CHAPTER 16

OPTIONS FOR COMMUNITY LIVING – STATE-FUNDED HOME AND COMMUNITY BASED SERVICES

16-1 LEGAL AUTHORITY

In accordance with the Rules of the Tennessee Commission on Aging and Disability Chapter 0030-2-1-.01, the State Agency on Aging (Tennessee Commission on Aging and Disability) shall implement the state-funded long-term care home and community based services program authorized by Tennessee Code Annotated 71-5-1408 which is intended to serve individuals who are at least sixty (60) years of age or adults (18 years of age or older) who have a disability due to a physical impairment, who do not qualify for long-term care services under the state medical assistance program, who are found to be at risk of losing their independence and for which there is no other resource available.

16-2 DEFINITIONS

(1) Allowable Cost per Consumer means the maximum amount of funds that can be used to provide services to an individual. Services provided under the OPTIONS program should not exceed $7,000 per consumer/per year.

(2) Applicant means an individual who resides in Tennessee and has completed a screening by an Area Agency on Aging and Disability (AAAD) for OPTIONS Program services.

(3) Area Agency on Aging and Disability means the agency designated by the Tennessee Commission on Aging and Disability in a planning and service area to develop and administer the area plan for a comprehensive and coordinated system

of services for older persons and for adults (18 years of age or older) with disabilities.

(4) Assessment (OPTIONS) means a component of service coordination (case management) that evaluates individuals by administering a structured assessment instrument(s), approved by the state agency, to gather information about individuals to determine need and/or eligibility for services. Information collected must include health and nutritional status, financial status, activities of daily living, instrumental activities of daily living, physical environment and social support system.

(5) Consumer means an individual who is a resident of Tennessee and is an adult eighteen (18) years of age and older with functional limitations who is receiving OPTIONS services.

(6) Homebound means an individual who, due to a mental, emotional, and/or physical condition, is confined to his/her home, unable to leave it without extraordinary effort and/or assistance.

(7) Household [for the purpose of determining poverty status and cost share] means the primary family unit residing in the same dwelling, such as:

(a) Consumer only;

(b) Consumer and spouse;

(c) Consumer, spouse and minor children;

(d) Consumer and minor children only.

In determining household for poverty status and cost share, an adult child living with his/her parents or a parent living in the home of adult child/children is considered a household of one. In these examples, there is no legal requirement for income sharing between the two units.

(8) Information and Assistance means a service that:

(a) Provides an individual with current information on opportunities and services available to the individual within their community, including information relating to assistive technology;

(b) Assesses the problems and capacities of the individual;

(c) Links the individual to the opportunities and services that are available; and,

(d) To the maximum extent practicable, insures that the individual receives the needed service(s) and are aware of the opportunities available to the individual by establishing adequate follow-up procedures.

(9) OPTIONS means the home and community based services program, OPTIONS for Community Living.

(10) Representative means any individual who the applicant or eligible consumer chooses to represent him/her at any stage of the OPTIONS screening and/or assessment process.

(11) Screening (OPTIONS) means a service that utilizes a brief standardized questionnaire, approved by the State Unit on Aging, to collect information to detect the presence of risk factors or conditions which indicate need for long-term care services and which would result in a referral for a comprehensive assessment and/or for long-term care services for which the individual is potentially eligible.

(12) Service Coordination means assistance whether in the form of access or care coordination in circumstances where the consumer and/or their caregivers are experiencing diminished functioning capacities, personal conditions or other characteristics which require the provision of services by formal service providers. Activities of service coordination include assessing needs, developing service plans, authorizing services, arranging services, coordinating the provision of services among providers and follow-up and reassessment as required.

(13) Service Provider (OPTIONS) means an entity or organization that is awarded a contract from an AAAD to provide OPTIONS services.

(14) Service Plan means a written document that specifies the types, frequency and amount of in-home services provided to an individual consumer based on a comprehensive assessment of the individual's needs.

16-3 SERVICE COMPONENTS

Tennessee's OPTIONS program was created to provide the elderly and adults with disabilities home and community based services choices. The services funded through the State for this program include the following:

(1) Homemaker services – Those household tasks that enable an individual to live in a clean, safe and sanitary home environment, including those Instrumental Activities of Daily Living (IADLs), such as:

(a) Shopping for groceries and personal items;

(b) Meal preparation;

(c) Managing money;

(d) Using the telephone; and

(e) Light housework.

(2) Personal care – Provision of personal assistance, stand-by assistance, supervision or cues for persons having difficulties with one or more of the following Activities of Daily Living (ADLs) that are not ordered by a physician, such as:

(a) Eating;

(b) Dressing;

(c) Bathing;

(d) Walking;

(e) Toileting; and

(f) Transferring in and out of bed or chair.

(3) Home-delivered meals – An appropriate, nutritionally-balanced meal that meets at least one-third (1/3) of the current Dietary Reference Intakes (DRI) and which is delivered to the individual's home.

Other services can be provided under OPTIONS if the Service Coordinator sees there is a need in order to provide minimal services to maintain consumer within the home. If other services are provided, the Service Coordinator must receive approval from the AAAD Director or their Designee.

Service Providers providing Personal Care or Homemaker services must be in accordance with the Rules of the Department of Mental Health and Developmental Disabilities Office of Licensure Chapter 0940-5-38, Minimum Requirements for Personal Support Service Agencies.

16-4 ELIGIBILITY

To be eligible for the OPTIONS program, an individual must:

(1) Be a resident of Tennessee;

(2) Be eighteen (18) years of age or older;

(3) Be functionally impaired as determined by the following:

(a) Homemaker: A total overall score (Social + Health + ADL/IADL) of at least three (3), with one (1) being an IADL.

(b) Personal Care: A total overall score (Social + Health + ADL/IADL) of at least three (3), with one (1) being an ADL.

(c) Home Delivered Meals: A total overall score (Social + Health + ADL/IADL) of at least six (6), with two (2) being ADL/IADL limitations.

a. Physically unable to access congregate meal site

b. Inadequate informal supports

c. Must be homebound

(4) Have a residence that is a safe setting for the consumer and any service providers.

Consumers of OPTIONS services will be adults with physical and/or cognitive disabilities (excluding individuals with mental retardation). Only consumers who are assessed with a pre-defined level of limitations of Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL) will be eligible for these services. Eligibility will be determined through the use of the Social Assistance Management System Independent Living Assessment (Nutrition Screening Initiative) 2010 [SAMS ILA (NSI) 2010].

16-5 PRIORITY

In providing services, priority shall be given to:

(1) Adult protective service clients, if there is an open case.

(2) Low income individuals.

16-6 ADMINISTRATIVE REQUIREMENTS

(1) The State Agency shall:

(a) Designate a coordinator to implement and oversee program development of the state-funded OPTIONS Home and Community Based Services Program.

(b) Develop and maintain consistent standards and mechanisms for the OPTIONS program to be implemented statewide. These standards and mechanisms shall be used to assure the quality of services provided in accordance with the Tennessee Code Annotated 71-5-1408 and TCAD policies and rules.

(c) Propose a mechanism to impose cost-sharing to be set by rule with respect to covered services.

(d) Provide technical assistance as needed.

(e) Assume quality assurance responsibilities for all state funded home and community based services programs to ensure compliance with standards, policies, and procedures of the State Agency.

(2) At a minimum each AAAD shall:

(a) Operate an Information and Assistance system and maintain a current database of all programs and services regardless of funding stream that a person needing home and community based services might find useful.

(b) Serve as the single point of entry for the OPTIONS Program. The AAAD shall provide intake screening, in-home assessment, service coordination, and annual reassessment or bi-annual if necessary (see Section 13-8).

(c) Coordinate involvement in the screening/assessment with health service providers, hospital discharge planners, the individual assessed and the individual's family or guardian, and others as appropriate.

(d) Arrange Memoranda of Agreement (MOA) with coordinating agencies.

(e) Coordinate OPTIONS program with other programs and service systems serving adults with disabilities.

(f) Ensure the provision of necessary OPTIONS services to eligible consumers within available funding limitations.

(g) Publicize the services to ensure that individuals throughout the area know about the availability of the services.

(h) Make OPTIONS program information available, upon request, to current residents of nursing facilities who could return to their home if determined to be eligible.

(i) Advocate meeting the needs of all consumers and other adults with physical disabilities, in partnership with common stakeholders.

(j) Conduct ongoing recruitment and authorization of service providers throughout the year, as needed.

(k) Renegotiate service provider contracts annually based upon performance and satisfactory compliance with contract specifications and quality assurance monitoring.

(l) Apply the OPTIONS Cost Sharing Plan.

(m) Compile and maintain waiting list.

(n) Ensure appropriate program/financial reporting, billing, and budget reconciliation.

(3) Consumer's Right to Self-Determination

All individuals have a right to choose how they will live, as well as where they will live, as long as they are competent to make that decision and are able to understand the consequences of their actions. All adult individuals are presumed legally competent unless they have been deemed incompetent by a court. It is essential, however, to guard against allowing a participant to continue to live in an environment or situation that is clearly unsafe. While it is essential to assist people however possible, OPTIONS personnel are not expected to assist a person in continuing to live in a situation that is unsafe or to make plans that are unrealistic and unsafe.

Reports to Adult Protective Services are mandated by state law when "any person" has reasonable cause to suspect abuse, neglect, (including self-neglect) or financial exploitation. This includes neighbors, friends, relatives, doctors, dentists, caregivers, agency personnel, etc. (Adult Protection Act T.C.A. 71-6-103(b)(1); [www.state.tn.us/humanserv/adpro.htm]).

(4) Confidentiality

The state agency requires that lists of older persons compiled under information and assistance provisions of the Older Americans Act, and data from client assessments, be used solely for the purpose of providing services. The client's right to personal autonomy and to privacy shall be respected in all cases. Details and identity will not be disclosed without his/her informed consent, except in compliance with court orders or to report elder abuse as required by TCA-71-6-101, The Tennessee Adult Protection Act.

The following procedures cover most day-to-day situations involving consumer records and office procedures and protect the consumer's right to confidentiality:

(a) All consumer files must be locked during non-working hours. During working hours, files may be unlocked if staff is present in the area. If staff is out of the office for more than one-half hour, even if in the building, the files should be locked.

(b) The key to the file cabinet should be controlled in each office.

(c) The original consumer files must not leave the office.

(d) Copies of assessments that are done in client homes are to be locked somewhere in an environment secure from unauthorized view.

(e) Discretion in discussing consumer information should be employed at all times. Many workers share office space with program staff from other agencies. Files should not be left on desks in plain view. No lists of names are to be left in view on bulletin boards. Discussion of consumer information should not be held in hallways or with staff not authorized to be involved with consumer.

(f) Data that is transferred electronically must be adequately secured to avoid unauthorized access.

(g) A confidentiality notice must accompany all facsimile (FAX) transmissions.

(h) All electronic data shall be maintained on agency controlled or authorized computers.

(5) Records

Each AAAD shall maintain separate records for each individual who applies for or receives services. Records for each consumer must include at a minimum:

(a) Individual's name, address, and telephone number;

(b) Individual's date of birth; gender, race/ethnicity;

(c) Physician's name, address and telephone number;

(d) Name, address, and phone number of person, other than spouse or relative with whom individual resides, to contact in case of emergency;

(e) ADL/IADL status;

(f) Cognitive impairment;

(g) Self-declared disability;

(h) Adults with Disabilities, as defined by Section 504 of the Rehabilitation Act of 1973, or other diagnosed medical problems;

(i) Perceived supportive service needs as expressed by the individual (or his/her representatives);

(j) Rural status;

(k) Living alone status;

(l) Whether or not the individual has an income at or below the poverty level for intake and reporting purposes;

(m) Nutrition screening form, (unless completed by case management staff); and

(n) Eligibility requirements for service authorization as determined by ADLs/IADLs.

Each consumer's records shall be maintained by the AAAD for a minimum of three (3) years after the consumer's termination from the program or other final action. Specific provisions include:

(a) The AAAD shall maintain the confidentiality of consumer files and records at all times. Such files and records shall not be disclosed except:

a. To the consumer or his or her representative;

b. To TCAD or other state agencies for purposes of monitoring and securing home and community based services;

c. To a (TDHS) Adult Protective Services Division worker;

d. Under court order; or

(b) The AAAD shall use consumer records for purposes of the OPTIONS program and for the coordination of other related services only. Any disclosure of information in a consumer's file for purposes of coordinating related services shall be limited to the information that is directly relevant to and required by the other related services.

16-7 SCREENING

The OPTIONS initial screening procedure developed by the Tennessee Commission on Aging and Disability (TCAD) shall be used by the Area Agency on Aging and Disability

(AAAD) to screen the applicant's risk of losing his or her independence and to review long-term care needs and resources.

All older consumers and adults with disabilities who contact the AAAD requesting in-home services will receive an initial screening. Individuals shall not be charged a fee for the screening. When the first contact with the AAAD is made, the initial screening form is completed. Screened consumers who have at least one ADL or IADL limitation may receive a full assessment. All consumers shall be provided current information on opportunities and services available within his/her community.

I&A Staff should complete the Screening Prioritization Form (Attachment A) on each consumer upon the completion of the initial screening. This form shall be used to rank the consumer on the waiting list with consumers with the highest risk score at the top of the list. If more than one consumer has the same score, then they should be ranked by date with the consumer with the earliest date going first.

16-8 ASSESSMENT AND REASSESSMENT

The SAMS ILA (NSI) 2010 (See Attachment E) developed by TCAD shall be used by the AAAD to assess the applicant's risk of losing his/her independence and to assist in the development of a service plan, if appropriate. All assessments shall be completed in a face-to-face interview with the consumer.

A reassessment is required at least annually for all in-home services; however, staff should be alert for changes in a consumer's condition or circumstances that may warrant a reassessment at an earlier date.

During the initial in-home assessment using the SAMS ILA (NSI) 2010 form, the service coordinator will make a determination whether the consumer is a low, medium or high priority using the following scores:

(1) Low Priority – Score of 39 or below

(2) Medium Priority – Score of 40 – 49

(3) High Priority – Score of 50 or above

Those consumers receiving medium priority shall receive a follow-up phone call at six (6) months. A six (6) month reassessment can be completed on consumers at medium priority if service coordinator sees the need. Consumers receiving high priority shall receive an in-home reassessment semi-annually (every 6 months).

16-9 HOME ENVIRONMENT AND SAFETY

A Home Environment Checklist will be completed by the AAAD to assess the safety and accessibility of all homes prior to a consumer receiving services. This checklist is a part of the SAMS ILA (NSI) 2010. The checklist can be used as an opportunity to talk with the consumer about assistance that may be available to correct problems in and around the home and to offer the necessary referrals.

The AAAD may use this checklist to determine whether or not a home is safe for the consumer as well its Service Providers. While it is essential to assist consumers however possible, OPTIONS personnel are not expected to assist a person in continuing to live in a situation that is unsafe or to make arrangements that are unrealistic and unsafe.

Each AAAD will be responsible for having a written policy to review potential denials of consumers due to home environment and safety. Consumers who are denied services because of home and environment and safety have the right to make a grievance complaint if desired. Grievance Complaints will be reviewed by the grantee agency in accordance with the agency's grievance policy.

16-10 SERVICE PLAN

If the individual is determined eligible for OPTIONS services, the AAAD shall develop a Service Plan without regard to the individual's income and/or assets.

Notwithstanding the above, a Service Plan shall not be developed in any of the following circumstances:

1. If the individual (or his/her representative) notifies/tells the AAAD that s/he does not want to proceed with the development of a Service Plan.
2. If the individual (or his/her representative) refuses to release or provide information that is necessary to develop a Service Plan.
3. If the AAAD does not have the resources, within the available funds, to develop and carry out a Service Plan.

Service decisions should always be made in the best interest of the individual consumer. The Service Plan is the consumer's plan of care. The individual (and his/her representative) will actively participate in the development of the Service Plan.

A Service Plan shall describe each of the following:

1. The problems and needs of the individual.
2. The services needed to maintain independence.
3. The services already being provided by other sources.
4. The cost of services that are needed.
5. The payment sources of those services.

6. The no-cost or voluntary services that can be provided to meet the individual's needs.

During the development of the Service Plan, needed communication aids, such as audio tapes, Braille material or language interpreters, shall be provided at no cost to the consumer.

All sections must be filled out and the Service Plan shall be written prior to obtaining the signature of the consumer (or his/her representative) and the Area Agency representative. When a change is made to the Service Plan it must be reviewed and approved by the individual (or his/her representative). This may be accomplished by the Service Coordinator reviewing the change with the individual (or the representative) during an in-home visit or by phone. If the change is reviewed during an in-home visit, the individual (or the representative) shall sign the up-dated Service Plan. If the change is reviewed by phone, the Service Coordinator shall document in the case note that the change was reviewed with the individual (or the representative) and the Service Coordinator and the Supervisor shall initial and date the Service Plan.

(1) Service Plan Updates

Service Plan reviews must be completed annually, but can be done more frequently as dictated by the consumer needs.

A Service Plan should be updated when a service is either decreased or a new service is added. When a change is made the consumer must be advised. A face-to-face visit may be made at the discretion of the Service Coordinator.

A consumer is considered in Interrupted Status if they do not receive services for thirty (30) days due to hospitalization or other causes. The Service Coordinator must maintain regular contact with the consumer during this time. The AAAD may terminate a consumer from the program after the consumer has been in Interrupted Status thirty (30) days.

(2) Service Coordinator

Each consumer shall have an assigned Service Coordinator, as appropriate. The consumer shall be notified of the name, business address and telephone number of the Service Coordinator. Designation of a Service Coordinator must be in accordance with the Area Plan.

Service Coordinators must have demonstrated qualifications and abilities to determine needs and community alternatives for persons with disabilities and aging adults, and knowledge of community resources that are alternatives to nursing facilities or institutional placement. Service Coordinators must have knowledge of the disabilities and conditions of consumers being served.

The minimum qualifications for Service Coordinators are as follows:

1. A Bachelor's Degree in social work, psychology, gerontology, sociology, counseling, nursing or equivalent degree; or
2. A valid license as a Licensed Practical Nurse/Registered Nurse or a Bachelor's Degree in any field with a minimum of two (2) years of direct service experience with adults with disabilities which includes activities such as assessment, care plan development, program implementation, and monitoring; or

3. A minimum of completion of two (2) years attendance at an accredited college or university and a minimum of two (2) years experience in the field of social work or a related field.

16-11 COST SHARING AND PARTICIPANT CONTRIBUTION REQUIREMENTS

(1) Each Area Agency on Aging and Disability (AAAD) shall adhere to the cost sharing requirement for recipients of services funded in whole or in part through the OPTIONS program who can pay all or a portion of the cost of the services rendered. Each AAAD will utilize the OPTIONS Cost Share Computation Worksheet provided by the Commission on Aging and Disability to calculate the correct consumer cost share.

(2) Each AAAD shall utilize a sliding fee scale to determine the amount a consumer of service must pay toward the cost of services the recipient receives, except that no cost sharing shall be required for home-delivered meals which are eligible for USDA (NSIP) reimbursement or for services funded in part with monies from a federal funding source that prohibits mandatory cost sharing. No cost sharing will be required when the only service provided is Information and Assistance.

(3) Except as otherwise provided, the cost sharing policies developed by the Tennessee Commission on Aging and Disability shall utilize the following sliding fee scale:

(a) Consumers with income less than 200% of the Federal Benefit Rate shall not be required to contribute toward the cost of services they receive.

(b) Consumers with income at or above 200% of the Federal Benefit Rate shall be required to contribute a percentage of the cost of the services they receive, but the cost share requirement shall not exceed forty-five percent (45%) of their income.

(c) Recipients with incomes greater than 600% of the Federal Benefit Rate may receive information and assistance, including referrals to service providers, but shall be required to contribute 100% of the cost of any additional services they receive.

(4) These cost sharing policies shall ensure that each AAAD will:

(a) Provide applicants of service with a written description of the cost sharing guidelines prior to the commencement of any services;

(b) Determine the cost share amount based solely on the self-declaration of individual income with no consideration of assets;

(c) Collect consumer's cost share obligations utilizing an invoice format at least quarterly;

(d) Issue a receipt of payment to any consumer of service making a payment pursuant to these policies;

(e) Safeguard all funds collected through the cost sharing process including a record of accounts receivable for each consumer;

(f) Use methods for receiving cost share payments and contributions that protect the privacy of each consumer with respect to the amount contributed;

(g) Make a good faith effort to collect cost sharing obligations from consumers of service where feasible and cost effective. If the AAAD finds that collecting a given amount is not cost effective, the AAAD may waive this amount;

(h) Be able to adjust the cost share responsibility for a consumer who is unable to comply with the cost share policy. This adjustment will be implemented on a case-by-case basis.

(i) Ensure that consumers of service who are not required to pay a part of the cost share amount be given an opportunity to make a voluntary contribution toward the cost of service being provided.

(j) All income collected in accordance with these rules shall be utilized by AAAD to provide additional home and community based services.

16-12 RATE OF SERVICE

The following table reflects the rates of service:

Service	Reimbursement Rate
Personal Care–OAA Title III	*The lesser of* $20.52 per hr. or usual and customary charges*
Personal Care–State Funds	*The lesser of* $20.52 per hr. or usual and customary charges*
Homemaker Services–OAA Title III	*The lesser of* $20.44 per hr. or usual and customary charges*
Homemaker Services–State Funds	*The lesser of* $20.44 per hr. or usual and customary charges*
Home-Delivered Meals–OAA Title III	*The lesser of* $ 7.41 per hr. or usual and customary charges*
Home-Delivered Meals–State Funds	*The lesser of* $ 7.41 per hr. or usual and customary charges*

**For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost for providing the service. The same requirements are to be applied in the above noted programs. Thus, only the lesser of the* *maximum rate as specified above or the usual and customary charges for each service should be billed.*

These are "set rates" which may **not** be exceeded; a lesser amount may be billed and reimbursed, if the provider's usual and customary charge to persons not participating in these programs is lower. From time to time, TCAD may issue a Program Instruction to address new rates reflecting cost of living increases.

16-13 REDUCTION/TERMINATION OF SERVICES

(1) The AAAD shall reduce services that are paid by the OPTIONS Program in any of the following circumstances:

(a) When the assessed level of need diminishes as established by an updated Service Plan;

(b) When the AAAD's OPTIONS service funds are insufficient to meet the service commitment to current consumers; all reasonable efforts have been made to secure resources to avoid service reductions; the AAAD has stopped performing new assessments and Service Plans; and the AAAD has adopted a fair and equitable policy for distributing service reductions among consumers. The fair and equitable policy should be based upon the following criteria:

1. The agency will suspend new enrollment;
2. Upon the discharge or death of a consumer, the agency will not fill the vacant slot;
3. The Service Coordinators will reduce all service plans not to exceed $2,500 per plan;

4. And if necessary, the agency will terminate consumers from the program on a case-by-case basis based on the priority level with persons with Low Priority (see Section 16-8) terminating first;

(c) When a current consumer becomes eligible for home and community based services from other sources for which he/she was not previously eligible and is <u>now</u> receiving those services;

(d) When other resources become available in the community and the consumer begins receiving those services that were not available at the time of the development of the previous Service Plan; or

(e) If services needed by the consumer, as determined by the assessment, would be so costly that payment for the needed services would cause the AAAD to exceed the allowable cost per consumer.

(2) The AAAD shall terminate services in any of the following situations:

(a) When a consumer begins receiving services through the Medicaid Waiver program;

(b) When the consumer's health or personal circumstances have improved so that he/she no longer needs home and community based services to maintain his or her independence in a safe, non-institutional environment;

(c) When the health, welfare, or safety of the consumer or providers can no longer be reasonably assured;

(d) When the services being provided are detrimental to the consumer's health;

(e) When the consumer or his/her representative has fraudulently obtained or misused HCBS funded services;

(f) When the consumer is in the hospital for longer than 30 days or has a permanent placement in a nursing facility;

(g) Upon the death of the consumer receiving services;

(h) When the consumer or his or her representative refuses to comply with the cost sharing agreement, unless it has been determined that they can not afford to pay the cost share then a waiver can be granted on a case-by-case basis which can be granted by the AAAD Director or their designee;

(i) When the consumer or his/her representative voluntarily requests termination;

(j) When the consumer or his/her representative refuses services necessary for his/her health and well being, or consumer is frequently not at home to receive services or refuses to let providers carry out their duties; or,

(k) When no service providers will provide services or service providers are not available in the area.

Individuals who become eligible for the Medicaid Home and Community Based Services Waiver Program but choose not to receive services under the Waiver program, regardless of the reason, shall not be terminated from the OPTIONS program or prohibited from being on the wait list to receive services under the OPTIONS program. The Service Coordinator will strive to build a relationship with the consumer and arrange for minimum OPTIONS services to assist the consumer in remaining in the home. When additional services are needed, the Service Coordinator will introduce the Waiver again to the consumer. Service Coordinators will also counsel consumers about the Waiver program to provide them a better understanding of the program and its services.

16-14 QUALITY ASSURANCE COMPONENTS

(1) Consumer Satisfaction Surveys - The program should conduct consumer satisfaction surveys on an annual basis. The results of the surveys should be analyzed and a report produced that documents the evaluation of provider efforts.

(2) Complaints and Incidents - Complaints and Incidents should be noted and their resolution should be documented on a monthly basis. It should also be noted and corrected whenever providers consistently show up on the Complaints and Incidents list.

(3) Client Record Review - To assure that needed services are being provided and documented, quality assurance should design a method for sampling client records and reviewing the service plan, all corroborating documentation, releases of information, service authorization, and cost share computation. Additionally, the service plan should be reviewed to assure that informal support systems, needs for all types of services regardless of payment type, and updates when services are increased or decreased.

(4) Provider Review - The Options program should assure that annual reviews are conducted with service providers, either by the area agency or by another area agency that also contracts with the provider.

16-15 AREA PLAN

Each AAAD must include in their Area Plan detailed information on plans for the agency to provide information, assessments, and services to adults with physical and cognitive disabilities who are at risk of entering long-term care facilities but desire to remain at home if they qualify. Approval of the Area Plan by the Tennessee Commission on Aging and Disability (TCAD) constitutes authorization for the Area Agency to provide services.

16-16 REPORTING REQUIREMENTS

(1) The OPTIONS Program Report (See Attachment C) shall be submitted no later than the 20^{th} of the month following the month being reported. When the due date falls on a weekend or holiday, the report will be due on the following business day.

(2) Required reports must be submitted to the Tennessee Commission on Aging and Disability according to the instructions, schedule and form(s) provided. Failure to comply with the report requirements may result in either withholding of funds or possible suspension/termination of operations [Policies and Procedures for Programs on Aging, Section 5-6-.01(d)].

16-17 BACKGROUND CHECKS

This program must be in compliance with Chapter 15 of the TCAD Policies and Procedures Manual.

16-18 CONSUMER TRANSFERS BETWEEN AAADs

Current OPTIONS consumers who move from one region to another region within Tennessee shall continue to receive services through the OPTIONS program maintaining a seamless system. The consumer shall be transferred to the AAAD that serves the county in which s/he moves. If there is an open slot, then the receiving AAAD would place the consumer into that open slot. If the receiving AAAD has no open slot available, the receiving AAAD would not deny services, but would arrange for services to be provided to the consumer and would bill the transferring AAAD the cost to provide services to the consumer. The receiving AAAD would continue to bill the transferring AAAD on a monthly basis until an open slot becomes available. The receiving AAAD shall provide transferring AAAD with written notice of the available slot and final billing.

Attachment A

OPTIONS FOR COMMUNITY LIVING

STATE-FUNDED HOME AND COMMUNITY BASED SERVICES

SCREENING PRIORITIZATION FORM

FOR USE BY TENNESSEE AREA AGENCIES ON AGING AND DISABILITY PROVIDING HOME AND COMMUNITY BASED SERVICES

Tennessee Commission on Aging and Disability

June 2010

Screening Prioritization Form

Name: ______________________________ **County:** ____________________

Caregiver: __________________________ **Age:** ________

Title III-B ☐
Title III-E ☐
Meals III ☐
OPTIONS ☐
Waiver ☐

ADLs______ **IADLs**_______

	Low	**Moderate**	**High**
ADL/IADL Deficits	1 (3 ADL/IADL)	2 (4-9 ADL/IADL)	3 10-14 ADL/IADL
Informal/Formal Support	1 (well supported in the home)	2 (support available but changing, inconsistent or inadequate)	3 (very little or no support in the home)
Health	1 (minimal with little impact on quality of life)	2 (chronic with moderate impact on quality of life)	3 (severe acute or chronic health problems with severe impact on quality of life)
Income	1 (more than 200% poverty level and/ or resources of $2000 or more)	2 (up to 200% poverty level and/or resources of less then $2000)	3 (Poverty level or less and resources of less then $2000)

Other Factors:

____

____

Total: __________

Low Risk (5 points) **Moderate Risk (6-8 points)** **High Risk (9-12 points)**

Screener: ______________________________________ **Date:** __________

Attachment B

OPTIONS FOR COMMUNITY LIVING

STATE-FUNDED HOME AND COMMUNITY BASED SERVICES

POVERTY INCOME GUIDELINES

FOR USE BY TENNESSEE AREA AGENCIES ON AGING AND DISABILITY PROVIDING HOME AND COMMUNITY BASED SERVICES

Tennessee Commission on Aging and Disability

June 2010

HHS 2009 POVERTY INCOME GUIDELINES

100% POVERTY LEVEL

Family Size	Annual
1	$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010

* For families of more than 8, add $3,740 annually for each additional member.

The poverty guidelines in this table were published in the **FEDERAL REGISTER**, Vol. 74, No. 14, January 23, 2009, pages 4199-4201. These figures are to be used by Area Agencies and Service Providers receiving funds under Title III and/or Title VII of the Older Americans Act in determining "greatest economic need: for reporting and targeting purposes.

These poverty guidelines do change each year. Updated Poverty Income Guidelines can be found through the United States Department of Health and Human Services by viewing the following website, http://aspe.hhs.gov/poverty/09Poverty.shtml.

Attachment C

OPTIONS FOR COMMUNITY LIVING

STATE-FUNDED HOME AND COMMUNITY BASED SERVICES

MONTHLY PROGRAM REPORT AND INSTRUCTIONS FOR COMPLETING REPORT

FOR USE BY TENNESSEE AREA AGENCIES ON AGING AND DISABILITY
PROVIDING HOME AND COMMUNITY BASED SERVICES

Tennessee Commission on Aging and Disability

June 2010

	OPTIONS FOR COMMUNITY LIVING MONTHLY PROGRAM REPORT	
	[Revised December 17, 2009]	
	Report Date	
	Month Reported	
	District Name	
	Report Prepared By	
I.	**PERSONS SERVED THIS MONTH**	
1	Total number of persons who received services in the month	
1.a.	Number of persons who received services under age 60	
1.b	Number of persons who received services age 60+	
2	Unduplicated number of active consumers at the end of the month	
II.	**PROGRAM YEAR-TO-DATE (JULY - JUNE)**	
1	Total number of persons who received services	
1.a.	Number who received services under age 60	
1.b.	Number who received services age 60+	
2	Total number of persons discharged from program	
2.a.	Number who were discharged under age 60	
2.b.	Number who were discharged age 60+	
3	Total number of persons on waiting list for services	
3.a.	Number of persons on wait list with SAMS ILA assessment	
3.b.	Number of persons on wait list without SAMS ILA assessment	

INSTRUCTIONS FOR COMPLETING
OPTIONS MONTHLY PROGRAM REPORT SPREADSHEET
[Revised December 17, 2009]

DUE DATE: The report shall be submitted no later than the 20th of the month following the month being reported. If the 20th falls on a weekend or holiday, it shall be due on the following business day.

SECTION I: PERSONS SERVED THIS MONTH

Only report information for the month being reported. This section is NOT cumulative year-to-date.

1. Total number of persons who received services in the month – Insert all persons who received authorized services. *The sum of lines I.1.a and I.1.b. should always be equal to this value.*

1.a. Number of persons who received services under age 60 – Include the number of persons who received authorized services who were under age 60.

1.b. Number of persons who received services age 60+ - Include the number of persons who received authorized services who were 60 and over.

2. Unduplicated number of active consumers at the end of the month – Insert the actual count of active consumers who are receiving services on the last service day of the month.

SECTION II: PROGRAM YEAR-TO-DATE (JULY – JUNE)

1. Total number of persons who received services – Include all persons who received authorized services for the program year-to-date. *The sum of lines II.1.a. and II.1.b. should be equal to this value.*

1.a. Number who received services under age 60 – Include persons who received authorized services who are under 60 years of age for the program year-to-date.

1.b. Number who received services age 60+ – Include persons who received authorized services who are 60 years of age and over for the program year-to-date.

2. Total number of persons discharged from program – Include all persons who were discharged from the program year-to-date. *The sum of lines II.2.a and II.2.b. should be equal to this value.*

2.a. Number who are discharged under age 60 – Include the number of persons who were discharged who were under age 60 for the program year-to-date.

2.b. Number who are discharged age 60+ - Include the number of persons who were discharged who were 60 years of age and over for the program year-to-date.

3. Total number of persons on waiting list for services – Include the total number of persons on the waiting list for the OPTIONS program. The sum of II.3.a. and II.3.b. should be equal to this value.

3.a. Number of persons on wait list with SAMS ILA assessment – Include the total number of persons on the waiting list for the OPTIONS program that have had a SAMS ILA assessment.

3.b. Number of persons on wait list without SAMS ILA assessment – Include the total number of persons on the waiting list for the OPTIONS program who have not received a SAMS ILA assessment.

Attachment D

OPTIONS FOR COMMUNITY LIVING

STATE-FUNDED HOME AND COMMUNITY BASED SERVICES

INITIAL SCREENING

FOR USE BY TENNESSEE AREA AGENCIES ON AGING AND DISABILITY PROVIDING HOME AND COMMUNITY BASED SERVICES

Tennessee Commission on Aging and Disability

June 2010

Intake/Screening

I. HCBS Screening Form

I.a. Initial Contact

1. **Person conducting screening:**

____

2. **Date information obtained:**

_____/_____/__________

3. **Caller's name:**

____

4. **Caller's phone number:**

____

5. **Caller's relationship to client:**

____

6. **Type assistance the client and family want:**

____
____
____
____

7. **Who was the client referred by?**

- ☐ Acute Care
- ☐ Adult Day Care
- ☐ Adult foster care
- ☐ Agency
- ☐ Board & Care
- ☐ Clergy
- ☐ County
- ☐ DPSS
- ☐ EPS (Elder Protective Services)
- ☐ Family
- ☐ Friend
- ☐ Group adult foster care
- ☐ Group Home
- ☐ Health Department
- ☐ Home Health
- ☐ Hospital
- ☐ ICF
- ☐ Managed Care
- ☐ Managed Care/Insurance
- ☐ Medicaid
- ☐ Nursing Home
- ☐ Nutrition Center
- ☐ Other
- ☐ Other Care
- ☐ Physician
- ☐ Self
- ☐ Senior Center
- ☐ Service Providers
- ☐ SNF
- ☐ Social Security
- ☐ Spouse
- ☐ SVC Provider
- ☐ Unavailable
- ☐ Unknown
- ☐ Welfare Department

I.b. Consumer Information

1. **Client's first name:**

____

2. **Client's middle initial:**

____

3. **Client's last name:**

____

4. **Client's marital status:**

- ☐ Married
- ☐ Widowed
- ☐ Separated
- ☐ Divorced
- ☐ Never Married
- ☐ Other

5. **Client's gender:**

- ☐ Female
- ☐ Male

6. **Client's date of birth: (month/day/year)**

_____/_____/__________

7. **Client's Social Security number:**

________-________-___________

8. **Client's phone number (include area code):**

____

9. **Street address of client's residence:**

____

10. **City:**

____

11. **Zip code:**

____

12. **County of residence:**

____

13. **Client's Post Office box or address if different from residence:**

____

14. **City:**

____

15. **State:**

____

16. **Zip code:**

____

17. **Who lives with you?**

- [ ] No one
- [ ] Spouse only
- [ ] Spouse and others
- [ ] Other relative(s)
- [ ] A friend
- [ ] Non-relative/paid helper
- [ ] Other: specify
- [ ] Information unavailable

18. **Identify client's current housing:**

- [ ] Owns house/apartment/condo
- [ ] Rents house/apartment/condo
- [ ] Lives in a family member's residence
- [ ] Elderly housing complex
- [ ] Residential/assisted living facility
- [ ] Boarding home or rented room
- [ ] Group home
- [ ] Nursing home/other institution
- [ ] Homeless
- [ ] Other

19. **Is client an older adult serving as parent of a relative under 18 (other than his/her child) living in the household:**

- [ ] Yes
- [ ] No
- [ ] Don't know

I.c. Emergency Contacts

1. **Emergency Contact (designee) (other than spouse):**

____

2. **Emergency contact's (designee) phone number:**

____

I.d. Primary Caregiver

1. **Primary caregiver's first name:**

____

2. **Primary caregiver's last name:**

____

3. **Client lives with primary caregiver: If yes, skip the next 2 questions.**

- [ ] Yes
- [ ] No

4. **Primary caregiver's address:**

____

____

____

____

5. **Primary caregiver's home phone number:**

____

6. **Primary caregiver's work phone number:**

____

7. **Primary caregiver's cell phone number:**

____

I.e. Current Health Status

1. **Tell me about health problems that interfer with normal daily activities:**

- ☐ Ankle/leg swelling
- ☐ Any urinary or bowel problems
- ☐ Arthritis/rheumatic disease/gout
- ☐ Cancer
- ☐ Chronic pain
- ☐ Do you take any medications for depression or anxiety
- ☐ Diabetes
- ☐ Have you ever had a stroke
- ☐ Hearing impairment
- ☐ Heart problems
- ☐ Memory Loss
- ☐ Missing limb (e.g., amputation)
- ☐ Problems with breathing
- ☐ Tremors
- ☐ Vision problems
- ☐ Other significant illness

2. **Are you being treated for TB or other contagious diseases?**

- ☐ Yes
- ☐ No

3. **Do you have any troubling skin conditions (burns, bruises, rashes, itchiness, ulcers)?**

- ☐ No
- ☐ Yes, being treated
- ☐ Yes, not being treated

4. **Select all conditions that are related to mental retardation/developmentally disabled status that were manifested before age 22, and are likely to continue indefinitely:**

- ☐ Not applicable — no MR/DD
- ☐ Autism
- ☐ Down's syndrome
- ☐ Other

I.f. Physician

1. **Primary physician's name:**

____

2. **Primary physician's phone number:**

____

3. **Date of the client's last physical exam:**

_____/_____/__________

I.g. Functional Status - ADL's

1. **Do you require assistance from another person to perform the following activities:**

- ☐ Bathing
- ☐ Dressing
- ☐ Toileting
- ☐ Getting in/out of bed/chairs
- ☐ Eating
- ☐ Mobility

2. **How many ADL impairments does the client have (Count):**

☐

I.h. Functional Status - IADL's

1. **Do you require assistance from another person to perform the following tasks:**

- ☐ Use Transportation, Drive or ride in car or van
- ☐ Using telephone
- ☐ Shopping
- ☐ Meal preparation
- ☐ Ordinary housework
- ☐ Heavy Housework
- ☐ Managing money
- ☐ Medication Management

2. **How many IADL impairments does the client have (Count):**

☐

I.i. Functional Status - Other

1. **Describe the client's ability to use a wheelchair:**

- ☐ Does not use wheelchair
- ☐ Independent
- ☐ Supervision
- ☐ Physical Assistance
- ☐ Total Dependence

2. **Indicate how the client managed their catheter equipment in the past 14 days:**

- ☐ Not used
- ☐ Independent
- ☐ Supervision
- ☐ Physical Assistance
- ☐ Total dependence

3. **Describe the client's ability to perform grooming:**

- ☐ Independent
- ☐ Supervision
- ☐ Physical assistance
- ☐ Total dependence

4. **Can the client do laundry without help:**

- ☐ Yes
- ☐ No

5. **Can client express basic wants and needs:**

- ☐ No apparent problem
- ☐ Sometimes a problem
- ☐ Often a problem

6. **Can client understand and follow very simple intructions:**

- ☐ No apparent problem
- ☐ Sometimes a problem
- ☐ Often a problem

I.j. Waiver and State HCBS LTC

1. **How is the client's orientation to people:**

- ☐ No apparent problem
- ☐ Sometimes a problem
- ☐ Often a problem

2. **How is the client's orientation to place:**

- ☐ No apparent problem
- ☐ Sometimes a problem
- ☐ Often a problem

3. **Indicate the behaviors the client has demonstrated at least once a week:**

- ☐ Memory deficit
- ☐ Impaired decision-making
- ☐ Verbally aggressive
- ☐ Physically aggressive
- ☐ Disruptive behavior
- ☐ Delusional
- ☐ Getting lost/wandering
- ☐ Not applicable

I.k. Benefits

1. **What is the client's current medical insurance status? Check all that apply:**

- ☐ Medicare A
- ☐ Medicare A and B
- ☐ Medicare D
- ☐ Medicaid
- ☐ Medicaid Pending
- ☐ VA
- ☐ Long-term care (LTC)
- ☐ Other
- ☐ None

2. **Does the client have QMB (Qualified Medical Beneficiary):**

- ☐ Yes
- ☐ No

3. **Is the client a veteran OR a dependent of a veteran:**

- ☐ No
- ☐ Yes

4. **Does the client have VA income benefits:**

- ☐ Yes
- ☐ No

5. **List all of the other public income supplements the client receives:**

- ☐ Food stamps
- ☐ Section 8 rental
- ☐ Social Security
- ☐ SSI
- ☐ Other

6. **List other current services or programs the client currently receives:**

____

____

____

____

I.l. Income

1. **Specify the client's total monthly income from all sources:**

$ ____________

2. What is the total income of the client's household per month:

$

I.m. Assets

1. Is the client's personal property, excluding home and car, valued at more than $2000 if single or $3000 if married?

- [ ] Yes
- [ ] No

I.n. Directions to Home

1. Directions to the client's home:

____

____

____

____

I.o. Pets in the Home

1. Are pets/animals a danger to those who come to the client's home:

- [ ] No
- [ ] Yes

I.p. Race/Ethnicity

1. Are you:

- [ ] Hispanic or Latino
- [ ] Not Hispanic or Latino
- [ ] Unknown

2. Are you:

- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Black or African American
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] White
- [ ] Other

I.q. Action Taken

1. Enter intake/referral comments:

____

____

____

____

2. Screened client is potentially eligible for the following program:

- [ ] None, I and A only
- [ ] Medicaid Waiver for Elderly and Disabled
- [ ] OAA Caregiver 60+
- [ ] OAA Caregiver, Grandparent
- [ ] State HCBS 60+/OAA, In-Home Services
- [ ] State HCBS for Elderly and Disabled <60

3. Date client was screened:

______/______/____________

Title :

Date

Title :

Date

Attachment E

OPTIONS FOR COMMUNITY LIVING

STATE-FUNDED HOME AND COMMUNITY BASED SERVICES

ASSESSMENT

SAMS ILA (NSI) 2010
Assessment Instructions

FOR USE BY TENNESSEE AREA AGENCIES ON AGING AND DISABILITY PROVIDING HOME AND COMMUNITY BASED SERVICES

Tennessee Commission on Aging and Disability

June 2010

SAMS ILA (NSI) 2010

0. Cover Sheet

0.A. Client Identification

1. **What is the date of the assessment?**

   ______/______/___________

2. **Specify the type of assessment, or the reason for the assessment.**

   - [ ] 1 - Initial assessment
   - [ ] 2 - Reassessment

3. **Where was the client interviewed?**

   - [ ] 1 - Home
   - [ ] 2 - Hospital
   - [ ] 3 - Nursing facility
   - [ ] 4 - Other

4. **Describe where the client was interviewed.**

   ____
   ____
   ____
   ____

5. **What is the name of the person conducting this assessment?**

   ____

6. **What is the name of the agency the assessor works for?**

   ____

7. **What is the client's last name?**

   ____

8. **What is the client's first name?**

   ____

9. **What is the client's middle initial?**

   ____

10. **Enter the client's name suffix.**

    ____

11. **Enter the client identifier for the client.**

    ____

12. **Enter the client's 'also known as' name.**

    ____

13. **What is the client's ethnicity?**

    - [ ] 1 - Hispanic or Latino
    - [ ] 2 - Not Hispanic or Latino
    - [ ] 3 - Unknown

14. **What is the client's race?**

    - [ ] 1 - American Indian/Native Alaskan
    - [ ] 2 - Asian
    - [ ] 3 - Black/African American
    - [ ] 4 - Native Hawaiian/Other Pacific Islander
    - [ ] 5 - Non-Minority (White, non-Hispanic)
    - [ ] 6 - Hispanic/Latino - White
    - [ ] 7 - Other

15. **Enter the client's telephone number.**

    ____

16. **What is the client's Social Security Number?**

    _________-_________-____________

17. **What is the client's date of birth?**

    ______/______/___________

18. **Enter the age of the client in years.**

    [   ]

19. **What document was used to verify the client's age?**

    - [ ] Birth certificate
    - [ ] Driver's license
    - [ ] Employment identification card
    - [ ] Military/veteran's identification card
    - [ ] Notarized affidavit
    - [ ] Passport
    - [ ] Self Declaration (Must Complete Age Declaration on Signature Page)
    - [ ] Social Security or Medicare card
    - [ ] U.S. census records
    - [ ] Wedding or divorce decree
    - [ ] Other (Answer Next Question if this is chosen)

20. **What other document was used to verify the client's age?**

____

21. **What is the client's gender?**

- [ ] M - Male
- [ ] F - Female

22. **Enter the client's residential street address or Post Office box.**

____

23. **Enter the client's residential city or town.**

____

24. **Residential zip code.**

____

25. **What county does the client reside in?**

____

26. **If different from residential address, enter the client's mailing street address or Post Office box.**

____

27. **If different from residential address, enter the client's mailing city or town.**

____

28. **If different from residential address, enter the client's mailing state.**

____

29. **If different from residential address, enter the client's mailing ZIP code.**

____

30. **What is the name of the client's caregiver?**

____

31. **What is the relationship of the primary helper to the client?**

- [ ] Daughter/Daughter-in-law
- [ ] Grandparent (55+)
- [ ] Husband
- [ ] Non-relative
- [ ] Other elderly non-relative (60+)
- [ ] Other elderly relative (60+)
- [ ] Other relative
- [ ] Relationship Missing
- [ ] Son/Son-in law
- [ ] Wife

0.B. Emergency Contact Information

1. **What is the name of the client's primary care physician?**

____

2. **What is the work phone number for the client's primary care physician?**

____

3. **Name of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.**

____

4. **Relationship of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.**

____

5. **Address of Friend or Relative (other than Spouse/Partner) to contact in an Emergency.**

____

6. **Work Telephone Number of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.**

____

7. **Home Telephone Number of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.**

____

8. **Cell Number of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.**

____

9. **What is the name of a second relative or friend of the client?**

____

10. **What is the work phone number of the second relative or friend of the client?**

____

11. What is the home phone number of the second relative or friend of the client?

____

12. What is the e-mail address of a Family Member?

____

0.C. Directions to Client's Home

Directions on how to get to the client's home.

____

____

____

____

1. Intake

1.A. Standard Data

1. **Did someone help the client or answer questions for the client?**

- [ ] Y - Yes
- [ ] N - No

2. **What is the name of the person that helped the client during this assessment?**

____

____

____

____

3. **What is the helper's relationship to the client?**

____

____

____

____

4. **Was communication/language assistance needed for this assessment?**

- [ ] Y - Yes
- [ ] N - No

5. **Specify the client's primary language.**

- [ ] English
- [ ] Spanish
- [ ] French
- [ ] Italian
- [ ] German
- [ ] Russian
- [ ] Other

6. **What type of communication/language assistance was needed for this assessment?**

____

____

____

____

1.B. Legal Representative

1. **Does the client have a power of attorney?**

- [ ] Y - Yes
- [ ] N - No

2. **What is the name of the client's power of attorney?**

____

3. **Enter the work phone number of the client's power of attorney.**

____

4. **Enter the home phone number of the client's power of attorney.**

____

5. **Does the client have a DPOA for health care?**

- [ ] Y - Yes
- [ ] N - No

6. **What is the name of the client's DPOA for health care?**

____

7. **Enter the work phone number of the client's DPOA for health care.**

____

8. **Enter the home phone number of the client's DPOA for health care.**

____

9. **Does the client have a DPOA for finances?**

- [ ] Y - Yes
- [ ] N - No

10. **What is the name of the client's DPOA for finances?**

____

11. **Enter the work phone number of the client's DPOA for finances.**

____

12. **Enter the home phone number of the client's DPOA for finances.**

____

13. **Does the client have a representative payee?**

- [ ] Y - Yes
- [ ] N - No

14. **What is the name of the client's representative payee?**

____

15. **Enter the work phone number of the client's representative payee.**

____

16. **Enter the home phone number of the client's representative payee.**

____

17. **Does the client have a legal guardian?**

- [ ] Y - Yes
- [ ] N - No

18. **What is the name of the client's guardian?**

____

19. **Enter the work phone number of the client's guardian.**

____

20. **Enter the home phone number of the client's guardian.**

____

21. **Does the client have a living will?**

- [ ] Y - Yes
- [ ] N - No

22. **Name of person holding copy of DPOA/Living Will.**

____

23. **Telephone number of person holding copy of DPOA/Living Will.**

____

24. **Address of person holding second copy of DPOA/Living Will.**

____

____

____

____

25. **If the client does not have a living will, was information provided about advanced directives?**

- [ ] Y - Yes
- [ ] N - No

1.C. Assessment Information

1. **Select the client's current marital status.**

- [ ] A - Single
- [ ] B - Married
- [ ] C - Separated
- [ ] D - Widowed
- [ ] E - Divorced
- [ ] F - Unavailable

2. **Indicate the type of residence that the client currently resides in.**

- [ ] A - House/mobile home
- [ ] B - Private apartment
- [ ] C - Private apartment in senior housing
- [ ] D - Residential care home
- [ ] E - Nursing home
- [ ] F - Unavailable
- [ ] Z - Other

3. **Is the client NSIP eligible for home delivered meal reimbursement? (Regardless of whether or not they need meals, if they are over the age of 60 or meet one of the conditions on the next question, you will generally check yes.)**

- [ ] Yes
- [ ] No

4. **For what reason is the client NSIP eligible for home delivered meals?**

- [ ] Disabled individual residing in an elderly housing which serves congregate meals
- [ ] Age 60+ or Tribal Age
- [ ] Spouse of someone who is NSIP eligible

1.D. Social Screening

1. **Select the client's current living arrangement.**

- [ ] A - Lives Alone (3)
- [ ] B - With spouse/partner
- [ ] C - Lives with spouse and child
- [ ] D - With child/children
- [ ] F - With others (2)

2. **If b, c, or d is checked: Ask if any of the person(s) that live with you are able to assist with your care? (If No, score 2)**

- [ ] No (2)
- [ ] Yes

3. What is the name of the client's spouse/partner?

____

____

____

____

4. How many people are there in the client's household?

- [ ] A - One person
- [ ] B - Two people
- [ ] C - Three people
- [ ] D - Four or more people

5. Does the client have any children nearby?

- [ ] Y - Yes
- [ ] N - No (2)

6. Does the client have contact with family often enough?

- [ ] Y - Yes
- [ ] N - No (3)

7. Does the client have contact with friends often enough?

- [ ] Y - Yes
- [ ] N - No (2)

8. Is there a friend or relative that could take care of the client for a few days?

- [ ] Y - Yes
- [ ] N - No (3)

9. When the client makes a decision about something, how does s/he do it?

- [ ] A - Independently and alone
- [ ] B - Independently after talking to family/friends (1)
- [ ] C - Follow advice of family/friends (2)
- [ ] D - Dependent (3)
- [ ] E - Information unavailable (Choose only if consumer not able to answer score 3)

10. Is the client currently employed?

- [ ] Yes
- [ ] No
- [ ] Full time

11. Is the client participating in any of the following services or programs?

- [ ] Statewide Medicaid Waiver/CHOICES
- [ ] Homemaker program
- [ ] Home Health Aide
- [ ] Nursing
- [ ] Speech therapy
- [ ] Occupational therapy
- [ ] Physical therapy
- [ ] Home delivered meals
- [ ] PERS - Personal Emergency Response System
- [ ] Senior companion
- [ ] Weatherization
- [ ] Congregate meals
- [ ] Adult day services
- [ ] Food stamps
- [ ] Fuel Assistance
- [ ] Telephone lifeline
- [ ] Medicaid
- [ ] SSI
- [ ] QMB/SLMB
- [ ] QI-1
- [ ] Personal care
- [ ] Respite care
- [ ] Minor Home Repairs
- [ ] Assistive Devices
- [ ] Private Duty
- [ ] 504 USDA program
- [ ] Extra help for Part D Medicare
- [ ] Other

12. Does the client want to apply for any of the following services or programs?

- [ ] B - Medicaid waiver
- [ ] C - Homemaker program
- [ ] I - Home delivered meals
- [ ] J - Emergency lifeline
- [ ] L - Weatherization
- [ ] M - Congregate meals
- [ ] O - Adult day services
- [ ] R - Fuel Assistance
- [ ] T - Medicaid
- [ ] U - SSI
- [ ] 1 - Personal care
- [ ] 2 - Respite care
- [ ] 3 - Minor Home Modifications
- [ ] 4 - Assistive Devices
- [ ] 5 - Private Duty
- [ ] O - Other

Enter Social Score

____

____

____

____

1.E. Health Screening

1. How does the client rate his/her health?

- [ ] A - Excellent
- [ ] B - Good
- [ ] C - Fair (2)
- [ ] D - Poor (3)
- [ ] E - Information unavailable

2. In the past year, how many times has the client stayed overnight in a hospital?

- [ ] 1 - Not at all (0)
- [ ] 2 - Once (1)
- [ ] 3 - 2 or 3 times (2)
- [ ] 4 - More than 3 times (3)

3. In the past 6 months has the client stayed in a nursing home, residential care home, or other institution?

- [ ] Y - Yes (2)
- [ ] N - No

4. Indicate which of the following conditions/diagnoses the client currently has.

- [ ] Addiction
- [ ] Alcoholism/substance abuse
- [ ] Allergies
- [ ] Alzheimer's disease
- [ ] Anemia
- [ ] Ankle/leg swelling
- [ ] Anxiety disorder
- [ ] Any psychiatric diagnosis
- [ ] Aphasia
- [ ] Arteriosclerosis heart disease (ASHD)
- [ ] Arthritis/rheumatic disease/gout
- [ ] Asthma
- [ ] Blood-related problems
- [ ] Breathing disorders
- [ ] Bruises
- [ ] Cancer
- [ ] Cardiac dysrhythmias
- [ ] Cataract
- [ ] Cerebral palsy
- [ ] Chronic pain
- [ ] Chronic weakness/fatigue
- [ ] Congestive heart failure
- [ ] Contractures
- [ ] Coronary artery disease
- [ ] Decubitus
- [ ] Deep vein thrombosis
- [ ] Depression
- [ ] Developmental disability
- [ ] Diabetes
- [ ] Diabetic retinopathy
- [ ] Dialysis
- [ ] Digestive problems
- [ ] Drug resistance (MRSA/VRE)
- [ ] Edema
- [ ] Emphysema/COPD/asthma
- [ ] Expressive communication
- [ ] Fibromyalgia
- [ ] Frailty
- [ ] Frequent falls
- [ ] Gastritis or related condition
- [ ] Glaucoma
- [ ] Hearing impairment
- [ ] Heart problems
- [ ] Hemiplegia/Hemiparesis
- [ ] High cholesterol
- [ ] Hip fracture
- [ ] HIV
- [ ] Hypertension
- [ ] Hyperthyroidism
- [ ] Hypotension
- [ ] Hypothyroidism
- [ ] Immune system disorders
- [ ] Incontinence, bladder
- [ ] Incontinence, bowel
- [ ] Incontinent
- [ ] Liver disease
- [ ] Macular degeneration
- [ ] Manic depression (bipolar disease)
- [ ] Memory Loss
- [ ] Missing limb (e.g., amputation)
- [ ] Multiple sclerosis
- [ ] Muscle or bone problems
- [ ] Nausea/vertigo
- [ ] Neurological condition
- [ ] Non-Alzheimer's dementia
- [ ] Osteoporosis
- [ ] Other cardiovascular disease
- [ ] Other eye condition
- [ ] Other fracture (except hip/spine)
- [ ] Other neurological
- [ ] Other significant illness
- [ ] Paralysis
- [ ] Paraplegia
- [ ] Parkinson's disease
- [ ] Pathological bone fracture
- [ ] Peripheral vascular disease
- [ ] Pneumonia
- [ ] Quadriplegia
- [ ] Receptive communication
- [ ] Renal failure
- [ ] Respiratory disease
- [ ] Schizophrenia
- [ ] Seizure disorder
- [ ] Speech impairment
- [ ] Stroke
- [ ] TB
- [ ] Thyroid disease
- [ ] Transient ischemic attack (TIA)
- [ ] Traumatic brain injury
- [ ] Tremors
- [ ] Urinary problems
- [ ] Urinary tract infection
- [ ] Vision problems
- [ ] None of the Above

5. Enter any comments regarding the client's medical conditions/diagnoses.

____

____

____

____

6. Is the client limited in what s/he can do because of this health problem?

- [ ] Y - Yes (3)
- [ ] N - No

7. How often does bad health, sickness, pain, or disability stop the client from doing things s/he would like to do?

- [ ] A - Never
- [ ] B - Sometimes (1)
- [ ] C - Often (2)
- [ ] D - Always (3)

8. Has the client fallen in the past three months?

- [ ] Y - Yes (3)
- [ ] N - No

9. In a typical week, during the last 30 days, how often did the client go outside of their residence (no matter for how short a period of time)?

- [ ] A - Two or more days a week
- [ ] B - One day a week or less (2)

10. Does the client use a walker/cane to get around?

- [ ] Y - Yes (3)
- [ ] N - No

11. Does the client use a wheelchair to get around or is bedbound?

- [ ] Y - Yes (3)
- [ ] N - No

12. Does the client have problems with hearing that are NOT corrected with aids/devices?

- [ ] Y - Yes (1)
- [ ] N - No

13. If the client has hearing aids/devices, are they in working order?

- [ ] Y - Yes
- [ ] N - No

14. Does the client have problems with vision that are not corrected with aids/devices?

- [ ] Y - Yes (1)
- [ ] N - No

15. If the consumer uses vision aids/devices, are they in working order?

- [ ] Y - Yes
- [ ] N - No

16. Does the client have problems with speech that are not corrected with aids/devices?

- [ ] Y - Yes (1)
- [ ] N - No

17. Describe any aids/devices used by the client to correct speech problems.

____

____

____

____

18. If the consumer uses speech aids/devices are they in working order?

- [ ] Y - Yes
- [ ] N - No

19. Does the client often feel sad or blue?

- [ ] Y - Yes (3)
- [ ] N - No

20. How many prescription medications does the client take?

[ ]

21. Is the number of Medications the client is taking 3 or more?

- [ ] Y - Yes (1)
- [ ] N - No

22. What was the client's response when asked, 'What year is it?'

- [ ] A - Correct answer
- [ ] B - Incorrect answer

23. What was the client's response when asked, 'What month is it?'

- [ ] A - Correct answer
- [ ] B - Incorrect answer

24. What was the client's response when asked, 'Where are we now?'

- [ ] A - Correct answer
- [ ] B - Incorrect answer

25. **Indicate worker's judgment of client's overall mental clarity/cognitive functions.**

- [ ] 1 - Good
- [ ] 2 - Fair (2)
- [ ] 3 - Poor (3)

26. **In the past six months, has the client lost more than 10 pounds without trying?**

- [ ] Yes (2)
- [ ] No

Enter Health Screening Score.

____

____

____

____

1.F. Nutrition Screening

1. **Has the client made any changes in lifelong eating habits because of health problems?**

- [ ] Y - Yes (2)
- [ ] N - No (0)

2. **Does the client eat fewer than 2 meals per day?**

- [ ] Y - Yes (3)
- [ ] N - No (0)

3. **Does the client eat fewer than five (5) servings (1/2 cup each) of fruits or vegetables every day?**

- [ ] Y - Yes (1)
- [ ] N - No (0)

4. **Does the client eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day?**

- [ ] Y - Yes (1)
- [ ] N - No (0)

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

- [ ] Y - Yes (2)
- [ ] N - No (0)

6. **Does the client have biting, chewing or swallowing problems that make it difficult to eat?**

- [ ] Y - Yes (2)
- [ ] N - No (0)

7. **Does the client sometimes not have enough money to buy food?**

- [ ] Y - Yes (4)
- [ ] N - No (0)

8. **Does the client eat alone most of the time?**

- [ ] Y - Yes (1)
- [ ] N - No (0)

9. **Does the client take 3 or more different prescribed or over-the-counter drugs per day?**

- [ ] Y - Yes (1)
- [ ] N - No (0)

10. **Without wanting to, has the client lost or gained 10 pounds in the past 6 months?**

- [ ] Y - Yes (2)
- [ ] N - No (0)

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

- [ ] Y - Yes (2)
- [ ] N - No (0)

Total score of Nutritional Risk Questions.

[ ]

What is the client's nutritional risk score rating?

- [ ] High risk (6-19)
- [ ] Moderate risk (3-5)
- [ ] No risk (0-2)

2. Functional Assessment

2.A. Activities of Daily Living (ADL)

1. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform BATHING (include shower, full tub or sponge bath, exclude washing back or hair)?

- [ ] 0 - Independent
- [ ] 1 - Supervision (1)
- [ ] 2 - Requires assistance sometimes (1)
- [ ] 3 - Mostly dependent (1)
- [ ] 4 - Totally dependent (1)
- [ ] 5 - Activity does not occur (1)

Is the help the client receives bathing enough?

- [ ] Y - Yes
- [ ] N - No

2. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform DRESSING?

- [ ] 0 - Independent
- [ ] 1 - Supervision (1)
- [ ] 2 - Limited Assistance (1)
- [ ] 3 - Extensive Assistance (1)
- [ ] 4 - Total Dependence (1)
- [ ] 5 - Activity did not occur (1)

Is the help the client receives dressing enough?

- [ ] Y - Yes
- [ ] N - No

3. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TOILET USE?

- [ ] 0 - Independent
- [ ] 1 - Supervision (1)
- [ ] 2 - Sometimes dependent (1)
- [ ] 3 - Mostly dependent (1)
- [ ] 4 - Totally dependent (1)
- [ ] 5 - Activity does not occur (1)

Is the help the client receives using the toilet enough?

- [ ] Y - Yes
- [ ] N - No

4. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform getting out of bed/chairs/transferring?

- [ ] 0 - Independent
- [ ] 1 - Supervision (1)
- [ ] 2 - Minimal assistance required (1)
- [ ] 3 - Mostly dependent (1)
- [ ] 4 - Totally dependent (1)
- [ ] 5 - Activity does not occur (1)

Is the help the client receives getting in and out of bed/chairs enough?

- [ ] Y - Yes
- [ ] N - No

5. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform EATING?

- [ ] 0 - Independent
- [ ] 1 - Supervision (1)
- [ ] 2 - Sometimes dependent (1)
- [ ] 3 - Mostly dependent (1)
- [ ] 4 - Totally dependent (1)

Is the help the client receives eating enough?

- [ ] Y - Yes
- [ ] N - No

6. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform WALKING IN HOME?

- [ ] 0 - Independent
- [ ] 1 - Supervision (1)
- [ ] 2 - Limited Assistance (1)
- [ ] 3 - Extensive Assistance (1)
- [ ] 4 - Total Dependence (1)
- [ ] 5 - Activity did not occur (1)

Is the help the client receives getting around the home enough?

- [ ] Y - Yes
- [ ] N - No

How many ADL impairments does the client have (Count or Total)?

2.B. Instrumental Activities of Daily Living (IADL)

1. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MEAL PREPARATION?

- [ ] 0 - Independent
- [ ] 1 - Sometimes dependent (1)
- [ ] 2 - Mostly dependent (1)
- [ ] 3 - Totally dependent (1)
- [ ] 4 - Activity does not occur (1)

Is the help the client receives preparing meals enough?

- [ ] Y - Yes
- [ ] N - No

2. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform SHOPPING?

- [ ] 0 - Independent
- [ ] 1 - Somewhat dependent (1)
- [ ] 2 - Mostly dependent (1)
- [ ] 3 - Totally dependent (1)
- [ ] 4 - Activity does not occur (1)

Is the help the client receives shopping enough?

- [ ] Y - Yes
- [ ] N - No

3. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MANAGING MEDICATIONS?

- [ ] 0 - Independent
- [ ] 1 - Needs reminders (1)
- [ ] 2 - Somewhat dependent (1)
- [ ] 3 - Totally dependent (1)
- [ ] 4 - Activity does not occur (1)

Is the help the client receives taking medication enough?

- [ ] Y - Yes
- [ ] N - No

4. Specify the client's ability to MANAGE MONEY.

- [ ] 0 - Completely independent
- [ ] 1 - Needs assistance sometimes (1)
- [ ] 2 - Needs assistance most of the time (1)
- [ ] 3 - Completely dependent (1)
- [ ] 4 - Activity does not occur (1)

Is the help the client receives managing money enough?

- [ ] Y - Yes
- [ ] N - No

5. Rank the client's ability to use the TELEPHONE.

- [ ] 0 - Independent
- [ ] 1 - Able to perform but needs verbal assistance (1)
- [ ] 2 - Can perform with some human help (1)
- [ ] 3 - Can perform with a lot of human help (1)
- [ ] 4 - Cannot perform function at all without human help (1)

Is the help the client receives using the telephone enough?

- [ ] Y - Yes
- [ ] N - No

6. Specify the client's ability to perform HEAVY HOUSEWORK CHORES.

- [ ] 0 - Independent
- [ ] 1 - Needs assistance sometimes (1)
- [ ] 2 - Needs assistance most of the time (1)
- [ ] 3 - Unable to perform tasks (1)
- [ ] 4 - Activity does not occur (1)

Is the help the client receives performing heavy household chores enough?

- [ ] Y - Yes
- [ ] N - No

7. Specify the client's ability to perform LIGHT HOUSEKEEPING.

- [ ] 0 - Independent
- [ ] 1 - Needs assistance sometimes (1)
- [ ] 2 - Needs assistance most of the time (1)
- [ ] 3 - Unable to perform tasks (1)
- [ ] 4 - Activity does not occur (1)

Is the help the client receives doing housework enough?

- [ ] Y - Yes
- [ ] N - No

8. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TRANSPORTATION?

- [ ] 0 - Independent
- [ ] 1 - Somewhat dependent (1)
- [ ] 2 - Mostly dependent (1)
- [ ] 3 - Totally dependent (1)

Is the help the client receives using transportation enough?

- [ ] Y - Yes
- [ ] N - No

9. Does the client have any of the following devices or equipment used to help perform the above ADL/IADL?

- ☐ Artificial limb
- ☐ Bath stool
- ☐ Bedside commode
- ☐ Cane
- ☐ Dentures
- ☐ Extended shower head/Hand held shower
- ☐ Eyeglasses
- ☐ Grab bars
- ☐ Hearing aid
- ☐ Hospital bed
- ☐ Lift chair
- ☐ Nebulizer
- ☐ Oxygen
- ☐ Raised toilet seat
- ☐ Ramp
- ☐ Walker
- ☐ Wheelchair
- ☐ Other

10. Any of Other devices or equipment not listed, if other.

____

____

____

____

How many IADL impairments does the client have (Count or Total)?

☐

Total Score (Social + Health+ADL/IADL)

____

____

____

____

3. Financial Resources

3.A.i. Client Resources

1. **Specify the client's monthly social security income.**

$

2. **Specify the client's monthly SSI income.**

$

3. **Specify the client's monthly retirement/pension income.**

$

4. **Specify the client's monthly interest income.**

$

5. **Specify the client's monthly VA benefits income.**

$

6. **Specify the client's monthly wage/salary/earnings income.**

$

7. **Specify the client's other monthly income.**

$

3.A.ii. Spouse Resources

1. **Specify the monthly social security income of the client's spouse.**

$

2. **Specify the monthly SSI income of the client's spouse.**

$

3. **Specify the monthly retirement/pension income of the client's spouse.**

$

4. **Specify the monthly interest income of the client's spouse.**

$

5. **Specify the monthly VA benefits income of the client's spouse.**

$

6. **Specify the monthly wage/salary/earnings income of the client's spouse.**

$

7. **Specify other monthly income of the client's spouse.**

$

3.A.iii. Total Resources

1. **Specify the client's MONTHLY income.**

$

2. **What is the client's monthly income?**

- ☐ $1,178 or less
- ☐ $1,420 or less
- ☐ $1,662 or less
- ☐ $695 or less
- ☐ $937 or less

3. **How many people in the household does the client support on his/her income?**

4. **What is the client's TOTAL MONTHLY HOUSEHOLD income?**

$

5. **Based on the Range, Is the CLIENT'S income level below the national poverty level?**

- ☐ Yes
- ☐ No

3.B. Monthly Housing Costs

1. **Specify the client's monthly rent.**

$

2. **Specify the client's monthly mortgage.**

$

3. **Specify the client's monthly property tax.**

$

4. **Specify the client's monthly heat bill.**

$

5. **Specify the client's monthly utilities bill.**

$

6. **Specify the client's monthly house insurance cost.**

$

7. **Specify the client's monthly telephone bill.**

$

8. **Specify the client's other monthly costs.**

$

9. **What is the consumer's estimated total medical monthly expenses(e.g. health insurance premiums, hospital and doctor bills, prescription costs)?**

$

10. **Enter the client's total monthly housing expenses.**

$

3.C. Savings/Assets

1. **What is the client's savings account/CD/investments balance?**

$

2. **What is the client's checking account balance?**

$

3.D. Health Insurance

1. **Enter the client's Medicare number.**

____

2. **Does the client have Medicare A health insurance?**

☐ Yes
☐ No

3. **Does the client have Medicare B health insurance?**

☐ Y - Yes
☐ N - No

4. **Does the client have Medigap health insurance?**

☐ Y - Yes
☐ N - No

What is the name of the client's Medigap health insurer?

____
____
____
____

5. **Does the client have Medicare D health insurance?**

☐ Y - Yes
☐ N - No

What is the name of the client's Medicare D company/plan?

____

6. **Does the client have LTC health insurance?**

☐ Y - Yes
☐ N - No

What is the name of the client's LTC health insurer?

____
____
____
____

7. **Does the client have other health insurance?**

☐ Y - Yes
☐ N - No

What is the name of the client's other health insurer?

____
____
____
____

3 Comments

Comment on the client's current financial situation.

4. Health Assessment

4.A. Current Health Status

1. Describe the client's allergies, if any.

2. Describe the client's special diet(s).

3. Does the client smoke or chew tobacco regularly?

- [ ] Deferred
- [ ] Don't know
- [ ] No
- [ ] Yes

4.B. Medication Use

1. List all prescribed and non prescribed medications taken by the client in the last 7 days.

a. Name and Dose: Record the name of the medication and dose ordered.

b. Form: Code the route of administration using the following list:

1 = by mounth (PO)	7 = topical
2 = sub lingual (SL)	8 = inhalation
3 = intramuscular (IM)	9 = enteral tube
4 = intravenous (IV)	10 = other
5 = subcutaneous (SQ)	11 = eye drop
6 = rectal (R)	12 = transdermal

d. Frequency: Code the number of times per period the med is administered using the following list:

PR = (PRN) as necessary	OO = every other day
1H = (QH) every hour	1W = (Q week) once each week
2H = (Q2H) every 2 hours	2W = 2 times every week
3H = (Q3H) every 3 hours	3W = 3 times every week
4H = (Q4H) every 4 hours	4W = 4 times each week
6H = (Q6H) every 6 hours	5W = 5 times each week
8H = (Q8H) every eight hours	6W = 6 times each week
1D = (QD or HS) once daily	1M = (Q month) once/mo.
2D = (BID) two times daily *(includes every 12 hours)*	2M = twice every month
3D = (TID) 3 times daily	C = Continuous
4D = (QID) four times daily	O = Other
5D = 5 times daily	

a. Name and Dose	b. Form	c. No. Taken	d. Freq	e. Comments

1. Continued

2. How does the client remember to take his/her medications?

5. Mental Health/Behavior/Cognition

5.A. Mental Health Services

1. In the past year, has the client received (or is the client currently receiving) mental health treatment or counseling?

- [ ] Y - Yes
- [ ] N - No

2. What kinds of services has the client received, or what kinds of services is the client receiving now?

____

____

____

____

5.B. Behavior

1. Does spouse, partner, caregiver or other person, including this assessor, suggest that the client has memory or emotional problems?

- [ ] Y - Yes
- [ ] N - No

2. How often does the client get lost or wander?

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

3. How often is the client physically abusive to him/herself?

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

4. How often is the client physically abusive to others?

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

5. How often is the client verbally abusive to him/herself or others?

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

6. How often does the client exhibit socially inappropriate/disruptive behavior?

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

7. How often does the client experience hallucinations/delusions?

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

5.C. Cognition

1. How often does the client have problems with his/her short term memory?

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

2. How often does the client have problems making him/herself understood?

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

3. How often does the client have problems with long term memory?

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

4. How often does the client have problems understanding others?

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

5. How often does the client have problems with decision making?

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

6. Home Environment

6.A. Environmental Checklist

1. **Does the client have problems with dangerous stairs or floors in his/her home?**
   - [ ] Y - Yes
   - [ ] N - No

2. **Is it difficult for the client to get to the entrance of his/her home?**
   - [ ] Y - Yes
   - [ ] N - No

3. **Is it difficult for the client to get to the bathroom or bedroom in his/her home?**
   - [ ] Y - Yes
   - [ ] N - No

4. **Does the client have problems with the major appliances or toilet in his/her home?**
   - [ ] Y - Yes
   - [ ] N - No

5. **Does the client have problems with the heating or cooling in his/her home?**
   - [ ] Y - Yes
   - [ ] N - No

6. **Does the client have problems getting water or hot water in his/her home?**
   - [ ] Y - Yes
   - [ ] N - No

7. **Does the client have difficulties keeping his/her home free from odor or pests?**
   - [ ] Y - Yes
   - [ ] N - No

8. **Does the client need a smoke alarm in his/her home?**
   - [ ] Y - Yes
   - [ ] N - No

9. **Does the client have problems with electrical hazards in his/her home?**
   - [ ] Y - Yes
   - [ ] N - No

10. **Does the client have problems with poor lighting in his/her home?**
   - [ ] Y - Yes
   - [ ] N - No

11. **Does the client have problems with an unsafe stove in his/her home?**
   - [ ] Y - Yes
   - [ ] N - No

12. **Does the client have problems with loose slippery rugs in his/her home?**
   - [ ] Y - Yes
   - [ ] N - No

13. **Does the client have problems with inadequate locks on the doors and/or windows in his/her home?**
   - [ ] Y - Yes
   - [ ] N - No

14. **Does the client have problems keeping his/her home clean and free of clutter?**
   - [ ] Y - Yes
   - [ ] N - No

15. **Does the client have any other environmental problems in his/her home?**
   - [ ] Y - Yes
   - [ ] N - No

16. **Describe any other environmental problems.**

____

____

____

____

17. **In the case of an emergency, would the client be able to get out of his/her home safely?**
   - [ ] Y - Yes
   - [ ] N - No

18. **In the case of an emergency, would the client be able to summon help to his/her home?**
   - [ ] Y - Yes
   - [ ] N - No

19. **Comment on the client's home environment in general and establish a safety evacuation plan if necessary.**

____

____

____

____

Title :

Date

Title :

Date

SAMS ILA (NSI) 2010

Assessment Instructions

0. COVER SHEET

0.A. Client Identification

3. Where was the client interviewed? – Mark the appropriate response. If *4 – Other* is marked, answer Question 4. If response 1 through 3 is answered, skip to Question 5.

11. Enter the client identifier for the client – The client identifier establishes a single file for each client for use in recording ALL services received from aging network agencies from all providers. If this is a new client, a number will be automatically generated from the client's date of birth and the last four digits of the Social Security number when the information is entered into the computer database. This number will be the same, no matter where the client receives services. It is critical that you ensure the accuracy of the numbers used to create the Client ID. If the numbers are incorrect, the client will appear as two different people in the database. This will result in inaccurate counts of individuals served by the various programs.

19. What document was used to verify the client's age? – Mark the appropriate response. If *Other* is marked then answer Question 20; however, if any other response is marked, skip to Question 21.

0.B. Emergency Contact Information

0.C. Directions to Client's Home

1. INTAKE

1.A. Standard Data

1.B. Legal Representative

1. Does the client have a power of attorney? – Mark Yes or No. Power of Attorney is a legal document, which allows a person, known as the principal, to authorize an agent to transact specified business on his/her behalf. Powers of Attorney are traditionally used for financial and other business affairs and are only effective as long as the principal is able to voluntarily direct the agent.

5. Does the client have a Durable Power of Attorney (DPOA) for health care? – Mark Yes or No. This Advance Directive enable adults to retain control over their own medical care during periods of incapacity (i.e., unable to speak for oneself) through the prior designation of an individual to make health care decisions on his/her behalf. The individual who holds the DPOA for Health Care will be able to make decisions regarding the person's health care if s/he is unable to speak for him/herself.

9. Does the client have a DPOA for finances? – Mark Yes or No. A Standard Power of Attorney is effective only as long as the person who issues it (the principal) is competent. A Durable Power of Attorney continues in effect even if the principal becomes mentally incapacitated for any period of time. This legal document must clearly state that it continues to be valid even after the onset of incapacity or mental disability.

13. Does the client have a representative payee? – Mark Yes or No. Representative payee is a person who manages income received from the Social Security Administration, such as Social Security, civil service, railroad retirement and Veterans Administration Checks. Rather than the beneficiary receiving the income directly, checks are sent to the Representative Payee who is responsible for using the funds in the best interest of the beneficiary.

17. Does the client have a legal guardian? – Mark Yes or No. An individual appointed by the Probate Court, either voluntarily or involuntarily, to manage some or all- financial and/or personal decisions of an individual.

1.C. Assessment Information

1.D. Social Screening

10. Is the client currently employed? – Mark the appropriate response. Only one response can be marked. If the client is working "part time" mark, *Yes*; however, if the client is working "Full time" mark, *Full time*.

1.E. Health Screening

3. In the past 6 months has the client stayed in a nursing home, residential care home, or other institution? – Mark the appropriate response. This would include any stay in rehab facility, mental institution, or any type of a facility/institution.

4. Indicate which of the following conditions/diagnoses the client currently has. – Mark the appropriate response.

   Definitions:

   Expressive communication – Expressive language disorder identifies developmental delays and difficulties in the ability to produce speech.

   Receptive communication - Mixed receptive-expressive language disorder identifies developmental delays and difficulties in the ability to understand spoken language and produce speech.

1.F. Nutrition Screening

Nutritional Risk Scores will be used to establish nutrition risk status for referral to appropriate resources for intervention. Client's determined to be High Risk (6-19) should be referred to appropriate resource for intervention if desired by client.

2. FUNCTIONAL ASSESSMENT

2.A. Activities of Daily Living (ADL)

2.B. Instrumental Activities of Daily Living (IADL)

9. Does the client have any of the following devices or equipment used to help perform the above ADL/IADL? – Mark the appropriate response. If *Other* is marked then answer Question 10; however, if any other response is marked, skip to Section 3.

3. FINANCIAL RESOURCES

3.A.i. Client Resources

2. Specify the client's monthly SSI income. – Insert the total monthly SSI income of the client. SSI is Supplemental Security Income. It is the national income support program for the poorest elders and adults living with disabilities.

3.A.ii. Spouse Resources

3.A.iii. Total Resources

1. Specify the client's MONTHLY income – Insert the total amount of the client's MONTHLY income. This is should equal the total amount of 3.A.i., questions 1 -7.

4. What is the client's TOTAL MONTHLY HOUSEHOLD income? – Insert the total monthly household income of the client. Household means the primary family unit residing in the same dwelling, such as:

   (a) Client only;

   (b) Client and spouse;

   (c) Client, spouse and minor children;

   (d) Client and minor children only.

   In determining household for poverty status and cost share, an adult child living with his/her parents or a parent living in the home of adult/children is considered a household of one. In these examples there is no legal requirement for income sharing between the two units.

5. Based on the Range, Is the CLIENT'S income level below the national poverty level? – Mark Yes or No. To review Poverty Income Guidelines, see Attachment B in Chapter 16 of the Tennessee Commission on Aging and Disability Policies and Procedures. However, poverty guidelines do change each year. Updated Poverty Income Guidelines can be found through the United States Department of Health and Human Services by viewing the following website, http://aspe.hhs.gov/poverty/index.shtml#latest and clicking on the latest version of poverty guidelines.

3.B. Monthly Housing Costs

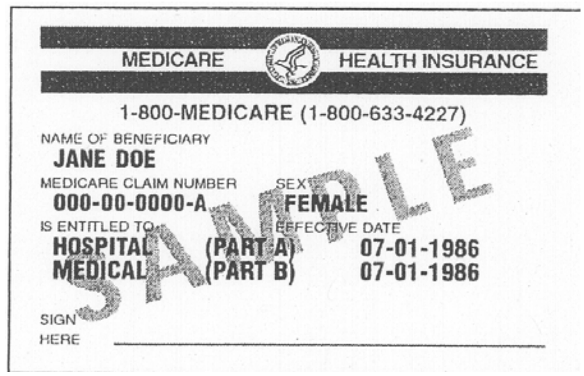
8. Specify the client's other monthly costs. – Enter the amount of the client's other monthly costs. This would include any credit cards, auto expenses, alimony, etc.

10. Enter the client's total monthly housing expenses. – This will not self calculate; therefore, the Service Coordinator must total Questions 1 – 9 and insert in Question 10.

3.C. Savings/Assets

3.D. Health Insurance

1. Enter the client's Medicare number – Enter the client's Medicare number. If the client has Medicare Advantage as well as original Medicare, make a notation including the name of the plan, plan number, and note if it includes drug coverage.



2. Does the client have Medicare A health insurance? – Mark the appropriate response. If the response is Yes, take note of the effective date.

3. Does the client have Medicare B health insurance? – Mark the appropriate response. If the response is Yes, take note of the effective date.

4. Does the client have Medigap health insurance? - Mark the appropriate response. If the response is Yes, in the second part of the question include plan name, id number, phone number, and monthly premium.

5. Does the client have Medicare D health insurance? – Mark the appropriate response. In the second part of the question include the company/plan name. Also, ask client if they receive X-tra Help through Medicare D.

4. HEALTH ASSESSMENT

4.A. Current Health Status

4.B. Medication Use

5. MENTAL HEALTH/BEHAVIOR/COGNITION

5.A. Mental Health Services

5.B. Behavior

5.C. Cognition

6. HOME ENVIRONMENT

The purpose of this section is to determine whether the consumer's house or apartment is safe and accessible. It also provides the opportunity to talk with the consumer about assistance that may be available to correct problems in and around the home and to offer the necessary referrals. Use your own powers of observation to make judgments about things you observe and talk about them with the consumer. A box is provided for comments.

6.A. Environmental Checklist

Go over each item in the Environmental Checklist, and check Yes, No, or Don't know, depending upon the consumer's response and your own observations. Discuss issues of concern with the consumer. Record specifics about problems in the comment box. Indicate clearly whether these are your concerns or those of the consumer. That will make it easier to know which problems the consumer may be willing to address first. Also, indicate if any of the problems are of immediate/serious danger to the consumer. Some possible observations:

- <u>Access</u> – Depending upon the consumer's physical condition, consider factors such as the consumer living above the first floor, no elevators, doorways too narrow for wheelchairs, bedrooms and bath on second floor, clutter or loose runners on stairs, stairs with narrow steps/no rails, need for visual marks or non-slip surfaces at stair edges. Pay special attention to the pathways between bedroom/bed and bathroom.

- <u>Structural/Electrical</u> – Look for areas such as exposed or frayed wiring or electrical cords, over-use of extension cords, damaged/improperly used electrical heaters. Uneven floors or ceiling with watermarks may suggest structural problems. Observe bathroom/kitchen for potential problems such as slippery floors, poor/glaring lighting, need for adaptive equipment such as grab bars, thresholds which present tripping hazards, skid proof strips in tub or shower, elevated toilet seat needed, toilets that are sinking or leaning suggesting rotten floor boards.

- <u>Other Hazards</u> – Pay attention to other possible dangers, such as unvented or improperly used space heaters, dangerous wood stove installation/chimney, no fire extinguisher, rugs not secured with non-slip backing, wall-to-wall clutter. Unsanitary conditions may be indicated by odors, pest or pet droppings, dirty clothing, etc. Some of these conditions, as well as excessive dirty dishes, may indicate a lack of hot water.

  17. <u>In the case of an emergency, would the client be able to get out of his/her home safely?</u> – Mark the appropriate response. Note any specific concerns in the box below. In your observations, consider areas such as those mentioned in the Environmental Checklist section above. Also, look for locks that make doors difficult to open, and inquire whether a caregiver is present to help in an evacuation. The client should be able to evacuate the bedroom form the window as well as the door. Check for barriers such as windows painted shut or barred.

18. In the case of an emergency, would the client be able to summon help to his/her home? – Mark the appropriate response. In addition to the client's opinion, mention any comments/problems you note in the box provided. Observe whether there is a telephone that is accessible and in working order and if the client has a Personal Emergency Response System (PERS).

Attachment F

OPTIONS FOR COMMUNITY LIVING

STATE-FUNDED HOME AND COMMUNITY BASED SERVICES

CONSUMER COST SHARE COMPUTATION WORKSHEET

FOR USE BY TENNESSEE AREA AGENCIES ON AGING AND DISABILITY
PROVIDING HOME AND COMMUNITY BASED SERVICES

Tennessee Commission on Aging and Disability

June 2010

Enter AAAD's name into Cell B1

CONSUMER'S COST SHARE COMPUTATION

Consumer's Name	Service Month
abc	July-05
	Date Computed
	1/20 11:51 AM

Income for Budget Group			$1,600.00
Individuals in Budget Group			1

Monthly Income Declared by consumer. Include income received by entire Budget Group **(Household)**.

Services Received	**Units**	**Rate**	
Estimated from Care Plan			
Personal Care	0.00	$25.00	$0.00
Homemaker	5.00	$20.52	$102.60
Service Name	0.00	$0.00	$0.00
Service Name	0.00	$0.00	$0.00
Service Name	0.00	$0.00	$0.00
Total Cost of Services			$102.60

Adjustment for Prior Month Estimated Services			
Actual - Service	0.00		
Estimate	0.00		
Difference	0.00	$25.00	$0.00
Actual - Service	0.00		
Estimate	0.00		
Difference	0.00	$20.52	$0.00
Total Adjustment to Estimated Services			$0.00

Income Computation				
a)	Declared Monthly Income			$1,600.00
Adjustments for Personal Needs:				
b)	Minimum Income Allowance - FBR @	200%		$1,348.00
c)	Income Subject to Cost Share			**$252.00**
Cost Share Rate Computation				
d)	Cost Share Equals full Charges at this level of FBR Rate	600%	$4,044.00	
	Range on which Cost Share is to be Applied:			
e)	Minimum (Line b)		$1,348.00	
f)	Maximum (Line d)		$4,044.00	
g)	Spread (e - f)		$2,696.00	
h)	Cost Share Rate (line c / line g)			10%
Monthly Computation of Cost Share				
i)	Monthly Services Charges Subject to Cost Share			$102.60
j)	Monthly Cost Share (line i * line h)			$10.00
k)	Monthly Cost Share Cap (line a * 45%)			$720.00
l)	**Consumer's Cost Share**			**$10.00**

Revised 7/15/05

Enter AAAD's name into Cell B1
Annualized Computations

Consumer's Name
abc

Year Beginning
July-05
Date Computed
1/20 11:51 AM

Projected Services to be Received	**Units**	**Rate**	
Estimated/Actual Services			
Personal Care	0.00	$25.00	$0.00
Homemaker	60.00	$20.52	$1,231.20
Service Name	0.00	$0.00	$0.00
Service Name	0.00	$0.00	$0.00
Service Name	0.00	$0.00	$0.00
Total Cost of Services			$1,231.20

Annual Income Computation		
Declared Annual Income		$19,200.00
Adjustments for Personal Needs:		
Minimum Income Allowance - FBR @	200%	$16,176.00
Income Subject to Cost Share		$3,024.00

Annual Projection of Cost Share	**% of Gross Income**	
Annual Services Charges Subject to Cost Share	6.41%	$1,231.20
Annual Cost Share	0.63%	$120.00
Annual Cost Share Cap (45%)	45.00%	$8,640.00
Consumer's Cost Share	0.63%	$120.00

Note: The computations above are estimates based on the current services and declared income. If the Care Plan changes the amounts above will also change.

Revised 7/15/05

Attachment G

OPTIONS FOR COMMUNITY LIVING

STATE-FUNDED HOME AND COMMUNITY BASED SERVICES

SERVICE PLAN

FOR USE BY TENNESSEE AREA AGENCIES ON AGING AND DISABILITY
PROVIDING HOME AND COMMUNITY BASED SERVICES

Tennessee Commission on Aging and Disability

June 2010

Options for Community Living
SERVICE PLAN

1. Initial ( ) Review ( )	2. Consumer Name:	3. Consumer Medical Diagnosis:
4. Physician(s):	6. Caregiver Information: (Name of each caregiver and schedule)	
5. Physician Phone No.		
8. Date Rec'd:	10. TennCare No.:	7. Safety Plan, if applicable: (see attached)
9. Date Prepared:		11. Social Security No: / 12. County:

SERVICE PLAN

13. Needs	14. Services Needed (frequency, amount, duration)	15. Goals	16. Any treatments, therapies, diets, adaptive equipment, etc.

Service Plan – Effective From: __________ To: __________

SERVICE AUTHORIZED

17. Services Authorized	18. Waiver	19. Funding Source	20. Provider.	21. Frequency	22. Total Units	23. Cost per Unit	24. Weekly Cost	25. Six Month Cost	26. Date Authorized	27. Start Date	28. End Date
	Y / N										
	Y / N										
	Y / N										
	Y / N										
	Y / N										

29. Next Service Plan Review ( ) 1 Month ( ) 2 Months ( ) 3 Months ( ) Other __________ Date: __________

30. General Comments:

I have been involved in developing this service plan. I understand that it may be revised as my preferences and needs change. I have been given the option to choose providers.

31. Signature of Consumer __________ 32. Signature of Service Coordinator __________ Date: __________

33. Authorized by AAAD __________ Date: __________ AAAD Financial Officer: __________ Date: __________