State of Alabama
Home and Community Based Services Program
Assessment

Basic Consumer Information	Prior Control Number:	- 000000	Medicaid Number:	
Name:	Last:	First:		Middle:

Address:	Mailing	Physical
Street:		
City/State/Zip:		
Telephone:		

Directions to home:

What is your birth date?

What is your gender? ❍ Male ❍ Female

What is your race?
- ❍ Black/African American
- ❍ White
- ❍ American Indian
- ❍ Native Hawaiian
- ❍ Other (Specify) _____
- ❍ Asian
- ❍ Alaska Native
- ❍ Pacific Islander

What is your ethnicity?
- ❍ Hispanic or Latino

What is your primary language?
- ❍ English
- ❍ Spanish
- ❍ Other (Specify) _____

Primary Physician:
Name: _____
Address: _____
City/State/Zip: _____
Phone:

Emergency Contact:
Name: _____
Address: _____
City/State/Zip: _____
Phone:

Assessment

Date Completed	
Date Current Waiver Eligibility Expires (Redetermination ONLY)	

- ❍ *Initial Assessment*
- ❍ *Redetermination*
- ❍ *Readmission*

Case Manager:

Name:	
Agency:	
Phone:	

Living Situation

What is your marital status?
- ❍ Never Married
- ❍ Separated
- ❍ Widowed
- ❍ Divorced
- ❍ Married /Domestic Partner

What is your living situation?
- ❍ Own home
- ❍ Rent a house or apartment
- ❍ Live with family
- ❍ Lives with non-relatives
- ❍ Other _____

How many people reside in household?

Others living in Client's Household

Name	Relationship	Is Adult?	Assists Care?	Employed?
		❍	❍	❍
		❍	❍	❍
		❍	❍	❍
		❍	❍	❍
		❍	❍	❍

Assists with Care but not living in household

Name	Relationship

Consumer Identification	Name :	Medicaid Number:

Primary Caregiver (PCG)

Has primary caregiver?	Yes	No	NR
	❍	❍	❍

Name:	Last:	First:	Middle:

Address: Street:

City/State/Zip:

Does the primary caregiver live with you?	Yes	No	NR
	❍	❍	❍

Caregiver employed?

❍ Unemployed ❍ Full time ❍ Homemaker
❍ Part time ❍ Retired
❍ Student ❍ Other

Does caregiver have reliable transportation?	Yes	No	NR
	❍	❍	❍

If not, who do you rely on to help with transportation?

❍ No Relations ❍ Neighbor
❍ Spouse ❍ Grandchild
❍ Parent ❍ Daughter/Son-in-law
❍ Domestic Partner ❍ Sibling
❍ Child ❍ Volunteer
❍ Friend ❍ Other Relative

Would you take public transportation?	Yes	No	NR
	❍	❍	❍

Relationship of Caregiver:

❍ No Relations ❍ Child ❍ Daughter/Son-in-law
❍ Spouse ❍ Friend ❍ Sibling
❍ Parent ❍ Neighbor ❍ Volunteer
❍ Domestic Partner ❍ Grandchild ❍ Other Relative

Availability of Caregiver:

❍ All the time
❍ Days only
❍ Nights only
❍ 1-2 times a week
❍ Specify _____

Overall, how stressed do you feel in caring for the recipient?

❍ Low
❍ Moderate
❍ Heightened
❍ Severe

Caregiver physically overwhelmed:

❍ Yes
❍ No
❍ Somewhat

Informal supportive service:

❍ None
❍ Willing indefinitely
❍ Willing a short time
❍ Willing occasionally

PCG Limitations or Constraints	Yes	No	NR
No particular constraints	❍	❍	❍
Lives at a distance	❍	❍	❍
Lacks knowledge, skills	❍	❍	❍
Alcohol, drug abuse	❍	❍	❍
Financial strain	❍	❍	❍
Poor relationship with consumer	❍	❍	❍
Poor health, disabled, frail	❍	❍	❍
Employed	❍	❍	❍
Providing care to others	❍	❍	❍
Not reliable	❍	❍	❍

Dependent on consumer for:

❍ Housing
❍ Money
❍ Other

ADL's/IADL's

How often do you need help with the following activities?

	Without Help	With Some Help	Unable	Assistance Provided by	Phone
Eating	❍	❍	❍		
Getting in and out of bed	❍	❍	❍		
Getting around inside	❍	❍	❍		
Dressing	❍	❍	❍		
Bathing	❍	❍	❍		
Transfer from bed to chair	❍	❍	❍		
Toileting	❍	❍	❍		
Doing heavy housework	❍	❍	❍		
Doing light housework	❍	❍	❍		
Cooking/Preparing meals	❍	❍	❍		
Shopping for groceries/clothes	❍	❍	❍		
Getting around outside	❍	❍	❍		
Managing money	❍	❍	❍		
Taking medications	❍	❍	❍		
Using the telephone	❍	❍	❍		
Transportation	❍	❍	❍		

Consumer Identification	Name :	Medicaid Number:

Medical Devices

	Does Not Need	Has, Uses	Has, Does Not Use	Needs, Does Not Have	Frequency Used
Artifical Limb	❍	❍	❍	❍	
Walker	❍	❍	❍	❍	
Cane	❍	❍	❍	❍	
Lift	❍	❍	❍	❍	
Wheelchair	❍	❍	❍	❍	
Oxygen	❍	❍	❍	❍	
Dentures	❍	❍	❍	❍	
Hearing Aids	❍	❍	❍	❍	
Glassess	❍	❍	❍	❍	
Shower Chair	❍	❍	❍	❍	
Toilet Seat	❍	❍	❍	❍	
Bedside Commode	❍	❍	❍	❍	
Incontinent Supplies	❍	❍	❍	❍	
Grab Bars	❍	❍	❍	❍	
Ramps	❍	❍	❍	❍	
Other Home Modifications	❍	❍	❍	❍	

Do you have elimination problems?	Yes ❍	No ❍	NR ❍

If yes, complete below

	Bowel	Bladder
Voluntary	❍	❍
Occasionally involuntary	❍	❍
Frequently involuntary	❍	❍
Catheter self-care	❍	❍
Catheter not self-care	❍	❍
Colostomy self-care	❍	❍
Colostomy not self-care	❍	❍

Do you have problems with the following:

	Yes	No	NR	Comments
Speech	❍	❍	❍	
Hearing	❍	❍	❍	
Vision	❍	❍	❍	

Home/Environmental Assessment

How do you heat your house in the winter?

- ❍ None
- ❍ Wood/Coal Stove
- ❍ Oil
- ❍ Gas
- ❍ Electric (Central)
- ❍ Fireplace
- ❍ Space heater(s)
- ❍ Other

	Yes	No	NR
Have you ever needed assistance paying utility bills?	❍	❍	❍
Do you have at least two identified escape routes in case of a fire?	❍	❍	❍
Have you ever had a house fire?	❍	❍	❍

(If yes, please explain below)

	Yes	No	NR
Do you carry a gun, knife, mace, etc for protection?	❍	❍	❍
Do you have any concerns about your safety?	❍	❍	❍

(If yes, please explain below)

	Yes	No	NR
Does your living arrangements cause any difficulties?	❍	❍	❍

(If yes, please explain below)

Do you have the following in your home? (Check all that apply)

	Yes	No	NR	Comments		Yes	No	NR	Comments
Proper heating/cooling of house	❍	❍	❍		Proper lighting	❍	❍	❍	
Cooking facilities	❍	❍	❍		Insect/rodent problem	❍	❍	❍	
A refrigerator/freezer	❍	❍	❍		Stairs	❍	❍	❍	
Washer/dryer	❍	❍	❍		Do stairs have handrail?	❍	❍	❍	
Water/hot water	❍	❍	❍		Physical barriers (i.e., loose or slippery rugs, dangerous stairs or floors, etc.)	❍	❍	❍	
Tub, shower, and toilet	❍	❍	❍						
Grab bars in bath or shower	❍	❍	❍		Fireplace	❍	❍	❍	
Telephone	❍	❍	❍		Pets	❍	❍	❍	
Smoke detectors that work	❍	❍	❍		Plumbing	❍	❍	❍	
Fire extinguisher	❍	❍	❍		Extension cords	❍	❍	❍	

***Case Manager, please make sure client has an escape plan.**

Consumer Identification	Name :	Medicaid Number:

General Health Assessment

How is your health?

❍ Excellent ❍ Good ❍ Fair ❍ Poor

How many times have you been hospitalized within the last year?

❍ None ❍ 1-2 times ❍ more than 2 times

Reason for Hospitalization

	Yes	No	NR
Have you had any falls or injuries in the past year?	❍	❍	❍
Do you have 3 or more drinks of beer, wine, or liquor almost every day?	❍	❍	❍
Do you currently use or have you ever smoked, used tobacco, snuff or other products?	❍	❍	❍
In the past year, have you lived in a nursing home or a convalescent center?	❍	❍	❍

(If yes, enter the name of the facility)

When you are sick which of the following do you do?

❍ Always see a doctor
❍ Use over counter/home remedies
❍ Share Rx
❍ Think it will pass
❍ Other _____

Please list any non-prescription drugs you take.

.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

How many physicians do you have?

Name	*Type of Doctor*	*Date Last Seen by Doctor*
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

Partial list of Types of Doctors

Cardiologist	Oncologist
Endrocinologist	Ophthalmologist
Gastroenterologist	Orthopedican
General Practician	Otorhinolaryngologist
Geriatican	Pediatrican
Gynecologist/Obstetrican	Radiologist
Internalist	Rheumatologist
Nephrologist	Surgeon
Neurologist	Urologist

How often do you do physical exercise?

❍ Daily ❍ Twice a week ❍ None
❍ Monthly ❍ > Twice a week ❍ No Response

What kinds of physical activities do you do?

❍ Walking ❍ Dancing ❍ Jogging ❍ Bowling ❍ No Response
❍ Swimming ❍ Gardening ❍ Lifting ❍ Stretching
❍ Bicycling ❍ Aerobics ❍ Tennis ❍ Other

Comments

Mental Health Assessment

Choose best answer for how you have felt over the past week:	Yes	No	NR
Are you basically satisfied with your life?	❍	❍	❍
Have you dropped many of your activities and interests?	❍	❍	❍
Do you often get bored?	❍	❍	❍
Are you in good spirits most of the time?	❍	❍	❍
Do you not feel like eating; appetite poor?	❍	❍	❍
Have you felt depressed?	❍	❍	❍
Have you felt restless; unable to sleep?	❍	❍	❍
Have you had crying spells?	❍	❍	❍
Do you want to stay home, rather than going out and trying new things?	❍	❍	❍

Consumer Identification	Name :	Medicaid Number:

General Health Assessment

Social/ Spiritual Assessment

Do you feel the need for the following in your life?	Yes	No	NR
A need for purpose	❍	❍	❍
A need for usefulness	❍	❍	❍
A need for hope	❍	❍	❍
A need for support in coping with change	❍	❍	❍
A need to adapt to increasing dependency	❍	❍	❍
A need for personal dignity	❍	❍	❍
A need to express feelings	❍	❍	❍
A need to fellowship with others	❍	❍	❍
A need to love and serve others	❍	❍	❍
Do you or have you regularly attended a religious establishment, i.e., church, synagogue, or mosque?	❍	❍	❍

How often do you visit your family or they visit you?

- ❍ Never
- ❍ About once a month
- ❍ Several times a week
- ❍ Yearly
- ❍ Weekly
- ❍ No Response

What kind of job did you have for most of your working life?

Are there skills you have and would you be interested in teaching others?	Yes	No	NR
	❍	❍	❍

(If client answers yes to question, please refer to Senior Employment coordinator at AAA.)

Mental/Emotional Status (Optional)

Folstein Mini Mental Status Examination

Task	Instructions	Scoring		Score
Date Orientation	"Tell me the date?" Ask for omitted items.	One point each for year, season, date, day of week, and month	5	
Place Orientation	"Where are you?" Ask for omitted items.	One point each for state, county, town, building, and floor or room	5	
Register 3 Objects	Name three objects slowly and clearly. Ask the patient to repeat them.	One point for each item correctly repeated	3	
Serial Sevens	Ask the patient to count backwards from 100 by 7. Stop after five answers. (Or ask them to spell "world" backwards.)	One point for each correct answer (or letter)	5	
Recall 3 Objects	Ask the patient to recall the objects mentioned above.	One point for each item correctly remembered	3	
Naming	Point to your watch and ask the patient "what is this?" Repeat with a pencil.	One point for each correct answer	2	
Repeating a Phrase	Ask the patient to say "no ifs, ands, or buts."	One point if successful on first try	1	
Verbal Commands	Give the patient a plain piece of paper and say "Take this paper in your right hand, fold it in half, and put it on the floor."	One point for each correct action	3	
Written Commands	Show the patient a piece of paper with "CLOSE YOUR EYES" printed on it	One point if the patient's eyes close	1	
Writing	Ask the patient to write a sentence.	One point if sentence has a subject, a verb, and makes sense	1	
Drawing 	Ask the patient to copy a pair of intersecting pentagons onto a piece of paper.	One point if the figure has ten corners and two intersecting lines	1	
	A score of 24 or above is considered normal.		30	

Nutritional Assessment

How is your appetite?

- ❍ Very good
- ❍ Good
- ❍ Fair
- ❍ Poor
- ❍ Don't know/Refused

How many meals do you eat in a day?	

Has your appetite changed recently?	Yes	No	NR
	❍	❍	❍

If so, how?

	Yes	No	NR
Do you eat fruits, vegetables, or milk products as part of your daily meals or snack?	❍	❍	❍
Have you experienced unexplained weight loss or gain without changing your eating habits?	❍	❍	❍
Do you sometimes lack the money to buy the food you need?	❍	❍	❍
Without wanting to, have you lost or gained 10 lbs. or more in the last 6 months?	❍	❍	❍
Does client have a special diet?	❍	❍	❍
Is that diet prescribed by your doctor?	❍	❍	❍

(Please answer kind of diet, if client has a special diet)

Kind of Diet

Low:	Fat	❍	Other:
	Salt	❍	
	Sugar	❍	
	Fiber	❍	
	Diabetic	❍	
	Cholesterol	❍	
High:	Fiber	❍	
	Protein	❍	
No fresh:	Vegetables	❍	
	Fruit	❍	
Renal:		❍	
Bland food:		❍	

Consumer Identification	Name :	Medicaid Number:

Financial Assessment

Do you receive any of the following?	Yes	No	NR
SSI	❍	❍	❍
Social Security	❍	❍	❍
SLMB	❍	❍	❍
Institutional Deeming	❍	❍	❍
Retirement Pension	❍	❍	❍
SUP	❍	❍	❍
Food Stamps	❍	❍	❍
QMB	❍	❍	❍
VA Benefits	❍	❍	❍
Do you have financial responsibilities related to the cost of your care that has caused problems for you?	❍	❍	❍

(If yes, explain)

	Yes	No	NR
Do you get any health insurance other than Medicare or Medicaid?	❍	❍	❍

If so, who is your third party insurer?

Name:

Address:

Telephone Number **Policy Nbr:**

Monthly Expenses	Amount		Amount
Rent/Mortgage		Water	
Food		Power	
Medications		Telephone	
Medical Supplies		Personal Items	
Medical Bills		Clothing	
Health Insurance			
Life Insurance			
Gas			
		TOTAL	

Services Assessment

	Doesn't Need	Needs	Uses	Frequency Used
E & D Medicaid Waiver Program				
AAA Case Management	❍	❍	❍	
(or) PHD Case Management	❍	❍	❍	
Homemaker	❍	❍	❍	
Personal Care	❍	❍	❍	
Unskilled Respite Care	❍	❍	❍	
Skilled Respite Care	❍	❍	❍	
Companion Services	❍	❍	❍	
Adult Day Health Care	❍	❍	❍	
Home-Delivered Frozen Meals	❍	❍	❍	
Public Health Department				
Home Health Nursing Service	❍	❍	❍	
Home Health Aide Service	❍	❍	❍	
Department of Human Resources				
Food Stamps	❍	❍	❍	
Title XX Homemaker Services	❍	❍	❍	
Title XX Adult Day Care Services	❍	❍	❍	
Protective Services	❍	❍	❍	
Area Agency on Aging				
Attends a local Senior Center	❍	❍	❍	
Meals at the Senior Center	❍	❍	❍	
Home-delivered meals from Center	❍	❍	❍	
Senior Center Transportation	❍	❍	❍	
Legal Services Program	❍	❍	❍	
Insurance Counseling	❍	❍	❍	
SenioRx Prescription Drug Program	❍	❍	❍	
Alabama Cares Caregiver Program	❍	❍	❍	
Long-Term Care Ombudsman	❍	❍	❍	
SCALF Medicaid Waiver	❍	❍	❍	
In-Home Services Program	❍	❍	❍	
Other				
OASIS	❍	❍	❍	
HRDC / OCAP Energy Assistance	❍	❍	❍	
Hospice Care	❍	❍	❍	
Home Repair	❍	❍	❍	
AL Power Senior Discount (SSI Rider)	❍	❍	❍	
BellSouth/CenturyTel (Life Line Senior Disc.)	❍	❍	❍	
Emergency Response System	❍	❍	❍	