SAMS Intake 2018

A. Intake/Assessment

A Intake/Assessment

1. What is the date of the screening?

_____/_____/_____

2. Specify the type of screening, or the reason for the screening.

- ☐ 1 - Initial screening
- ☐ 2 - Rescreen

3. What is the name of the person conducting this screening?

_____

4. What Is the Callers Name?

_____

5. What Is the Callers Phone Number?

_____

6. What Is the Callers Relationship To the Client?

_____

7. How did the client/caller hear about the program?

_____

_____

_____

_____

8. Does the client know the referral is being made?

- ☐ 1 - Yes
- ☐ 2 - No

9. Describe formal/informal supports already in place.

_____

10. Comment on type of assistance requested.

_____

_____

_____

_____

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

- ☐ 1 - Energy assistance (LIHEAP)
- ☐ 2 - Food stamps (SNAP)
- ☐ 3 - Home Repair/Weatherization
- ☐ 4 - QMB/SLMB/LIS/Q1
- ☐ 5 - SSI
- ☐ 6 - Medicare Counseling
- ☐ 7 - None

B. Individual Identification

B Individual Identification

1. What is the client's first name?

_____

2. Enter the client's 'also known as' first name.

_____

3. What is the client's middle initial?

_____

4. What is the client's last name?

_____

5. What is the client's date of birth?

_____/_____/_____

6. What is the client's Pension/Social Security Number? (Optional or collect if making CHOICES referral)

_____-_____-_____

7. Enter the client's telephone number.

_____

8. Alternate telephone number for client

_____

9. What is the client's e-mail address?

_____

10. Enter the client's residential street address.

_____

11. Enter the client's residential city or town.

_____

12. Enter the client's residential zip code.

_____

13. What county does the client reside in?

_____

14. Describe how to get to the client's home.

_____

_____

_____

_____

15. Enter the client's mailing street address or Post Office box.

_____

16. Enter the client's mailing city or town.

_____

17. Enter the client's mailing state.

_____

18. Enter the client's mailing ZIP code.

_____

19. Select the client's current living arrangement.

- ☐ 1 - Lives Alone (3)
- ☐ 2 - Lives with spouse only
- ☐ 3 - Lives with spouse and others
- ☐ 4 - Lives with others.

C. Demographics

C Demographics

1. What is the client's ethnicity?

- ☐ 1 - Hispanic or Latino
- ☐ 2 - Not Hispanic or Latino
- ☐ 3 - Unknown

2. 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 - White-Hispanic
- ☐ 7 - Other

3. What is the client's gender?

- ☐ 1 - Male
- ☐ 2 - Female
- ☐ 3 - Other

4. Select the client's current marital status.

- ☐ 1 - Single
- ☐ 2 - Married
- ☐ 3 - Divorced
- ☐ 4 - Widowed
- ☐ 5 - Separated
- ☐ 6 - Other

D. Caregiver Identification

D Caregiver Identification

1. Does the client have an identified primary (informal) helper/caregiver who provides care on a regular basis?

- ☐ 1 - Yes
- ☐ 2 - No, If no, skip to next section. (2)

2. What is the caregiver's first name?

_____

3. What is the caregiver's last name?

_____

4. Caregiver's birth date?

_____/_____/_____

5. What is the caregiver's telephone number?

_____

6. What is the caregiver's e-mail address?

_____

7. What is the address of the client's caregiver?

_____

_____

_____

_____

8. What is the client's caregiver's Zip Code?

_____

9. What is the caregiver's relationship to the elderly care recipient?

- ☐ 1 - Child
- ☐ 2 - Spouse/Partner/Significant other
- ☐ 3 - Other relative
- ☐ 4 - Other non-relative

10. How often does the client receive assistance from the primary caregiver?

- [ ] 1 - Daily
- [ ] 2 - Several times a week
- [ ] 3 - Weekly
- [ ] 4 - Less than weekly

E. Emergency Contacts

E Emergency Contacts

1. Name of Friend or Relative (outside client's home) to contact in case of an Emergency.

_____

2. Relationship of Friend or Relative (outside client's home) to contact in case of an Emergency.

_____

3. Primary Telephone Number of Friend or Relative (out side client's home) to contact in case of an Emergency.

_____

4. Alternate Telephone Number of Friend or Relative (ou tside client's home) to contact in case of an Emergency.

_____

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

_____

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

_____

7. What is the alternate phone number of the second relative or friend of the client?

_____

F. Social Screening

F Social Screening

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

- [ ] 1 - Yes
- [ ] 2 - No (3)

G. Health Screening

G Health Screening

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

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

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

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

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

- [ ] 1 - Yes (3)
- [ ] 2 - No

4. Is the client homebound?

- [ ] 1 - Yes (3)
- [ ] 2 - No

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

- [ ] Alzheimer's disease/other Dementia
- [ ] Ankle/leg swelling
- [ ] Any urinary, bowel problems, or incontinence
- [ ] Arthritis/rheumatic disease/gout
- [ ] Cancer
- [ ] Chronic pain
- [ ] Contagious/Communicable Disease
- [ ] Do you take any medication for depression or anxiety
- [ ] Diabetes
- [ ] Have you ever had a stroke
- [ ] Hearing impairment
- [ ] Heart problems
- [ ] Hypertension
- [ ] Intellectual/Developmental disability
- [ ] Memory Loss
- [ ] Missing limb (e.g., amputation)
- [ ] Problems with breathing
- [ ] Tremors
- [ ] Vision problems
- [ ] Other significant illness
- [ ] None of the Above

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

_____

_____

_____

_____

H. Mental Health Observations

H Mental Health Observations

1. Can the client express basic needs and wants?

- ☐ 1 - Yes
- ☐ 2 - No

2. How many days per week does the client have problems making him/herself understood?

- ☐ 1 - Never
- ☐ 2 - Sometimes (1)
- ☐ 3 - Always (2)**

3. Can the client understand and follow simple instructions?

- ☐ 1 - Yes
- ☐ 2 - No

4. How many days per week does the client have problems understanding others?

- ☐ 1 - Never
- ☐ 2 - Sometimes (1)
- ☐ 3 - Always (2)**

5. How is the client's orientation to people?

- ☐ 1 - No apparent problem
- ☐ 2 - Sometimes a problem - 1 to 3 days (1)
- ☐ 3 - Often a problem - 4 to 7 days (2) **

6. How is the client's orientation to place?

- ☐ 1 - No apparent problem
- ☐ 2 - Sometimes a problem - 1 to 3 days (1)
- ☐ 3 - Often a problem - 4 to 7 days (2) **

7. Has the individual exhibited behavior problems?

- ☐ 1 - No apparent problem
- ☐ 2 - Sometimes a problem - 1 to 3 days (1)
- ☐ 3 - Often a problem - 4 to 7 days (2)**

8. What behaviors has the individual demonstrated?

- ☐ Verbally aggressive
- ☐ Physical aggression
- ☐ Disruptive behavior
- ☐ Delusional
- ☐ Getting lost/wandering
- ☐ Presents other problems

I. ADL/IADL and Other Limitations

I ADL

1. During the past 7 days, and considering all episodes, was the client able to BATHE without help?

- ☐ 1 - Yes
- ☐ 2 - No, required assistive technology - 1
- ☐ 3 - No, required supervision (SBA -Verbal someone there to watch or prompt)- 2
- ☐ 4 - No, required limited assistance (1 to 3 days physical hands on help) - 3
- ☐ 5 - No, required extensive/total assistance (4 to 7 days a week hands on help) - 4

2. During the past 7 days, and considering all episodes, was the client able to Dressing without help?

- ☐ 1 - Yes
- ☐ 2 - No, required assistive technology - 1
- ☐ 3 - No, required supervision (SBA -Verbal someone there to watch or prompt) - 2
- ☐ 4 - No, required limited assistance (1 to 3 days physical hands on help)- 3
- ☐ 5 - No, required extensive/total assistance (4 to 7 days a week hands on help) - 4

3. During the past 7 days, and considering all episodes, was the client able to TRANSFER without help?

- ☐ 1 - Yes
- ☐ 2 - No, required assistive technology - 1
- ☐ 3 - No, required supervision (SBA -Verbal someone there to watch or prompt) - 2
- ☐ 4 - No, required limited assistance (1 to 3 days physical hands on help) - 3
- ☐ 5 - No, required extensive/total assistance (4 to 7 days a week hands on help)** - 4

4. During the past 7 days, and considering all episodes, was the client able to GET AROUND THE HOME without help?

- ☐ 1 - Yes
- ☐ 2 - No, required assistive technology - 1
- ☐ 3 - No, required supervision (SBA -Verbal someone there to watch or prompt) - 2
- ☐ 4 - No, required limited assistance (1 to 3 days physical hands on help) - 3
- ☐ 5 - No, required extensive/total assistance (4 to 7 days a week hands on help)** - 4

5. During the past 7 days, and considering all episodes, was the client able to EAT without help?

- ☐ 1 - Yes
- ☐ 2 - No, required assistive technology - 1
- ☐ 3 - No, required supervision (SBA -Verbal someone there to watch or prompt) - 2
- ☐ 4 - No, required limited assistance (1 to 3 days physical hands on help) - 3
- ☐ 5 - No, required extensive/total assistance (4 to 7 days a week hands on help)** - 4

6. During the past 7 days, and considering all episodes, was the client able to USE THE TOILET without help?

- ☐ 1 - Yes
- ☐ 2 - No, required assistive technology - 1
- ☐ 3 - No, required supervision (SBA -Verbal someone there to watch or prompt) - 2
- ☐ 4 - No, required limited assistance (1 to 3 days physical hands on help) - 3
- ☐ 5 - No, required extensive/total assistance (4 to 7 days a week hands on help)** - 4

This is an autocalculated SRT ADL score. Please enter it in the ADL count below. It cannot be greater than 6

7. Enter the total ADL impairments as calculated above?

I IADL

1. During the past 7 days, and considering all episodes, was the client able to MANAGE MEDICATIONS without help?

- ☐ 1 - Yes
- ☐ 2 - No, required assistive technology - 1
- ☐ 3 - No, required supervision (SBA -Verbal someone there to watch or prompt) - 2
- ☐ 4 - No, required limited assistance (1 to 3 days physical hands on help)- 3
- ☐ 5 - No, required extensive/total assistance (4 to 7 days a week hands on help)** - 4

2. Is the client able to MANAGE MONEY without help?

- ☐ 1 - Yes
- ☐ 2 - No - 1

3. Is the client able to SHOP without help?

- ☐ 1 - Yes
- ☐ 2 - No - 1

4. Is the client able to PREPARE MEALS without help?

- ☐ 1 - Yes
- ☐ 2 - No - 1

5. Is the client able to do HEAVY HOUSEWORK without help?

- ☐ 1 - Yes
- ☐ 2 - No - 1

6. Is the client able to do LIGHT HOUSEKEEPING without help?

- ☐ 1 - Yes
- ☐ 2 - No - 1

7. Is the client able to USE TRANSPORTATION without help?

- ☐ 1 - Yes
- ☐ 2 - No - 1

8. Is the client able to USE THE TELEPHONE without help?

- ☐ 1 - Yes
- ☐ 2 - No - 1

This is the autocalculated SRT IADL score. Please enter it in the question below. This score cannot be greater than 8.

9. Enter the Total IADL impairments as calculated above

10. Comment on the client's functional ability.

J. Home Hazards

J Home Hazards

1. Does the client have difficulties keeping his/her home free from odor or pests?

- ☐ 1 - Yes
- ☐ 2 - No

2. Is there evidence of pets/animals that are a danger to those who come to the client's home?

- ☐ 1 - Yes
- ☐ 2 - No

K. Financial Resources

K Total Resources

1. What is the total income of the client's household per month?

$

2. How many people does the household income support?

3. Is the client's income level below the national poverty level?

- ☐ 1 - Yes (2)
- ☐ 2 - No

4. Specify the client's monthly income (or client and spouse if married).

$

5. What is the client's Monthly or joint Income Range if married?

- ☐ 1 - Below 150% federal poverty level (3)
- ☐ 2 - Over 150% of poverty level up to 200% of poverty level
- ☐ 3 - More than 200% of poverty level but less than 300% of FBR
- ☐ 4 - Over 300% federal benefit rate

6. Does the client have excessive expenses, such as medical bills, that prevent them from meeting their needs?

- ☐ 1 - Yes (1)
- ☐ 2 - No

K Other Assistance

1. Is the client a veteran OR a spouse/widow of a veteran?

- [ ] 1 - Yes
- [ ] 2 - No

K Health Insurance

1. Does the client have Medicare A health insurance?

- [ ] 1 - Yes
- [ ] 2 - No (Skip next two questions)
- [ ] 3 - Don't know

2. Enter the client's Medicare number.

_____

3. What is the effective date of the client's Medicare A policy?

_____/_____/_____

4. Does the client have Medicare B health insurance?

- [ ] 1 - Yes
- [ ] 2 - No (Skip next question)
- [ ] 3 - Don't know

5. What is the effective date of the client's Medicare B policy?

_____/_____/_____

6. Does the client have Medigap health insurance?

- [ ] 1 - Yes
- [ ] 2 - No

7. Does the client have Medicare D health insurance?

- [ ] 1 - Yes
- [ ] 2 - No

8. Does the client have LTC health insurance?

- [ ] 1 - Yes
- [ ] 2 - No

9. Does the client have Medicaid or TennCare?

- [ ] 1 - Yes
- [ ] 2 - No

10. Does the client have other health insurance?

- [ ] 1 - Yes
- [ ] 2 - No

11. Please indicate if the individual has QMB/SLMB

_____

L. CHOICES Screening

L CHOICES

1. Does the client own his/her home or any other property?

- [ ] 1 - Yes
- [ ] 2 - No

2. What are the client's resources/assets?

- [ ] 1 - Certificate of Deposits
- [ ] 2 - Checking Account
- [ ] 3 - Savings certificate
- [ ] 4 - IRA or Annuity
- [ ] 5 - Savings Account
- [ ] 6 - Stocks, Bonds
- [ ] 7 - Burial contract
- [ ] 8 - Life insurance policy with cash value
- [ ] 9 - Property other than home

3. Are the Consumer's assets valued at less than $2000?

- [ ] 1 - Yes
- [ ] 2 - No
- [ ] 3 - Don't Know

4. Has the client transferred any property or money in the last five years?

- [ ] 1 - Yes
- [ ] 2 - No

5. While you are more likely to get more services sooner by getting CHOICES, getting CHOICES also means that any property and assets you have are subject to Estate Recovery. Knowing this, would you still like to be screened for CHOICES?

- [ ] 1 - Yes
- [ ] 2 - No

6. What is the date of the consumer's last medical evaluation by a physician?

_____/_____/_____

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

_____

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

_____

M. Other Observations

M Other Observations

1. Enter intake/referral comments.

_____

_____

_____

_____

N. Prioritization

N Prioritization

1. Client is assigned for in-depth assessment for the following programs:

- ☐ 1 - CHOICES
- ☐ 2 - OPTIONS
- ☐ 3 - TitleIIIE, NFCSP services
- ☐ 4 - Title IIIB
- ☐ 5 - Title IIIC, Home Delivered Meals
- ☐ 6 - None

2. Is this an APS Referral?

- ☐ 1 - Yes
- ☐ 2 - No

3. Other Factors

_____

_____

_____

_____

Calculated Priority Score

4. Enter the Total Priority Score as calculated above

☐

5. Total Risk Level

- ☐ 1 - Low Risk (1 to 15)
- ☐ 2 - Moderate Risk (16 to 30)
- ☐ 3 - High Risk (31-70)

Title : _____ Date

Title : _____ Date