Florida Department of Elder Affairs
701S Screening Form
Rule: 58-A-1.010, F.A.C.

Provider ID: _____ **Provider Screener ID:** _____

Screener Name: _____ **Signature:** _____

1. **SCREENER: What is the purpose of this assessment?**
☐ Initial ☐ Annual ☐ Health ☐ Living situation ☐ Caregiver ☐ Environment ☐ Income

2. Social Security number: _____

We are required to explain that your Social Security number is being collected pursuant to Title 42, Code of Federal Regulations, Section 435.910, to be used for screening and referral to programs or services that may be appropriate for you. The provision of your Social Security number is voluntary, and your information will remain confidential and protected under penalty of law. We will not use or give out your Social Security number for any other reason unless you have signed a separate consent form that releases us to do so.

3. Name: a. First: _____ b. Middle initial: _____
c. Last: _____

4. Medicaid number: _____

5. Phone number: _____

6. Date of birth *(mm/dd/yyyy)*: _____

7. Sex: ☐ Male ☐ Female

8. Race *(Mark all that apply.)*: ☐ White ☐ Black/African American ☐ Asian
☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other

9. Ethnicity: ☐ Hispanic/Latino ☐ Other

10. Primary language: ☐ English ☐ Spanish ☐ Other: _____

11. Does client have limited ability reading, writing, speaking, or understanding English? ☐ No ☐ Yes

12. Marital status: ☐ Married ☐ Partnered ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

13. **SCREENER: Current Physical Location Address** *(If type is a facility, enter facility name.)*
a. Street: _____
b. City: _____ c. ZIP code: _____
d. Type: ☐ Private residence ☐ Assisted living facility (ALF) ☐ Nursing facility
☐ Hospital ☐ Adult day care ☐ Other
e. Name: _____

14. Home Address *(If different from current physical location)*
a. Street: _____
b. City: _____ c. ZIP code: _____

15. Mailing Address *(If different from current physical location)*
a. Street: _____ b. City: _____
c. State: _____ d. ZIP code: _____

16. **SCREENER: Assessment date:** *(mm/dd/yyyy)* _____

17. **SCREENER: Referral date:** *(mm/dd/yyyy)* _____

18. **SCREENER: Referral source:** ☐ Self/Family ☐ Nursing facility ☐ Case management agency
☐ CARES ☐ Aging out ☐ Hospital ☐ Department of Children and Families ☐ Other
☐ APS; *Select level of APS risk:* ☐ High ☐ Intermediate ☐ Low

19. **SCREENER: Transitioning out of a nursing facility?** ☐ No ☐ Yes

20. **SCREENER: Imminent risk of nursing home placement?** ☐ No ☐ Yes

21. Is there a primary caregiver? ☐ No ☐ Yes

22. Living situation: ☐ With primary caregiver ☐ With other caregiver ☐ With other ☐ Alone

23. Individual monthly income: $ _____ ☐ Refused

24. Couple monthly income: $ _____ ☐ Refused ☐ N/A

25. Estimated total individual assets: $ _____
☐ $0 to $2,000 ☐ $2,001 to $5,000 ☐ $5,001 or more ☐ Refused

26. Estimated total couple assets: $ _____
☐ $0 to $3,000 ☐ $3,001 to $6,000 ☐ $6,001 or more ☐ Refused ☐ N/A

27. Are you receiving S/NAP (food stamps)? ☐ No ☐ Yes

28. Do you need other assistance for food? ☐ No ☐ Yes (*complete Nutritional Risk Score Section)*

29. **SCREENER: Is someone besides the client providing answers to questions?** ☐ No *(Skip to 30)* ☐ Yes:
a. Name: _____ b. Relationship: _____

30. How would you rate your overall health at this time? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

31. Compared to a year ago, how would you rate your health?
☐ Much better ☐ Better ☐ About the same ☐ Worse ☐ Much worse

32. How often are there things you want to do but cannot because of physical problems?
☐ Never ☐ Occasionally ☐ Often ☐ All of the time

33. When you need medical care, how often do you get it?
☐ Always ☐ Most of the time ☐ Rarely ☐ Only in an emergency ☐ Never

34. When you need transportation to medical care, how often do you get it?
☐ Always ☐ Most of the time ☐ Rarely ☐ Only in an emergency ☐ Never

35. How often do finances/insurance allow you to obtain healthcare and medications when you need them?
☐ Always ☐ Most of the time ☐ Rarely ☐ Only in an emergency ☐ Never

36. Has a doctor or other health care professional told you that you suffer from memory loss, cognitive impairment, any type of dementia, or Alzheimer's disease? ☐ No ☐ Yes

37. In the last year were you in a nursing or rehabilitation facility? ☐ No ☐ Yes

Notes & Summary:

38. How much assistance do you <u>need</u> with the following tasks?

Task	No assistance needed	Uses assistive device	Needs supervision or prompt	Needs assistance (but not total help)	Needs total assistance (cannot do at all)
a. Bathing	☐	☐	☐	☐	☐
b. Dressing	☐	☐	☐	☐	☐
c. Eating	☐	☐	☐	☐	☐
d. Using the bathroom	☐	☐	☐	☐	☐
e. Transferring	☐	☐	☐	☐	☐
f. Walking/Mobility	☐	☐	☐	☐	☐

39. How much assistance do you <u>have</u> with the following tasks?

Task	No assistance needed	Always has assistance	Has assistance most of the time	Rarely has assistance	Never has assistance
a. Bathing	☐	☐	☐	☐	☐
b. Dressing	☐	☐	☐	☐	☐
c. Eating	☐	☐	☐	☐	☐
d. Using the bathroom	☐	☐	☐	☐	☐
e. Transferring	☐	☐	☐	☐	☐
f. Walking/Mobility	☐	☐	☐	☐	☐

40. How much assistance do you <u>need</u> with the following tasks?

Task	No assistance needed	Uses assistive device	Needs supervision or prompt	Needs assistance (but not total help)	Needs total assistance (cannot do at all)
a. Heavy chores	☐	☐	☐	☐	☐
b. Light housekeeping	☐	☐	☐	☐	☐
c. Using the telephone	☐	☐	☐	☐	☐
d. Managing money	☐	☐	☐	☐	☐
e. Preparing meals	☐	☐	☐	☐	☐
f. Shopping	☐	☐	☐	☐	☐
g. Managing medication	☐	☐	☐	☐	☐
h. Using transportation	☐	☐	☐	☐	☐

Notes & Summary:

41. How much assistance do you <u>have</u> with the following tasks?

Task	No assistance needed	Always has assistance	Has assistance most of the time	Rarely has assistance	Never has assistance
a. Heavy chores	☐	☐	☐	☐	☐
b. Light housekeeping	☐	☐	☐	☐	☐
c. Using the telephone	☐	☐	☐	☐	☐
d. Managing money	☐	☐	☐	☐	☐
e. Preparing meals	☐	☐	☐	☐	☐
f. Shopping	☐	☐	☐	☐	☐
g. Managing medication	☐	☐	☐	☐	☐
h. Using transportation	☐	☐	☐	☐	☐

42. Have you been told by a physician that you have any of the following health conditions?
SCREENER: Indicate whether a problem occurred in the past by marking the first box and when a problem is current by marking the second box. Mark all that apply.

Past	Current	Health Conditions				
☐	☐	Acid reflux/GERD				
☐	☐	Allergies, list: _____				
☐	☐	Amputation, site: _____				
☐	☐	Anemia	☐ Severe	☐ Moderate	☐ Mild	
☐	☐	Arthritis, type: _____				
☐	☐	Bed sore(s) (Decubitus), location: _____				
☐	☐	Blood pressure	☐ High	☐ Low		
☐	☐	Broken bones/fractures, location: _____				
☐	☐	Cancer, site: _____				
☐	☐	Chlamydia				
☐	☐	Cholesterol	☐ High	☐ Low		
☐	☐	Dehydration				
☐	☐	Diabetes	☐ IDDM	☐ NIDDM		
☐	☐	Dizziness	☐ Constant	☐ Frequent	☐ Occasional	☐ Rare
☐	☐	Fibromyalgia				
☐	☐	Gallbladder	☐ Removal	☐ Problems		
☐	☐	Gonorrhea				
☐	☐	Heart problems	☐ Pacemaker	☐ CHF	☐ MI	☐ Other
☐	☐	Head, brain, or spinal cord trauma				
☐	☐	Herpes				
☐	☐	Human Immunodeficiency Virus (HIV)				
☐	☐	Human Papillomavirus (HPV)/Genital warts				

Past	Current	Health Conditions, continued				
☐	☐	Incontinence, Bladder	☐ Constant	☐ Frequent	☐ Occasional	☐ Rare
☐	☐	Incontinence, Bowel	☐ Constant	☐ Frequent	☐ Occasional	☐ Rare
☐	☐	Kidney problems or Renal disease		End stage?	☐ No	☐ Yes
☐	☐	Liver problems	☐ Cirrhosis	☐ Hepatitis		
☐	☐	Lung problems	☐ Emphysema	☐ Asthma	☐ Pneumonia	☐ COPD
☐	☐	Lupus				
☐	☐	Multiple Sclerosis				
☐	☐	Muscular Dystrophy				
☐	☐	Osteoporosis				
☐	☐	Parkinson's disease				
☐	☐	Paralysis	☐ Full	☐ Partial	☐ Local, site: _____	
☐	☐	Seizure disorder, type & frequency: _____				
☐	☐	Shingles				
☐	☐	Stroke/CVA				
☐	☐	Syphilis				
☐	☐	Thyroid problems/Graves/Myxedema		☐ Hyper	☐ Hypo	
☐	☐	Tumor(s), site: _____				
☐	☐	Ulcer(s), site: _____				
☐	☐	Urinary Tract Infection (UTI)				
☐	☐	Other: _____				

43. Provide information on the frequency of current therapies or specialty care:

Treatment type:	N/A or None	Monthly	Weekly	Several times a week	Daily	Several times a day
a. Bladder/bowel treatment	☐	☐	☐	☐	☐	☐
b. Catheter, type: _____	☐	☐	☐	☐	☐	☐
c. Dialysis	☐	☐	☐	☐	☐	☐
d. Insulin assistance	☐	☐	☐	☐	☐	☐
e. IV Fluids/IV Medications	☐	☐	☐	☐	☐	☐
f. Occupational therapy	☐	☐	☐	☐	☐	☐
g. Ostomy, site: _____	☐	☐	☐	☐	☐	☐
h. Oxygen	☐	☐	☐	☐	☐	☐
i. Physical therapy	☐	☐	☐	☐	☐	☐
j. Radiation/Chemotherapy	☐	☐	☐	☐	☐	☐
k. Respiratory therapy	☐	☐	☐	☐	☐	☐
l. Skilled nursing	☐	☐	☐	☐	☐	☐
m. Speech therapy	☐	☐	☐	☐	☐	☐
n. Suctioning	☐	☐	☐	☐	☐	☐
o. Tube feeding	☐	☐	☐	☐	☐	☐
p. Wound care/Lesion irrigation	☐	☐	☐	☐	☐	☐
q. Other therapy, type:	☐	☐	☐	☐	☐	☐

44. Caregiver full name: a. First: _____ b. Middle Initial: _____

c. Last: _____

45. Caregiver phone number: _____

46. How much of a mental or emotional strain is it on you to provide care for the client?

☐ None ☐ Some strain ☐ A lot of strain

47. Considering other aspects of your life, rate the level of difficulty in your physical health:

☐ No difficulty ☐ Little difficulty ☐ Some difficulty ☐ Moderate difficulty ☐ A lot of difficulty

48. How confident are you that you will have the ability to continue to provide care?

☐ Very confident *(Skip to 49)* ☐ Somewhat confident *(Skip to 49)* ☐ Not very confident

a. What is the main reason you may be unable to continue to provide care? _____

49. **SCREENER: Is the caregiver in crisis?** ☐ No ☐ Yes; *check all that apply:*

☐ Financial ☐ Emotional ☐ Physical

Nutritional Risk Score Section

50. Do you usually eat at least two meals a day? ☐ No ☐ Yes

51. Do you eat alone most of the time? ☐ No ☐ Yes

52. On average, how many servings of fruits and vegetables do you eat every day? (*One "serving" is one small piece of fruit or vegetable, about one-half cup of chopped fruit or vegetable, or one-half cup of fruit or vegetable juice.)* #_____

53. On average, how many servings of dairy products do you have every day? *(One "serving" of dairy is about a slice of cheese, a cup of yogurt, or a cup of milk or dairy substitute.)* #_____

54. Have you lost or gained weight in the last few months? ☐ Unsure *(Skip to 55)* ☐ No *(Skip to 55)* ☐ Yes

a. How much? ☐ Less than five pounds ☐ Five to ten pounds ☐ Ten pounds or more

b. Was the weight loss/gain on purpose *(i.e., dieting or trying to lose/gain weight)?* ☐ No ☐ Yes

55. Are you on a special diet(s) for medical reasons? ☐ No *(Skip to 56)* ☐ Yes; *check any/all*:

☐ Calorie supplement ☐ Low fat/cholesterol ☐ Low salt/sodium ☐ Low sugar/carb ☐ Other

a. How long have you been on this diet? _____

b. Why are you on this diet? _____

56. Do you have any problems that make it hard for you to chew or swallow? ☐ No ☐ Yes; *check any/all*:

☐ Mouth/tooth/dentures ☐ Pain or difficulty swallowing ☐ Taste ☐ Nausea

☐ Saliva production ☐ Other, *describe*: _____

57. Do you take three or more prescribed or over-the-counter medications a day? ☐ No ☐ Yes

58. How many days in a typical week do you drink alcohol?

☐ Refused *(Skip a-b)* ☐ None *(Skip a-b)* ☐ One to two ☐ Three to five ☐ Six to seven

a. On the days when you have some alcohol, about how many drinks do you usually have?

☐ One to two (*Skip b*) ☐ Three to five ☐ Six or more

b. About how many times in the last month have you had four or more drinks in a day?

☐ None ☐ One to two ☐ Three to five ☐ Six or more