NYSOFA 246 (04/19)

***COMPASS* – Comprehensive Assessment for Aging Network Community-Based Long Term Care Services**

INTAKE INFORMATION

A. Person's Name: _____

B. Address: _____

C. Phone #: H: _____ C: _____ E-mail: _____

D. Date of Referral: _____ (mm/dd/yyyy)

E. Referral Source *(Specify Name, Agency and Phone):* _____

F. Presenting Problem/Person's Concern(s): _____

G. Does the person know that a referral has been made? [ ] Yes [ ] No if no why not?_____

H. Intake Workers Name: _____ E-mail: _____

The client information contained in this assessment instrument is confidential and may be shared with others only as necessary to implement the client's care plan and comply with program requirements, including but not limited to monitoring, research and evaluation.

NYSOFA 246 (04/19) CO M PASS - Comprehensive Assessment for Aging Network
Community Based Long Term Care Services

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CASE IDENTIFICATION

Client ID: _____

Assessment Date (mm/dd/yyyy): ___/___/_____
Assessor Name: _____

Assessment Agency: _____

Reason for COMPASS Completion:
[ ] Initial Assessment
[ ] Reassessment

Next Assessment Date (mm/dd/yyyy): ___/___/_____
HDM Recipient 6 Month Contact Date Due (mm/dd/yyyy): ___/___/_____ (for those clients whose cluster 1 services only include Home Delivered Meals)

I CLIENT INFORMATION

A. Person's Name: _____
B. Address (including zip code):

_____
_____
_____

C. E-mail: _____
D. Phone Numbers:
Home: _____
Work: _____
Cell: _____

E. Social Security No. (Last 4 digits only): _____

F. Marital Status: (Check one)

[ ] Married [ ] Widowed [ ] Domestic Partner or Significant Other [ ] Divorced
[ ] Separated [ ] Single

G. Sex:

What was your sex at birth (on your original birth certificate)?

[ ] Female [ ] Male

H. Transgender - Gender Identity or Expression?

Some people describe themselves as transgender when they experience a different gender identity from their sex at birth. For example, a person, born into a male body, but who feels female or lives as a woman. Do you consider yourself to be transgender?

[ ] No;

[ ] Yes, transgender male to female;

[ ] Yes, transgender female to male;

[ ] Yes, transgender, do not identify as male or female.

[ ] Did not answer.

I. Birth Date (mm/dd/yyyy): _____ Age: _____

J. Race/Ethnicity

Race (check one)

[ ] American Indian/Native Alaskan [ ] Asian [ ] Black or African American

[ ] White – Hispanic [ ] White - Not Hispanic

[ ] Native Hawaiian/Other Pacific Islander [ ] Other Race [ ] 2 or More Races

Ethnicity (check one)

[ ] Not Hispanic or Latino [ ] Hispanic or Latino

K. Sexual Orientation

Do you think of yourself as: [ ] Heterosexual or Straight [ ] Homosexual or Gay

[ ] Lesbian [ ] Bisexual [ ] Not Sure

[ ] Did Not Answer [ ] Other

L. Creed: [ ] Christianity [ ] Islam [ ] Hinduism [ ] Buddhism [ ] Judaism [ ] Did Not Answer

[ ] Atheist [ ] Other (Specify) _____

M. National Origin: _____

N. Primary Language (Check all that apply)

	English	Spanish	Chinese	Russian	Italian	Haitian Creole	Korean	Other
Speaks	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Reads	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Understands orally	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

O. Client does not speak English as their primary language and has ONLY a limited ability to read, speak, write or understand English. [ ] Yes* [ ] No

* Identify Primary Language: _____

Client has been informed of their right to no cost interpretation? [ ] Yes [ ] No

Communication plan identifying how language access needs will be met during service delivery:

_____

If professional interpretation services are declined, has client has signed waiver of declination of interpreter services? [ ] Yes [ ] No

Does the client have a hearing, speech or visual impairment that requires accommodation for effective communication with service providers? [ ] Yes* [ ] No

*Communication plan (i.e. use of 711/Relay, reading of printed material, ASL interpreter):_____

P. Living-Arrangement:

[ ] Alone [ ] With Spouse [ ] Domestic Partner Only [ ] With Domestic Partner & Others

[ ] With Spouse & others [ ] With Relatives (excludes spouse) [ ] With Non-Relative(s)

[ ] Others Not listed

Q. Contact Information:

1. Emergency Contact:

Primary		**Secondary**	
Name:		Name:	
Address:		Address:	
Relationship:		Relationship:	
Home Phone:		Home Phone:	
Cell Phone:		Cell Phone:	

Contact	Relation	Address	Home Phone	Work Phone	Mobile Phone	Care Giver	Status	Type

R. Elder Abuse/Neglect Issues

1. During the last 6 months have you experienced any of the following forms of abuse?

[ ] Physical Abuse [ ] Active and Passive Neglect [ ] Sexual Abuse

[ ] Self Neglect [ ] Emotional Abuse [ ] Domestic Violence

[ ] Financial Exploitation [ ] Other (e.g. Abandonment) [ ] None Reported

Was this referred to:

[ ] Adult Protective Services [ ] AAA [ ] Police Agency

[ ] Domestic Violence Service Provider [ ] Not Referred [ ] Other _____

Check if any of the following has occurred:

a. Do you feel unsafe at home with the people you have regular contact with?	[ ] Yes [ ] No	b. Has anyone forced you to sign document(s) that you did not want to sign - like checks or Power of Attorney?	[ ] Yes [ ] No
c. Has anyone scolded, yelled at, or threatened you in the last year?	[ ] Yes [ ] No	d. Has anyone taken things that belong to you without your consent?	[ ] Yes [ ] No
e. Does anyone force you to do things that you do not want to do?	[ ] Yes [ ] No	f. Has anyone tried to physically hurt or harm you in the last year?	[ ] Yes [ ] No
g. Have there been repeated times in the last year when the person you rely on to help you with household tasks, such as cleaning or shopping, or with personal assistance, such as bathing, has not done so?	[ ] Yes [ ] No	h. Has anyone living with you stopped contributing to household expenses like rent or food where they have previously agreed to do, and are capable of doing so now?	[ ] Yes [ ] No

S. a. Is the client frail? [ ] Yes [ ] No
b. Is the client disabled? [ ] Yes [ ] No

T. Is client providing care for another individual? [ ] Yes [ ] No
Relationship, nature of care, frequency _____

II HOUSING STATUS

A. Type of Housing:
[ ] multi-unit housing [ ] single family home [ ] other specify _____

B. Rent or Own: [ ] owns [ ] rents [ ] other specify _____

C. Home Safety Checklist: (Check all that apply)

Housing Issues: Please select all that apply:			
[ ]	Accumulated garbage	[ ]	Bad odors
[ ]	Carbon monoxide detectors not present/not working or older than 7 years	[ ]	Client has no adequate/consistent heat and hot water
[ ]	Client has no/inadequate lighting	[ ]	Client has serious plumbing problems
[ ]	Client is at imminent risk of eviction/foreclosure	[ ]	Client is at imminent risk of utility shut off
[ ]	Dirty living areas?	[ ]	Doorway widths are inadequate
[ ]	Exposed wiring/electric cords?	[ ]	Floors and stairways dirty and cluttered
[ ]	Furnace not working	[ ]	Insects/vermin?
[ ]	Loose scatter rugs present in one or more rooms	[ ]	Mold/mildew signs present?
[ ]	No access to phone/emergency numbers?	[ ]	No grab bar in tub or shower
[ ]	No handrails on the stairway	[ ]	No lamp or light switch within easy reach of the bed
[ ]	No lights in the bathroom or in the hallway	[ ]	No locks on doors or not working
[ ]	No rubber mats or non-slip decals in the tub or shower	[ ]	Roof leaks
[ ]	Smoke detectors not present/not working or older than 10 years	[ ]	Smokers in household
[ ]	Stairs are not lit	[ ]	Stairways are not in good condition
[ ]	Telephone and appliance cords are strung across areas where people walk	[ ]	Traffic lane from the bedroom to the bathroom is not clear of obstacles
[ ]	Other (Specify)	[ ]	No Housing Issues

D. Does the client have a working air conditioner? [ ] Yes [ ] No
If' 'Yes', does the client use the air conditioner in the summer? [ ] Yes [ ] No

E. Energy Checklist
[ ] Presence of drafts or cold spots
[ ] Use of space heaters
[ ] Heating fuel used: [ ] natural gas; [ ] oil; [ ] electric; [ ] propane; [ ] wood; [ ] other:_____
[ ] Estimate monthly energy bill: $_____

F. Does the client have family/friends who visit at least weekly? [ ] Yes [ ] No

G. Does the client speak with family/friends at least several times weekly? [ ] Yes [ ] No

H. Is the client able to participate in any outside social activities such as church, etc. at least weekly?
[ ] Yes [ ] No

I. Is neighborhood safety an issue? [ ] Yes [ ] No If Yes, Describe)_____
Neighborhood Comments: _____

J. 1. Does client have pet(s)? [ ] Yes [ ] No
a. [ ] Cats # of ____
b. [ ] Dogs# of ____
c. [ ] Other Specify: _____
2. Are the pets a barrier to service provision? [ ] Yes [ ] No
3. Is the pet a Service Animal? [ ] Yes [ ] No
4. Have all pets had all required vaccinations including rabies shot this year (e.g. rabies, parvo, distemper, etc.)? [ ] Yes [ ] No If no explain: _____
5. In the event of an "emergency" are there plans for the care of the pet(s)? [ ] Yes [ ] No

K. Is client able to self-evacuate their residence in the event of emergency? [ ] Yes [ ] No

*Identify needs and evacuation plan (i.e. mobility impaired, lives on 3rd floor-elevator required, client on special needs registry) _____

L. Is the client currently receiving ongoing medical treatments that require accommodation in the event of emergency or inclement weather? (i.e. dialysis, chemotherapy, methadone maintenance)
[ ] Yes [ ] No

Treatment/Provider Contact Information: _____

M. a. In the event of emergency or power outage does the client utilize devices or equipment that require electricity or an alternate power source? (i.e. oxygen, nebulizer, C-Pap machine, power chair that requires daily charging) [ ] Yes [ ] No

b. Identify equipment, service provider contact information:

Equipment	Provider/Contact	Backup plan	Release on File Y N

III HEALTH STATUS

A. Health Care Providers:		
	Name	Telephone
Primary Physician:		
Clinic/HMO		
Hospital:		
Primary Pharmacy:		
Dentist or Hygienist:		
Other:		

B. Medical Insurance:

	Name	Number
Health Insurance Provider:		
Secondary Health Insurance Provider:		
Prescription Coverage Plan:		
Other Health Insurance Provider:		

Has Medicaid:	[ ] Yes [ ] No	Medicaid No.:		
Has Medicare:	[ ] Yes [ ] No	Medicare No.:		
Medicare Type:	[ ] A and B	[ ] A and D	[ ] A only	[ ] A, B, and D
[ ] A, B, and C	[ ] A, B, C, and D	[ ] B and D	[ ] B only	[ ] D only

C. Does the client have an assigned case manager/care coordinator/case worker through their health plan or other long term care plan? [ ] Yes [ ] No
Case Manager/Care Coordinator Name and Contact Info:_____

D. Does the person have a self-declared chronic illness and/or disability?

[ ] Alcoholism*	[ ] Alzheimer's	[ ] Anorexia*
[ ] Arthritis	[ ] Asthma	[ ] Back Problems
[ ] Cancer*	[ ] Cellulitis	[ ] Chronic Diarrhea*
[ ] Chronic Obstructive Pulmonary Disease (COPD)	[ ] Chronic Pain	[ ] Colitis*
[ ] Colostomy*	[ ] Congestive heart failure*	[ ] Constipation*
[ ] Decubitus Ulcers*	[ ] Dehydration*	[ ] Dementia Related Illness
[ ] Dental problems*	[ ] Dev. disabilities	[ ] Diabetes (Type 1) *
[ ] Diabetes (Type 2) *	[ ] Dialysis*	[ ] Digestive problems*
[ ] Diverticulitis*	[ ] Emphysema	Fractures (recent)
[ ] Frequent falls	[ ] Gall bladder disease*	[ ] Glaucoma
[ ] Hearing impairment	[ ] Heart disease*	[ ] Hiatal hernia
[ ] High blood pressure*	[ ] High cholesterol*	[ ] Hyperglycemia*
[ ] Hypoglycemia*	[ ] Incontinence	[ ] Legally blind*
[ ] Liver disease	[ ] Low blood pressure	[ ] Mobility Impairment
[ ] Morbid obesity*	[ ] Multiple Sclerosis	[ ] Osteoporosis
[ ] Oxygen dependent	[ ] Paralysis	[ ] Parkinson's

[ ] Pernicious anemia*	[ ] Renal disease*	[ ] Respiratory problems
[ ] Shingles	[ ] Smelling impairment*	[ ] Speech problems*
[ ] Stroke*	[ ] Swallowing difficulties*	[ ] Taste impairment*
[ ] Thyroid*	[ ] Traumatic brain injury	[ ] Tremors
[ ] Tuberculosis	[ ] Ulcer*	[ ] Urinary Tract infection
[ ] Visual impairment	[ ] Other (Specify)	
*May indicate need for assessment by nutritionist		

E. 1. Does the person have an assistive device? [ ] Yes [ ] No If yes, check all that apply

[ ] Accessible vehicle	[ ] Bed rail	[ ] Cane
[ ] Commode	[ ] Denture - Full	[ ] Denture - Partial
[ ] Grab Bars	[ ] Glasses	[ ] Hand Held Shower
[ ] Hearing Aid	[ ] Lift Chair	[ ] PERS
[ ] Prosthesis	[ ] Raised Toilet Seat	[ ] Scooter
[ ] Transfer Bench	[ ] Tub Seat	[ ] Walker
[ ] Wheelchair\Transportable folding	[ ] Other	

2. Does the person need an assistive device? [ ] Yes [ ] No
If yes, specify device: _____

3. Does the person and/or caregiver need training on the use of an assistive device?
[ ] Yes [ ] No If yes, describe training needs _____

F. Health Care Visits:

	Date of Last Visit	Number of Visits in last 12 Months	Reason for Visit(s)
Primary Medical Provider			
Dentist or Hygienist			
Hospitalization			
Clinic/Community Health Center			
Emergency Room			
Eye/Retinologist			
Audiologist			

G. Has a PRI been completed in the past 90 days?
[ ] Yes [ ] No If Yes, describe the reason for completion _____
PRI Score: _____
Completed by: _____
(Name and Affiliation)
Date completed: Month: _____ Year: _____
Comments: _____

H. Has a UAS Assessment been completed in the past 6 months?
[ ] Yes [ ] No If Yes, describe the reason for completion _____
Completed by: _____
(Name and Affiliation)
Date completed: Month: _____ Year: _____
Comments: _____

I. Advanced Directives and Legal Information

Power of Attorney:	[ ] Yes	[ ] No
Power of Attorney Name	_____	
Power of Attorney Type:	[ ] Durable	[ ] Finance
Power of Attorney Name		
Power of Attorney Type:	[ ] Durable	[ ] Finance
Legal Guardian	[ ] Yes	[ ] No
Legal Guardian Name:	_____	
Legal Guardian Type:	[ ] Article 81	[ ] Article 17-A
Legal Guardian Name:		
Legal Guardian Type:	[ ] Article 81	[ ] Article 17-A
Do Not Resuscitate (DNR)	[ ] Yes	[ ] No
Health Care Proxy:	[ ] Yes	[ ] No
MOLST:	[ ] Yes	[ ] No
Living Will:	[ ] Yes	[ ] No
Estate Will:	[ ] Yes	[ ] No

Would the client like more information on completing advanced directives? [ ] Yes [ ] No

Legal Comments: _____

IV. NUTRITION

A. Person's height _____ Source: _____

B. Person's weight _____ Source: _____

C. Body Mass Index _____
Calculated from height and weight as follows:
Weight in pounds x 703. Divide this number by height in inches then divide by height in inches again.
Healthy older adults should have a BMI between 22 and 27. A BMI outside of this range may indicate the need for a referral to a dietitian.

D. Are the person's refrigerator/freezer and cooking facilities adequate?

[ ] Yes [ ] No If no, describe _____

E. Is the person able to open containers/cartons and cut up food?

[ ] Yes [ ] No If no, describe _____

F. In the event of emergency or inclement weather, does the client maintain a shelf stable food supply that does not require refrigeration or heating? [ ] Yes [ ] No*

*If no, case manager should be addressing in care plan (e.g. referral to food pantry, list of supplies, purchase non electric can opener)

G. Does the person have a physician prescribed modified therapeutic diet?

[ ] Yes (If yes, check all that apply)

[ ] Texture-Modified	[ ] Calorie Controlled Diet	[ ] Sodium Restricted
[ ] Fat Restricted	[ ] High Calorie	[ ] Renal
[ ] Diabetic	[ ] Liquid Nutritional Supplement	[ ] Other (Specify)_____

[ ] If No, Check all that apply

[ ] Regular	[ ] Special Diet	[ ] Vegetarian
[ ] Ethnic/Religious (specify)		

H. Does the person have a physician-diagnosed food allergy?
[ ] Yes [ ] No If yes, describe _____

I. Does the person use nutritional supplements?

[ ] Yes [ ] No If yes specify who prescribed and the supplement _____

J. Nutritional Risk Status

Check all that apply and circle the corresponding number at right	Score
[ ] Has an illness or conditions that made you change the kind and/or amount of food you eat.	2
[ ] Eats fewer than 2 meals per day.	3
[ ] Eats few fruits or vegetables, or milk products.	2
[ ] Has 3 or more drinks of beer, liquor, or wine almost every day.	2
[ ] Has tooth or mouth problems that make it hard for me to eat.	2
[ ] Does not always have enough money to buy the food they need.	4
[ ] Eat alone most of the time.	1
[ ] Takes 3 or more different prescribed or over-the-counter drugs a day.	1
[ ] Without wanting to, lost or gained 10 or more pounds in the last 6 months.	2
[ ] Not always physically able to shop, cook, and/or feed themselves.	2

NSI Score: _____

A score of 6 or more indicates "High" nutrition risk. 3-5 Indicates "Moderate "' nutrition risk, and 2 or less Indicates “Low” nutritional risk.

Conclusion: Based on the NSI score, this person is at check one:
[ ] High Risk [ ] Moderate Risk [ ] Low Risk Comments: _____

K. Does client exhibit any of the following?

[ ] Anorexic Behaviors	[ ] Bulimic Behaviors	[ ] Compulsive Overeating
[ ] Decreased Appetite	[ ] Difficulty Chewing	[ ] Difficulty holding utensils and opening packages
[ ] Loose/Ill-fitting dentures	[ ] No appetite due to medication or medication side effect	[ ] No teeth at all and no dentures
[ ] Overweight	[ ] Underweight	

L. In the past 3 months, has the client been able to brush their teeth and/or clean their dentures regularly (at least once a day)? [ ] Yes [ ] No
If' No, Select all that apply)

[ ] Cannot hold toothbrush/denture brush
[ ] Has trouble remembering/forgets
[ ] No toothbrush/ denture brush
[ ] No toothpaste/ denture cleaner
[ ] Other

M.Is the client unable to attend a congregate meal program because of an accident, illness or frailty?
[ ] Yes [ ] No
N. Does the client lack formal or informal supports who can regularly provide meals? [ ] Yes [ ] No
O. Is the client able to live safely at home if home delivered meal services are provided? [ ] Yes [ ] No
P. The client is unable to prepare meals because (Select all that apply):
[ ] Lacks adequate cooking facilities
[ ] Lacks knowledge or skills to prepare meals
[ ] Unable to safely prepare meals
[ ] Unable to shop or cook
Q. Is there a non-senior spouse who is less than 60 years of age who would receive a HDM?
[ ] Yes [ ] No
R. Is there a disabled dependent who is less than 60 years of age who would receive a HDM?
[ ] Yes [ ] No
S. Frozen Meal Eligibility Screening:

1. Does the client have a working freezer, refrigerator and equipment to heat their meal?
   [ ] Yes [ ] No
2. Is there sufficient freezer capacity to store 3 or more packages of meals each measuring 9x7x2?
   [ ] Yes [ ] No
3. Can the client safely operate/manage a microwave oven, toaster oven and/or oven?
   [ ] Yes [ ] No
4. Can the client read and safely follow instructions about storage and re-heating meals?
   [ ] Yes [ ] No
5. Can the client safely manage the receipt of multiple meals and cold packs from a deliverer at their front door and manage placement of those items in the refrigerator and freezer independently?
   [ ] Yes [ ] No
6. Is the client able to handle a frozen meal? (Must answer the previous 5 questions)
   [ ] Yes [ ] No

Please indicate client's meal preference: (applies to both weekday and weekend meals)
[ ] Hot [ ] Chilled [ ] Frozen [ ] Regular [ ] Other: _____

T. Have you been referred to a registered dietician? [ ] Yes [ ] No (if no, referral should be added to care plan).

V. Psycho-Social Status

A. Psycho-Social Condition

Does the person appear, demonstrate and/or report any of the following (check all that apply)?

[ ] alert	[ ] cooperative	[ ] dementia
[ ] depressed	[ ] disruptive socially	[ ] hallucinations
[ ] hoarding	[ ] impaired decision making	[ ] lonely
[ ] memory deficit	[ ] physical aggression	[ ] self-neglect
[ ] sleeping problems	[ ] suicidal behavior	[ ] suicidal thoughts
[ ] verbal disruption	[ ] worried or anxious	[ ] other (specify)

B. Evidence of substance abuse problems? [ ] Yes [ ] No If yes describe _____

C. The CAGE Questionnaire - Substance Abuse Screening Tool

1. Have you ever felt you ought to cut down on your drinking or drug use? [ ] Yes [ ] No
2. Have people annoyed you by criticizing your drinking or drug use? [ ] Yes [ ] No
3. Have you felt bad or guilty about your drinking or drug use? [ ] Yes [ ] No
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? [ ] Yes [ ] No

D. Behavioral Health

1. Problem behavior reported? [ ] Yes [ ] No If yes, describe _____
2. Diagnosed mental health problems? [ ] Yes [ ] No If yes, describe _____
3. History of mental health treatment? [ ] Yes [ ] No If yes, describe _____

E. In the past 12 months, the client experienced the death of: (check all that apply)
[ ] Caregiver [ ] Child [ ] Other family or household member
[ ] Spouse/domestic partner [ ] Pet

F. Client reports little interest/pleasure in doing things. [ ] Yes [ ] No

G. Client has thoughts that he/she would be better off dead or of hurting self in some way.
[ ] Yes [ ] No

H. Does it appear that a mental health evaluation is needed?
[ ] Yes [ ] No (If Yes, note Referral Plan in the Care Plan)

Comments: _____

VI. PRESCRIBED MEDICATIONS OVER THE COUNTER MEDICATIONS

A. MEDICATIONS.

Name	Dose/Frequency	Reason Taken

B. Primary Pharmacy: Name_____ Phone: _____

C. Does client receive medication via mail order? [ ] Yes [ ] No

D. Does the person have any problems taking medications? [ ] Yes [ ] No

E. Adverse reactions/allergies/sensitivities? [ ] Yes [ ] No if Yes. Describe_____

F. Cost of medication [ ] Yes [ ] No if Yes. Describe_____

G. Obtaining medications [ ] Yes; (if yes describe) _____ [ ] No

H. Other (Describe)

Comments: _____

Fall Risks Factors:

Fall within the past year:	[ ] No	[ ] Yes	Living Alone and > 85 years old:	[ ] No	[ ] Yes
Cognitive Impairment:	[ ] No	[ ] Yes	Cardiovascular Impairment:	[ ] No	[ ] Yes
Sensory Impairment:	[ ] No	[ ] Yes	Neuromuscular Changes:	[ ] No	[ ] Yes
Depression:	[ ] No	[ ] Yes	Urological Changes:	[ ] No	[ ] Yes
Stress:	[ ] No	[ ] Yes	Malnutrition:	[ ] No	[ ] Yes
PolyPharmacy:	[ ] No	[ ] Yes	Dehydration:	[ ] No	[ ] Yes
Substance Abuse/Use:	[ ] No	[ ] Yes	Acute Illness:	[ ] No	[ ] Yes
CVA History:	[ ] No	[ ] Yes	Home Hazards:	[ ] No	[ ] Yes

Housing Fall Risk Comments: _____

VII. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

STATUS/UNMET NEED

Activity Status: ***(Use for Sec. VII & VIII)***

1=Totally Able
2=Requires intermittent supervision and/or minimal assistance.
3=Requires continual help with all or most of this task
4=Person does not participate; another person performs all aspects of this task.

Check if assistance is/will be provided by

	Is Need Met*	Activity Status	Informal Supports	Formal Services	With Assisted Devices	**Comments**: *Describe limitations, parts of tasks to be done and responsibilities of informal supports and formal Services.*
A. Housework /cleaning						
B. Shopping						
C. Laundry						
D. Use transportation						
E. Prepare & cook meals						
F. Handle personal business/finances						
G. Use Telephone		`				
H. Self-admin of medication						

*Is Need Met Currently (at time of Assessment)?

Are changes in IADL capacity expected in the next 6 months?
[ ] Yes [ ] No If Yes, Describe_____

VIII. ACTIVITIES OF DAILY LIVING (ADLs) STATUS/UNMET NEED

Check if assistance is/will be provided by

	Is Need Met*	Activity Status	Informal Supports	Formal Services	With Assisted Devices	Comments *Describe limitations, parts of tasks to be done and responsibilities of informal supports and forma! services.*
A. Bathing 1. Requires no supervision or assistance. May use adaptive equipment. 2. Requires intermittent checking and observing/minimal assistance at times 3. Requires continual help. 4. Person does not participate.						
B. Personal Hygiene 1. Requires no supervision or assistance 2. Requires intermittent supervision and/or minimal assistance. 3. Requires continual help with all or most of personal grooming. 4. Person does not participate; another person performs all aspects of personal hygiene	.					
C. Dressing 1. Needs no supervision or assistance. 2. Needs intermittent supervision/minimal assistance at times. 3. Requires continual help and/or physical assistance. 4. Person does not participate, is dressed by another, or bed gown is generally worn due to condition of person.						
D. Mobility 1. Walks with no supervision or assistance. May use adaptive equipment. 2. Walks with intermittent						

supervision. May require human assistance at times. 3. Walks with constant supervision and/or physical assistance. 4. Wheels with no supervision or assistance, except for difficult maneuvers, or is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.						
E. Transfer 1. Requires no supervision or assistance. May use adaptive equipment. 2. Requires intermittent supervision. May require human assistance at times. 3. Requires constant supervision and/or physical assistance. 4. Requires lifting equipment and at least one person to provide constant supervision and/or physically lift, or cannot and is not taken out of bed.						
F. Toileting 1. Requires no supervision or physical assistance. May require special equipment, such as raised toilet or grab bars. 2. Requires intermittent supervision and/or minimal assistance. 3. Continent of bowel and bladder. Requires constant supervision and/or physical assistance. 4. Incontinent of bowel and/or bladder.						
G. Eating 1. Requires no supervision or assistance. 2. Requires intermittent supervision and/or minimal physical assistance. 3. Requires continual help and/or physical assistance. 4. Person does not manually participate. Totally fed by hand, a tube or parental feeding for primary intake of food,						

*Is Need Met Currently (at time of Assessment)?
Are changes in ADL capacity expected in the next 6 months? [ ] Yes [ ] No If Yes, Describe_____

IX. SERVICES CLIENT CURRENTLY IS RECEIVING

A. What formal service(s) does the person currently receive? *(Check all that apply)*
[ ] none utilized

Provider Information

[ ] adult day health care
[ ] assisted transportation
[ ] caregiver support
[ ] case management
[ ] community-based food program

[ ] consumer directed in-home services
[ ] congregate meals
[ ] equipment/supplies
[ ] friendly visitor/telephone reassurance
[ ] health promotion

[ ] health insurance counseling
[ ] home health aide
[ ] home delivered meals
[ ] hospice
[ ] housing assistance

[ ] legal services
[ ] mental health services
[ ] nutrition counseling
[ ] occupational therapy
[ ] outreach

[ ] personal care level 1
[ ] personal care level 2
[ ] personal emergency response system (PERS)
[ ] physical therapy
[ ] protective services

[ ] respite
[ ] respiratory therapy
[ ] senior center
[ ] senior companions
[ ] services for the blind

[ ] shopping
[ ] skilled nursing
[ ] social adult day care
[ ] speech therapy
[ ] transportation

[ ] other (specify)_____

X. INFORMAL SUPPORT STATUS

A. Does the person have family, friends and/or neighbors who help or could help with care?
[ ] Yes [ ] No (If No, skip to question C of this section)

Primary Informal Support

1. Name:

Address:

Relationship:

Home Phone: Work Phone: Cell Phone:

E-mail:

Involvement: (Type of help/frequency) _____

1. a. Does the consumer appear to have a good relationship with this informal support?
[ ] Yes [ ] No (Explain) _____

1. b. Would the consumer accept help, or more help, from this informal support in order to remain at home and/or maintain independence? (Check one)
[ ] willing to accept help [ ] unwilling to accept any help

1. c. Are there any factors that might limit this informal support's involvement? (Check all that apply)

[ ] job	[ ] finances	[ ] family
[ ] responsibilities	[ ] physical burden	[ ] transportation
[ ] emotional burden	[ ] health problems	[ ] reliability
[ ] living distance	[ ] overwhelmed	

1. d. Is the informal support received: [ ] adequate [ ] inadequate [ ] temporarily unavailable

1. e. Would this informal support be considered the caregiver? (Definition of caregiver can be found in the COMPASS instructions.) [ ] Yes [ ] No

1. f. Does the caregiver identify the need for respite? [ ] Yes [ ] No

If yes, when?

[ ] Morning	[ ] Afternoon	[ ] Evening
[ ] Overnight	[ ] Weekend	[ ] Needs relief and would take it any time
[ ] Day & Evening	[ ] Other	

1. g. Which of these services could be provided as respite for the caregiver?

[ ] Adult Day Services [ ] Personal Care Level 1 [ ] Personal Care Level 2

[ ] In Home Contact & Support (Paid Supervision)

1. h. Would the caregiver like to receive information about other caregiver services? [ ] Yes [ ] No

Secondary Informal Support:

2. Name:

Address:

Relationship:

Home Phone: Work Phone: Cell Phone:

E-mail:

Involvement: (Type of help/frequency)

2. a. Does the consumer appear to have a good relationship with this informal support? [ ] Yes [ ] No (Explain)

2. b. Would the consumer accept help, or more help, from this informal support in order to remain at home and/or maintain independence? (Check one)

[ ] willing to accept help [ ] unwilling to accept any help

2. c. 1. Are there any factors that might limit this informal support's involvement? (Check all that apply)

[ ] job	[ ] finances	[ ] family
[ ] responsibilities	[ ] physical burden	[ ] transportation
[ ] emotional burden	[ ] health problems	[ ] reliability
[ ] living distance	[ ] overwhelmed	

2. d. Is the informal support received [ ] adequate [ ] inadequate [ ] temporarily unavailable

2. e. Would this informal support be considered the caregiver? (Definition of caregiver can be found in the COMPASS instructions.) [ ] Yes [ ] No

2. f. Does the caregiver identify the need for respite? [ ] Yes [ ] No

If yes, when?

[ ] Morning	[ ] Afternoon	[ ] Evening
[ ] Overnight	[ ] Weekend	[ ] Needs relief and would take it any time
[ ] Day & Evening	[ ] Other	

2. g. Which of these services could be provided as respite for the caregiver?

[ ] Adult Day Services [ ] Personal Care Level 1 [ ] Personal Care Level 2

[ ] In Home Contact & Support (Paid Supervision)

2.h. Would the caregiver like to receive information about other caregiver services? [ ] Yes [ ] No

B. Can other Informal supports) provide temporary care to relieve the caregiver(s)?

[ ]Yes [ ] No If Yes, Describe_____

B. Does the person have any community, neighborhood or religious affiliations that could provide assistance? [ ] Yes [ ] No

If Yes, describe who might be available, when they might be available and what they might be willing to do _____

Comments: _____

XI. MONTHLY INCOME

A.

		Monthly Income*			
		A. Individual Being Assessed	**B.** Person's Spouse	**C.** Other Family/ Household Income	D. Total Family/ Household Income
1.	Social Security (net)				
2.	Supplemental Security Income: (SSI)				
3.	Personal Retirement Income				
4.	Interest				
5.	Dividends				
6.	Salary/Wages				
7.	Other				
	Total Monthly Income:				

*Note only columns A + B are used for EISEP cost share.

B. Number of people in household _____

C. Is client a veteran? _____

D. [ ] Check if person will provide no financial information (Describe) _____

E. Is client registered to vote? [ ] yes [ ] no

F. If no, was client offered a voter registration application? [ ] yes [ ] no

XII. BENEFITS/ENTITLEMENTS

Benefit Status Code must be noted:	
A. Has the benefit/entitlement	F. Application pending
B. Does not have the benefit/entitlement	G. Does not need.
C. May be eligible and is willing to pursue benefit/entitlement	H. Not applicable
D. Refuses to provide Information	I. Not eligible
E. Denied	

Benefit	Benefit Status Code	Comments
Income Related Benefits		
Social Security		
SSI*		
Railroad retirement		
SSD		
Veteran's Benefits (Specify)		
Other (Specify)		
Entitlements		
Medicaid Number		
Food Stamps (SNAP)		
Public Assistance		
Other (Specify)		
Health Related Benefits		
Medicare Number		
QMB		
SLMB/QI		
EPIC		
Low Income Subsidy (LIS)		
Medicare Part D (Drug Coverage)		
Medigap Insurance/Medicare Advantage (Specify)		
Long Term Care Insurance (Specify)		
Other Health Insurance (Specify)		
Housing Related Benefits		
Senior Citizens Exemption (Local option income based)		

SCRIE		
Section 8		
IT214		
Veteran Tax Exemption		
Reverse Mortgage		
Real Property Tax Exemption (Enhanced STAR)		
Real Property Tax Exemption (Basic STAR)		
HEAP		
Other		

Persons receiving SSI is categorically eligible for Medicaid and should have a Medicaid card.

XIII. CARE PLAN

Date (mm/dd/yy): _____

Person's Name: _____

Address: _____

Prepared by: _____

Person's Phone: _____

A. Is the person self-directing/able to direct care? [ ] Yes [ ] No If No, who will provide direction? _____

B. What are the person's preferences regarding provision of services? _____

_____

C. Issues/Problems to be referred: _____

_____

D. Identified areas of needs to be addressed? _____

_____

E. Action Steps agreed to: _____

_____

F. Information/special instructions that have direct bearing on implementation of the care plan: _____

_____

G. Plan has been discussed and accepted by client and/or Informal supports? [ ] Yes [ ] No

If No, explain: _____

H. OK to discuss with informal supports? [ ] Yes [ ] No

I. Plan approved by: _____

Date (mm/dd/yy): _ _____

Phone: _____

Signature and Title: _____

For each Issue/Needs:

Issue/Problem	Goals	Care Plan Objectives	Proposed Time Frame	Action Steps	Comments

For each service client should receive:

D. Types of services to be provided	Quantity	Frequency*	When	Start Date	Projected End Date	Provided: Informal/ Formal	Provider

* W = Weekly; M = Monthly or O = Services only delivered as needed

G. Has person been placed on waiting list for any service need? [ ] Yes [ ] No
If Yes, List the Services

Service	Provider	Date Placed on List

SERVICE/CARE PLAN TERMINATION

A. What is being terminated? Services(s) Care Plan
If Service, Specify which one(s)

B. Termination Date:

C. Reason for termination: (Check all that apply)

[ ] None (Reason Unknown)
[ ] Goal Met: (Specify) _____
[ ] Client Request
[ ] Client Moved
[ ] Hospitalization
[ ] Nursing Facility
[ ] Assisting Living
[ ] Death
[ ] Other: (specify) _____

D. Service of Care Plan Related Client Outcome(s) Statements: _____
_____
_____

E. Terminated by: _____

_____ _____
Signature Title

_____ _____ _____ _____
Date: Work Phone: Cell Phone: E-mail