizziness
- [ ] Fullness/ Pressure in Head/ Sinuses
- [ ] Headaches
- [ ] Hearing Loss
- [ ] Hoarseness
- [ ] Persistent Cough
- [ ] Other-Document Details in Notes

3. Current treatments for ENT diagnoses:

- [ ] None
- [ ] Esophageal Dilatation
- [ ] Feeding Tube
- [ ] Hearing Aid
- [ ] Implants
- [ ] Medications-Document Details in Notes
- [ ] Tracheostomy
- [ ] Other-Document Details in Notes

4.H. MOUTH

1. Select all MOUTH conditions and/ or diagnoses:

- [ ] None-Skip to 5.A.1
- [ ] Dry Mouth
- [ ] Edentulous/ Toothless
- [ ] Gingivitis
- [ ] Thrush
- [ ] Ulcer(s)
- [ ] Other-Document Details in Notes

2. Signs and symptoms of MOUTH conditions and/ or diagnoses:

- [ ] None
- [ ] Halitosis
- [ ] Pain
- [ ] Swelling
- [ ] Thrush
- [ ] Other-Document Details in Notes

5. OTHER MEDICAL INFORMATION

5.A. FRAILTY SCORE

1. Are you tired?

- [ ] No
- [ ] Yes

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?

- [ ] No
- [ ] Yes

5. Have you lost more than 5% of your weight in the last year? Document details for the weight changes in 5.B.3.

- [ ] No
- [ ] Yes

6. Individual shows symptoms of being frail?

5.B. HEIGHT/WEIGHT

1. What is the individual's height?

_____

2. What is the individual's weight?

_____

3. Document the reason(s) for weight gain or loss (See 5.A.5)

- [ ] Diet/ Intentional
- [ ] Fluid Loss
- [ ] Fluid Retention
- [ ] Increased Appetite
- [ ] Poor Appetite
- [ ] Unable to Determine
- [ ] Other

4. Is physician aware of the weight change?

- [ ] No
- [ ] Yes

5. What is the individual's weight type?

- [ ] Normal-height/ weight appropriate
- [ ] Morbidly Obese
- [ ] Obese
- [ ] Overweight
- [ ] Underweight

5.C. FALLS

1. Is the individual at risk of falling?

- [ ] No
- [ ] Yes
- [ ] Unable to determine

2. Select the number of times the individual has fallen in the LAST 6 MONTHS.

- [ ] None-Skip to 6.A.1
- [ ] 1
- [ ] 2
- [ ] 3 or More

3. Reasons for falls-Document Details in Notes

- [ ] Medical
- [ ] Environmental
- [ ] Accidental
- [ ] Other-Document Details in Notes

6. ACTIVITIES OF DAILY LIVING (ADLs)

6.A. ADLs

1. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

2. 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
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

3. 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
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

4. EATING: Ability to eat/ drink; cut, chew, swallow food; and to use any needed assistive devices

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance
- ☐ 4 - Does not eat

5. TRANSFER: Ability to move between surfaces, including to/ from bed, chair, wheelchair, or to a standing position; onto or off a commode; and to manage/ use any needed assistive devices.

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

6. TOILETING: Ability to manage bowel and bladder elimination.

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance
- ☐ 4 - Self management of indwelling catheter/ ostomy

7. BLADDER CONTINENCE: Indicate the description that best describes the individual's BLADDER function.

- ☐ 1 - Continent - Complete control, no type of catheter or urinary collection device
- ☐ 2 - Usually Continent - Incontinence episodes once a week or less
- ☐ 3 - Incontinent - Inadequate control, multiple daily episodes
- ☐ 4 - Self management of indwelling catheter or ostomy

8. WALKING: Ability to safely walk to/ from one area to another; manage/ use any needed ambulation devices.

- ☐ Independent
- ☐ Limited Assistance
- ☐ Total Assistance

7. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

7.A. IADLs

1. MEAL PREPARATION: Ability to plan/ prepare meals, use of kitchen appliances, heat meals. List any needed adaptive equipment/ assistive devices in Notes.

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

1a. How often is support available for MEAL PREPARATION? Document Details in Notes

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Other-Document Details in Notes

2. HOUSEWORK: Ability to maintain living space, includes tasks such as dishwashing, making the bed, dusting, running the vacuum or sweeping an area. List any needed adaptive equipment/ assistive devices in Notes.

- ☐ 1 - Independent
- ☐ 2 - Limited assistance
- ☐ 3 - Total Assistance

3. LAUNDRY: Ability to gather clothes, place clothes 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 in Notes.

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

4. SHOPPING: Ability to go to the store and purchase needed items, including groceries and other items. List any needed adaptive equipment/ assistive devices in Notes.

- ☐ 1 - Independent
- ☐ 2 - Limited assistance
- ☐ 3 - Total Assistance

5. TRANSPORTATION: Ability to travel on public transportation or drive a car. List any needed adaptive equipment/ assistive devices in Notes.

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

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
- ☐ 2 - Limited assistance
- ☐ 3 - Total Assistance

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
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

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
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

9. MANAGING MEDICATIONS: What is the individual's ability level to manage medication?

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

8. INFORMAL SUPPORTS

8.A. INFORMAL HELPER(S) INFORMATION

1. Does the individual have any NON-PAID helpers that provide care or assistance on a regular basis?

- ☐ No-Skip to 8.B.1
- ☐ Yes-Complete Section 8.A & B

2. List names, phone numbers and email addresses of the non-paid helpers. Use the Note section if more room is needed.

_____

_____

_____

_____

3. Do any of the non-paid helpers reside in the individual's home?

- ☐ No
- ☐ Yes-Document Details in Notes

4. Select the relationships of the individual's non-paid helpers:

- ☐ Child/ Child-in-Law
- ☐ Friend
- ☐ Neighbor
- ☐ Parent
- ☐ Spouse/ Domestic Partner
- ☐ Other-Document Details in Notes

8.B. ACCESS TO SERVICES

1. Does the individual have an issue with access to needed services or supports?

- ☐ No
- ☐ Yes-Document Details in Notes

2. If the individual does not have access to the needed services or supports, what assistance is needed?

_____

_____

_____

_____

9. PHYSICAL ENVIRONMENT

9.A. CURRENT DWELLING UNIT

1. Is the individual able to remain in his/ her current residence?

- [ ] No-Document Details in Notes
- [ ] Yes
- [ ] Uncertain-Document Details in Notes

2. What conditions of the home environment cause health and safety risks to the individual? Document in notes what and where are the problems.

- [ ] None
- [ ] Appliances
- [ ] Clutter
- [ ] Cooling system
- [ ] Environmental pests
- [ ] Furnishings
- [ ] Hallways
- [ ] Heating system
- [ ] Lack of electricity
- [ ] Lack of fire safety devices
- [ ] Lack of refrigeration
- [ ] Lack of toilet
- [ ] Lack of water
- [ ] Lighting
- [ ] Pets
- [ ] Poor flooring
- [ ] Shower
- [ ] Stairs
- [ ] Structural issues
- [ ] Other-Document Details in Notes

3. What areas of the home environment impact accessibility? Document in Notes, what and where problems exist.

- [ ] Bathroom
- [ ] Bedroom
- [ ] Hallways
- [ ] Home entryways
- [ ] Kitchen
- [ ] Laundry
- [ ] Stairs
- [ ] Other-Document Details in Notes

10. EMERGENCY INFORMATION

10.A. EMERGENCY INFORMATION

1. What are the individual's physical limitations that would prevent individual leaving the home alone in an emergency?

- [ ] None
- [ ] Bed bound/ immobile
- [ ] Dementia (May be reluctant to leave.)
- [ ] Hearing impaired (May need special warnings.)
- [ ] Intellectual disabilities (Supervision needed.)
- [ ] Lives alone (May be reluctant to leave.)
- [ ] Morbid Obesity
- [ ] Visually impaired (Guide dogs may become disoriented in a disaster.)
- [ ] Wheelchair bound (Special transportation needed.)
- [ ] Other-Document Details in Notes

2. Does the individual have any of the following special medical needs during a public emergency?

- [ ] None
- [ ] Dialysis
- [ ] Insulin
- [ ] Life sustaining equipment or treatment
- [ ] Nasal/ gastrointestinal tubes/ suctioning
- [ ] Oxygen
- [ ] Respirator
- [ ] Special medications & management needs
- [ ] Specialized transportation
- [ ] Supervision
- [ ] Other-Document Details in Notes

3. Select ALL types of Personal Emergency Response Systems (PERS) with which the individual is currently utilizing:

- [ ] None
- [ ] PERS/ w 24 hour family/ designated contact notification
- [ ] PERS/ w 24 hour response for elopement (GPS)
- [ ] Other-Document Details in Notes

4. Is the consumer enrolled in a community response program?

- [ ] No
- [ ] Yes-Document Details in Notes

11. EMERGENCY PLANNING

11.A. EMERGENCY PLANNING

1. Is individual meal dependent?

- ☐ Yes
- ☐ No

2. Is individual medication dependent?

- ☐ Yes
- ☐ No

3. Is individual electricity dependent?

- ☐ Yes
- ☐ No

4. Is individual transportation dependent?

- ☐ Yes
- ☐ No

5. Is individual attendant dependent?

- ☐ Yes
- ☐ No

6. Is individual oxygen dependent?

- ☐ Yes
- ☐ No

7. Is individual mobility dependent?

- ☐ Yes
- ☐ No

12. REFERRAL FOR NAT OR LEVEL OF CARE DETERMINATION

12.A. REFERRAL FOR NAT OR LEVEL OF CARE DETERMINATION

1. Case Aide believes the individual should be referred for a NAT or level of care determination:

- ☐ No
- ☐ Yes

2. Signature of Case Aid/ Staff:

_____

_____

_____

_____

3. Date of Case Aid/ Staff's Signature:

_____/_____/_____

4. Care Manager believes the individual should be referred for a NAT or level of care determination:

- ☐ No
- ☐ Yes

5. Signature of Care Manager:

_____

6. Date of Care Manager's Signature:

_____/_____/_____

7. Supervisor believes the individual should be referred for a NAT or level of care determination:

- ☐ No
- ☐ Yes

8. Signature of Supervisor:

_____

9. Date of Supervisor's Signature:

_____/_____/_____