MoW Assessment

General

Assessment Information

Date Assessment Completed:

_____/_____/__________

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

- [ ] Initial assessment (In person)
- [ ] Annual assessment (In person)
- [ ] Follow-up assessment (Phone)

Referred by:

- [ ] Adult Day Care
- [ ] Adult Protective Services
- [ ] Anonymous
- [ ] Area Agency on Aging (other than SMAA)
- [ ] Assisted Living / Residential Care Facility
- [ ] Caregiver
- [ ] Case Manager
- [ ] Clergy / Religious Organization
- [ ] CMS (Medicare/Medicaid)
- [ ] County
- [ ] DHHS (not APS)
- [ ] EIM / Home & Community Care Org
- [ ] Family
- [ ] Fire Deptartment / EMT / Rescue
- [ ] Friend
- [ ] Hospice (home based)
- [ ] Hospice (facility based)
- [ ] Home Health (not Hospice Program)
- [ ] Hospital / Acute Care Facility
- [ ] Housing Authority
- [ ] Information & Referral Service
- [ ] Insurance Company
- [ ] Law Enforcement
- [ ] Legal Rep
- [ ] Neighbor
- [ ] Nursing Home
- [ ] Ombudsman
- [ ] Other
- [ ] Other Federal Agency
- [ ] Other Nonprofit Organization
- [ ] Other Service Provider
- [ ] Other State Agency
- [ ] Personal Care / Homemaking Agency
- [ ] Pharmacy
- [ ] Physician / Medical Provider
- [ ] Self
- [ ] Senior Center
- [ ] Skilled Nursing Facility (Rehab)
- [ ] SMAA (internal referral or repeat client)
- [ ] Social Security
- [ ] Unknown
- [ ] Veterans' Administration
- [ ] Volunteer (Outside SMAA)

Identifying Client Information

What is the client's first name?

____

What is the client's middle initial?

____

What is the client's last name?

____

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

____

Enter the second line of the client's street address.

____

Enter the client's residential city or town.

____

Enter the client's telephone number.

____

What is the client's gender?

- [ ] Declined to Disclose
- [ ] Female
- [ ] Male
- [ ] Other
- [ ] Transgendered
- [ ] Unknown

If gender is other, what does the client identify as gender?

____

____

____

____

What is the client's date of birth?

_____/_____/__________

Emergency Contacts - List POA/Guardian first

First emergency contact - Is legally appointed guardian?

- [ ] No
- [ ] Yes

First emergency contact - name:

____

First emergency contact - relationship to client:

____

First emergency contact - home phone:

____

First emergency contact - cell phone:

____

First emergency contact - work phone:

____

First emergency contact - physical address:

____

Second emergency contact - name:

____

Second emergency contact - relationship to client:

____

Second emergency contact - home phone:

____

Second emergency contact - cell phone:

____

Second emergency contact - work phone:

____

Second emergency contact - address:

____

Changes Since Last Assessment

Medical problems / health information / changes since last home-delivered meals assessment:

____

____

____

____

Meals Eligibility - Must Meet all Sections

Section 1 - Eligibility Group

Select the Title IIIc eligibility group that applied to client

- [ ] 60+ years old and client of Adult Protective
- [ ] 60+ years old and in greatest socio-economic need
- [ ] Spouse (any age) of a current Home Delivered Meals participant. ELIGIBLE
- [ ] Under 60 years old, disabled, and living with a current HDM participant
- [ ] None of the above

Select the SSBG eligibility group that applies to client (subject to funding ability)

- [ ] Under 60 years old and client of Adult Protective Services
- [ ] 60+ years old, and at risk of NF placement or with LTC needs
- [ ] Under 60 years old, blind, or disabled
- [ ] None of the above

Section 2 - Meal Preparation

Ability to prepare meals - at least 2 items needed to meet test

- [ ] Doesn't understand how to prepare well-balanced meals
- [ ] Can't access items in cupboard, stove or refrigerator
- [ ] Endurance too low to prepare well-balanced meal and then eat
- [ ] Can't turn stove/oven on/off due to physical limitations
- [ ] Can't shop/obtain food adequate for preparing well-balanced meals
- [ ] None of the above (NOT ELIGIBLE)

Supports are available to assist with meal preparation.

- [ ] No
- [ ] Yes (NOT ELIGIBLE)

Section 3 - Isolation

Client is homebound or otherwise isloted

- [ ] No (NOT ELIGIBLE)
- [ ] Yes

Section 4 - Meal Availability

Lives in assisted housing where meal preparation is available/provided?

- [ ] No
- [ ] Yes (NOT ELIGIBLE)

Eligibility Determination

Meal Eligibility: 1=Eligible, 0=Not Eligible, -1=UK, Answer all Questions

Based on the score above, is the client eligible for home delivered meals?

- [ ] No (Skip to Additional Needs Screening section)
- [ ] Yes

Meal Delivery

Enter meal delivery needs

Number of months client is anticipated to need home delivered meals (6 maximum)

Describe any special diet or meal-prop needs the client has.

Select all days that meal delivery is being requested/needed

- [ ] Monday
- [ ] Tuesday
- [ ] Wednesday
- [ ] Thursday
- [ ] Friday
- [ ] Saturday
- [ ] Sunday

Are Home Delivered Meals hot or frozen?

- [ ] Don't Know
- [ ] Frozen
- [ ] Hot

Number of hot meals per week needed:

Number of frozen meals per week needed:

Nutrition Screening Initiative - Determine Your Nutritional Health

Screening Required?

Is this 1) an in-person assessment, 2) with a client who is at least 60 years old, AND 3) client has met eligibility criteria above?

- [ ] No (skip to the next section)
- [ ] Yes (answer screening questions below)

Screening Questions

How much do you currently weigh?

What is your height in Inches (4'=48", 5'=60", 6'=72")?

Has illness or condition made the client change the kind and/or amount of food eaten?

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

Does the client eat fewer than 2 meals per day?

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

Does the client eat few (less than 5) vegetables or fruits, or milk products per day?

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

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

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

Does the client have tooth or mouth problems that make it hard to eat?

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

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

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

Does the client eat alone most of the time?

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

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

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

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

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

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

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

Nutritional Risk

Client's Nutritional Risk Score

Is the nutritional risk score above 6 or more?

- [ ] Don't know
- [ ] No - (0-2: Good/Low Risk, 3-5: Moderate Risk)
- [ ] Yes - Client is at High Nutritional Risk

Additional NAPIS Questions - Required for Title IIIc Funding

Ability to Perform Acitivities of Daily Living (ADLs) in the last 7 days

Eating performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Dressing performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Bathing performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Toilet use performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Transfering performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Walking (in home) performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

What is the client's ADL count?

ASSESSOR. Please indicate any UNMET ADL needs, including areas where client has services that are not fully meeting the need.

____

____

____

____

Ability to Perform Instrumental Activities of Daily Living (IADLs) in the last 7 days

Meal preparation performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Shopping performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Medication management performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Money management performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Telephone use performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Heavy housework performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Light housekeeping performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Transportation performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

What is the client's IADL count?

ASSESSOR. Please indicate any UNMET IADL needs, including areas where client has services that are not fully meeting the need.

____

____

____

____

Ethnicity and Race

Ethnicity:

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

Race:

- [ ] American Indian/Native Alaskan
- [ ] Asian
- [ ] Black/African American
- [ ] Hispanic
- [ ] Native Hawaiian/Other Pacific Islander
- [ ] Non-Minority (White, non-Hispanic)
- [ ] Other
- [ ] Two or More Races
- [ ] Unknown
- [ ] White-Hispanic

Nutrition Education

Nutrition Information Left with Client

- [ ] No
- [ ] Yes

Additional Needs Screening

Demographics

Select the client's current marital status.

- [ ] Civil union
- [ ] Divorced
- [ ] Legally Separated
- [ ] Married
- [ ] Significant Other
- [ ] Single
- [ ] Widowed

Does the Client live alone?

- [ ] Declined to Disclose
- [ ] No
- [ ] Unknown
- [ ] Yes

Client lives with:

- [ ] Don't Know
- [ ] Family other then Spouse
- [ ] Friend
- [ ] Homeless / Temporary Housing
- [ ] Other
- [ ] Spouse

Type of housing:

- [ ] Acute/hospital
- [ ] Apartment - private
- [ ] Apartment - Subsidized/low income
- [ ] Assisted Living
- [ ] Group Home
- [ ] Homeless
- [ ] Nursing home
- [ ] Own home or condo
- [ ] Private home (not client's)
- [ ] Single room occupancy (SRO)
- [ ] Other

Number and types of pets in home:

____

Client is a veteran:

- [ ] Declined to Disclose
- [ ] No
- [ ] Spouse of a Veteren
- [ ] Yes

Sevice-Connected Disability:

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

Served during wartime:

- [ ] No
- [ ] Yes

Veteran status comments:

____

____

____

____

Financial

Is client willing and able to share household income information?

- [ ] Don't Know
- [ ] No (skip to next sub-section)
- [ ] Yes

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

- [ ] One
- [ ] Two
- [ ] Three
- [ ] Four
- [ ] Five
- [ ] Six
- [ ] Seven
- [ ] Eight
- [ ] Greater than eight
- [ ] Information unavailable

Mo income for current household size: 100% FPL

Mo income for current household size: 125% FPL

Mo income for current household size: 150% FPL

Mo income for current household size: 200% FPL

Mo income for current household size: 250% FPL

Mo income for current household size: 300% FPL

Based on the chart above, is the client's income level at or below 100% of the Federal Poverty Level?

- [ ] Don't know
- [ ] No
- [ ] Yes (skip to next subsection)

Based on the above guidelines, what is the client's income range?

- [ ] Don't know
- [ ] 101% - 125% FPL
- [ ] 126% - 150% FPL
- [ ] 151% - 200% FPL
- [ ] 201% - 250% FPL
- [ ] 251% - 300% FPL
- [ ] Over 300% FPL

Difficulty paying monthly bills:

- [ ] No - able to afford bills
- [ ] Sometimes - occassionally some bills go unpaid
- [ ] Always - some bills go unpaid every month

Most Concerning Expenses to Client:

- [ ] None
- [ ] Other - Describe in field notes
- [ ] Unable to afford food
- [ ] Unable to afford medical expenses that are not covered by insurance/Medicare
- [ ] Unable to afford medicine or medical supplies
- [ ] Unable to afford rent/utility bills

Housing

Client satisfied with current living environment:

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

If not satisfied, reason(s):

____

____

____

____

Client receives rental assistance:

- [ ] Don’t Know
- [ ] No
- [ ] Yes

Client receives Rental Subsidy:

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

Client receives Rent Rebate / Property Tax Rebate:

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

Client keeps heat turned down in winter to save money:

- [ ] No
- [ ] Yes

Client applied for Low Income Home Energy Assistance Plan (LIHEAP):

- [ ] Don’t Know
- [ ] No
- [ ] Yes

Nutrition & Hunger Risk

Client receives SNAP (Food Stamps):

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

Other nutritional supports client is interested in (check all that apply):

- [ ] Commodity Supplemental Food Program
- [ ] Congregate Meals
- [ ] Farmshare
- [ ] Food Pantry
- [ ] Nutrition Counseling
- [ ] Other - Specify in Field Notes
- [ ] None at this time

In-Home Support

Adaptive equipment used by Client:

____

Adaptive equipment needed that client doesn't have:

- [ ] Don't know
- [ ] Bedside commode
- [ ] Cane
- [ ] Crutches
- [ ] Dentures
- [ ] Grab bars
- [ ] Hospital bed
- [ ] Hoyer Lift
- [ ] Lift Chair
- [ ] Prothesis
- [ ] Ramp access
- [ ] Shower Bench/Shower Chair
- [ ] Transfer Equipment
- [ ] Walker
- [ ] Wheelchair cushion
- [ ] Wheelchair, electric
- [ ] Wheelchair, manual
- [ ] Other - Specify in field notes
- [ ] None at this time

Memory Concerns

Client has concerns about his/her memory:

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

ASSESSOR. Does Client's perception of memory status match your observations?

- [ ] No
- [ ] Yes

ASSESSOR. Explain basis for answer:

____

____

____

____

ASSESSOR. Are you aware of any other information (eg., caregiver concerns, known diagnoses, etc.) that Indicates there are memory concerns?

- [ ] No
- [ ] Yes

ASSESSOR. If yes, describe:

____

____

____

____

Count as Potential Person with Dementia

ASSESSOR. Count as potential person with dementia (answer Yes if indicator above = 1)

- [ ] No
- [ ] Yes

Managing Chronic Conditions

Client Reports Challenges with (check all the apply):

- [ ] Hearing
- [ ] Visual
- [ ] Speech or Language
- [ ] Physically disabled
- [ ] Weakness or Fatigue
- [ ] Shortness of Breath
- [ ] None

ASSESSOR. Explain checked chronic conditions reported above:

____

____

____

____

Name of Client's primary care physician:

____

Practice client's primary doctor is affiliated with:

____

Client has seen his/her doctor within:

- [ ] 0 - 6 months
- [ ] 6 - 12 months
- [ ] over 12 months
- [ ] Unknown

Name of care manager, if Client has one:

____

____

____

____

Name of additional health care provider:

____

____

____

____

Additional organization(s) that help Client:

____

____

____

____

Has Client been in hospital or emergency room in past 12 mos.?

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

If yes, describe (reason, date, location, duration, etc.):

____

____

____

____

Falls Prevention

Last time client fell:

- [ ] Never
- [ ] Don't know
- [ ] Within last year
- [ ] 1-3 years ago
- [ ] More than 3 years ago

Client worries/thinks about falling:

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

Health Insurance

Client has questions about health insurance or needs help with insurance paperwork:

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

Prescriptions

Client has difficulty obtaining all needed prescriptions or over-the-counter medications:

- [ ] Don't Know
- [ ] N/A
- [ ] No
- [ ] Yes

If trouble obtaining medications, reason(s):

____

____

____

____

Clients largest concerns about medications:

____

____

____

____

Isolation / Socialization

The next few questions are about how you feel about different aspects of your life.

- [ ]

How often do you feel that you lack companionship: Hardly ever, some of the time, or often?

- [ ] Don't know
- [ ] Hardly Ever
- [ ] Some of the Time
- [ ] Often

How often do you feel left out: Hardly ever, some of the time, or often?

- [ ] Don't know
- [ ] Hardly Ever
- [ ] Some of the Time
- [ ] Often

How often do you feel isolated from others? (Is it hardly ever, some of the time, or often?)

- [ ] Don't know
- [ ] Hardly Ever
- [ ] Some of the Time
- [ ] Often

What is your degree of satisfaction with your ability to spend time with others?

- [ ] Don't know
- [ ] Very Satisfied
- [ ] Somewhat Satisfied
- [ ] Not too Satisfied
- [ ] Not at all Satisfied

Transportation

Client able to get to the places he/she needs to go:

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

If no, type(s) of transportation needed:

- [ ] Shopping/errands
- [ ] Medical Appointments
- [ ] Social/Recreational
- [ ] Other - Indicate in field notes

Client knows how to access transportation resources in the area:

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

Abuse / Neglect / Exploitation

Client feels safe in home and community:

- [ ] No
- [ ] No response
- [ ] Not applicable - explain in field notes
- [ ] Sometimes
- [ ] Unclear response - explain in field notes
- [ ] Yes

If not, what makes client feel unsafe:

____

____

____

____

ASSESSOR. Signs or risk factors of abuse, neglect, or exploitation were observed during assessment:

- [ ] Unsure
- [ ] No
- [ ] Yes

If yes, describe:

____

____

____

____

Home Safety

ASSESSOR. Home safety concerns observed during assessment (check all that apply):

- [ ] Aggressive or Neglected Animals
- [ ] Fire Hazards / Lack of Smoke Alarms
- [ ] Hoarding
- [ ] Inaccessible exits / entrances
- [ ] Inadequate heating or cooling
- [ ] Insects/Rodents Present
- [ ] Insufficient lighting
- [ ] Maintenance/repair needs
- [ ] Neighborhood concerns
- [ ] Unsanitary living conditions
- [ ] Parking Issues
- [ ] Plumbing problems
- [ ] Rancid/improperly stored food
- [ ] Safety modifications needed (grab bars, railings, ramp)
- [ ] Tripping Hazards (rugs, cords, clutter)
- [ ] Weapons
- [ ] Yard maintenance (snow removal, lawn care)
- [ ] Other - Specify in field notes
- [ ] No home safety concerns noted

Legal

ASSESSOR. Client expressed legal concerns:

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

Caregiver Concerns

ASSESSOR. Describe any concerns reported by Caregiver:

____

____

____

____

ASSESSOR. Caregiver interested hearing from Family Caregiver Support Program about:

- ☐ Don't know
- ☐ Adult Day Services
- ☐ Classes
- ☐ Finding Resources
- ☐ Help with Problem Solving
- ☐ Options Counseling
- ☐ Respite
- ☐ Setting up LTC Services and Supports
- ☐ Other - Specify in field notes
- ☐ None at this time

Volunteer

Interested in volunteer opportunities:

- ☐ Don't know
- ☐ No
- ☐ Yes

If yes, volunteer activies client is interested in:

____

____

____

____

Other

ASSESSOR. Pertinent Social History (childhood, occupation, hobbies):

____

____

____

____

ASSESSOR. Other concerns not already described in assessment:

____

____

____

____

Outcome

ASSESSOR. Based on this Assessment, will you be completing an internal referral to SMAA Community Services?

- ☐ No
- ☐ Yes

ASSESSOR. Based on this assessment have you or will you be making a referral to:

- ☐ Adult Protective
- ☐ Commodity Supplemental Food Program
- ☐ None

ASSESSOR. If no referral to be made, indicate reason:

- ☐ Client Declined Referral
- ☐ No Referral Needs Identified
- ☐ Identified Referral Need(s) already addressed by CS on intake

ASSESSOR. If client declined referral, indicate any reason given:

____

____

____

____

Title :

Date

Title :

Date