DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

PRIORITY SCORE:

Department of Elder Affairs Assessment Instrument

Rule 58A-1.010, F.A.C.

RISK SCORE:

OWNER ID _____ OWNER ASSESSOR ID _____

PROVIDER ID _____ PROVIDER ASSESSOR ID _____

ASSESSOR NAME _____ SIGNATURE _____

##: Items required in CIRTS **P**: Priority Score Items **(O)**: Items required for OAA **(C)**: Items required for CARES

(O) (C) A. Demographic Information

##1. Name:

First Middle Initial Last

##2. Social Security Number: - -

3. Medicaid Number:

3a. Consumer Type: ☐ Caregiver (C) ☐ Elder Recipient (E)

3b. Are you the caregiver of a grandchild or child, under 19 or disabled? ☐ Yes (Y) ☐ No (N)

##4. Physical Address:

Street

City State ZIP County

4a. Mailing Address (if different)

Street

City State ZIP County

4b. Phone Number:

( )

##4c. Is this Public Housing? ☐ Yes (Y) ☐ No (N)

##4d. Assessment Date ____ ____ ____

M M D D Y Y Y Y

##4e. Assessment Site ☐ Home (CH) ☐ Hospital (H) ☐ Nurs. Home (NH) ☐ Day Care (DC) ☐ ALF (ALF) ☐ Other (O)

##4f. Assessment Type ☐ OAA (O) ☐ OA3E (O3E) ☐ Update (U) ☐ signif. change ☐ Initial (I) Asmt. ☐ Waiting List Full Asmt. (WL) ☐ CARES (C) non-community ☐ Annual (A)

##5. Date of Birth ____ ____ ____

M M D D Y Y Y Y

##6. Sex ☐ Female (F) ☐ Male (M)

##7. Race ☐ White (W) ☐ Black (B) ☐ Native Am. (N) ☐ Asian/Pacific (A) ☐ Other (O)

##8. Ethnicity ☐ Hispanic (H) ☐ Other (O)

##9. Primary language _____

##10. Marital Status ☐ Married (M) ☐ Single (S) ☐ Separated (P) ☐ Widowed (W) ☐ Divorced (D) ☐ Partner (O)

##11. Referral Source ☐ CARES (C) ☐ APS (A) ☐ Lead Agency (L) ☐ Hospital (H) ☐ Upstreaming/CARES (U) ☐ Other (O) ☐ Self (S) ☐ Aging Out - DCF CCDA ☐ Aging Out - DCF HCDA

If consumer at Imminent Risk of NH placement, check : ☐ Imminent Risk (IM)

If Transitioning out of a Nursing Home, check : ☐ Transition from NH (TRNH)

##If APS, check level of risk: ☐ High (H) ☐ Medium (M) ☐ Low (L)

##11a. Referral Date ____ ____ ____

M M D D Y Y Y Y

##12. Is there a Primary Caregiver? **P** ☐ Yes (Y) ☐ No (N)

##13. Living Situation **P** ☐ With Caregiver (WC) ☐ With Other (WO) ☐ Alone (AL)

##14. Need outside assistance to evacuate? ☐ Yes (Y) ☐ No(N)

##15. Registered with County Special Needs Registry? ☐ Yes (Y) ☐ No(N)

##16a. Individual Monthly Income _____ ☐ Refused (OAA only)

##16b. Couple Monthly Income _____ ☐ Refused (OAA only)

##16c. Receiving Food Stamps? ☐ Yes (Y) ☐ No (N)

##17a. Estimated Total Individual Assets ☐ Refused (OAA only) ☐ $0 - $2,000 (M) ☐ $2,001 - $5,000 (N) ☐ over $5,000 (P)

##17b. Estimated Total Couple Assets ☐ Refused (OAA only) ☐ $0 - $3,000 (M) ☐ $3,001 - $6,000 (N) ☐ over $6,000 (P)

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

B. CONSUMER CONDITIONS

1. Mental Health/Behavior/Cognition

(O) **##Who is answering questions?** ☐ Consumer ☐ Other

(O) ##a. How would you describe your satisfaction with life in general?

☐ Excellent (1) ☐ Good (2) ☐ Fair (3) ☐ Poor (4)

(O) ##b. Compared to a year ago, how is your attitude on life?

☐ Much Better (1) ☐ Better (2) ☐ About same (3) ☐ Worse (4)

##c. **ASSESSOR:** Are behavioral problems present?

☐ Yes (Y) ☐ No (N)

(O) ##d. **ASSESSOR:** Does behavior indicate a need for supervision?

☐ Yes (Y) ☐ No (N)

CHECK ALL THAT APPLY:

YES (Y) or NO (N)

(O)
- ☐ Wanders for no apparent reason
- ☐ Demonstrates significant memory problems
- ☐ Appears to be depressed
- ☐ Appears to be lonely or dangerously isolated
- ☐ Has thoughts of suicide
- ☐ Exhibits abusive, aggressive or disruptive behavior
- ☐ Presents other problems

ENTER Y = CORRECT N = INCORRECT

(O) ##e. What is today's date?

Month _____ ☐

Day _____ ☐

Day/Week _____ ☐

Year _____ ☐

Where are we?

Home Address or Facility Name: _____ ☐

City _____ ☐

State _____ ☐

County _____ ☐

(O) **(C)** ##f. Count Backwards from 20 to 1

20, 19, 18, 17, 16, 15, 14, 13, 12, 11, 10, 9, 8, 7, 6, 5, 4, 3, 2, 1

Mark total number of errors (Max = 10)

0	1	2	3	4	5	6	7	8	9	10

##g. **ASSESSOR:** Are cognitive problems present?

☐ Yes (Y) ☐ No (N)

##h. Currently receiving mental health services? ☐ Yes (Y) ☐ No (N)

##i. **ASSESSOR:** Need for mental health referral?

☐ Yes (Y) ☐ No (N)

C. CONSUMER RESOURCES

##a. **ASSESSOR:** Formal and/or informal resources provide services as needed to address the mental health/cognitive needs of the consumer.

☐ Always Available (1) ☐ Sometimes Available (2) ☐ Rarely Available (3) ☐ Unavailable (4) ☐ Not Needed (5)

SUMMARY

##b. **ASSESSOR:** Consumer oriented to time?

☐ Always (1) ☐ Sometimes (2) ☐ Rarely (3) ☐ Never (4)

##c. **ASSESSOR:** Consumer oriented to place?

☐ Always (1) ☐ Sometimes (2) ☐ Rarely (3) ☐ Never (4)

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

B. CONSUMER CONDITIONS

(O)##2. Physical Health

##a. How would you rate your overall health at the present time? **P**

☐ Excellent (1) ☐ Good (2) ☐ Fair (3) ☐ Poor (4)

##b. Compared to a year ago, how would you rate your health? **P**

☐ Much Better (1) ☐ Better (2) ☐ About same (3) ☐ Worse (4)

##c. How much do your physical problems stand in the way of your doing the things you want to do? **P**

☐ Not at all (1) ☐ Occasionally (2) ☐ Often (3) ☐ All the time (4)

(O) (C)##3. Functional

How much help do you need with the following Activities of Daily Living (ADL's)? **P**

(Codes: 0=No Help, 1=No help but relies on Assistive Device, 2=Supervision, 3=Some Help, 4=Total Help, can't do at all)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	**##a. Bathe**
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	**##b. Dress**
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	**##c. Eat**
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	**##d. Use Bathroom**
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	**##e. Transfer**
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	**##f. Walking/Mobility**

(O) (C)##4. How much help do you need with the following Instrumental Activities of Daily Living (IADL's)? **P**

(Codes: 0=No Help, 1=No help but relies on Assistive Device, 2=Supervision, 3=Some Help, 4=Total Help, can't do at all)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	**##a. Do heavy chores**
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	**##b. Do light housekeeping**
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	**##c. Use phone**
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	**##d. Manage money**
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	**##e. Prepare meals**
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	**##f. Do shopping**
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	**##g. Take medication**
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	**##h. Use transportation**

C. CONSUMER RESOURCES

(O)##2.

##a. Is medical care readily available? **P**

☐ Always (4) ☐ Sometimes (3) ☐ Rarely (2) ☐ Never (1)

##b. Is transportation to medical care readily available? **P**

☐ Always (4) ☐ Sometimes (3) ☐ Rarely (2) ☐ Never (1)

##c. Do your finances/insurance permit access to healthcare and medications? **P**

☐ Always (4) ☐ Sometimes (3) ☐ Rarely (2) ☐ Never (1)

(O)##3.

How often do you have adequate assistance with the following ADL's? **P**

(Codes: 3=Always, 2=Sometimes, 1=Rarely 0=Never, 0=No help needed)

☐ 3 ☐ 2 ☐ 1 ☐ 0	**##NEED FOR ASSISTIVE DEVICES?**
☐ 3 ☐ 2 ☐ 1 ☐ 0	☐ Yes ☐ No
☐ 3 ☐ 2 ☐ 1 ☐ 0	If yes, explain:
☐ 3 ☐ 2 ☐ 1 ☐ 0	
☐ 3 ☐ 2 ☐ 1 ☐ 0	
☐ 3 ☐ 2 ☐ 1 ☐ 0	

(O)4##How often do you have adequate assistance with the following IADL's?

(Codes: 3=Always, 2=Sometimes, 1=Rarely 0=Never, 0=No help needed)

☐ 3 ☐ 2 ☐ 1 ☐ 0	**##NEED FOR ASSISTIVE DEVICES?**
☐ 3 ☐ 2 ☐ 1 ☐ 0	☐ Yes ☐ No
☐ 3 ☐ 2 ☐ 1 ☐ 0	If yes, explain:
☐ 3 ☐ 2 ☐ 1 ☐ 0	
☐ 3 ☐ 2 ☐ 1 ☐ 0	
☐ 3 ☐ 2 ☐ 1 ☐ 0	
☐ 3 ☐ 2 ☐ 1 ☐ 0	
☐ 3 ☐ 2 ☐ 1 ☐ 0	

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

NUTRITION SCORE:

(O) ##D. Nutrition Status

YES (Y) or NO (N)

(C) ☐ ##1. Have you lost or gained 10 pounds or more in the last 6 months without trying?
Yes (2) No (0)
If yes, Gain: _____ *Loss:* _____

(C) ☐ ##2. Do you take 3 or more kinds of medicine a day? (Include over-the-counter AND prescription medicines)
Yes (1) No (0)

☐ ##3. Do you have 2 or more drinks of beer, wine, or liquor almost every day?
Yes (2) No (0)

☐ ##4. Do you have an illness or condition that made you change the food you eat?
Yes (2) No (0)
Are you on any special diets for medical reasons? If on special diet(s), check all that apply:
☐ *Low sodium/salt* ☐ *Low fat/cholesterol* ☐ *Low Sugar* ☐ *Calorie supplement*
☐ *Other (specify)* _____

☐ ##5. Do you eat at least two meals a day?
Yes (0) No (3)
How is your appetite? Would you say that your appetite is:
☐ *Good* ☐ *Fair* ☐ *Poor*

☐ ##6. Do you eat some fruits and vegetables every day?
Yes (0) No (1)
Briefly describe what you usually eat and drink during a typical day (including food on weekends):

_____

_____

_____

☐ ##7. Do you have some milk products every day?
Yes (0) No (1)

☐ ##8. Do you have any problems with your teeth, mouth, or throat that make it hard for you to chew or swallow?
Yes (2) No (0)
☐ *Tooth or mouth problems* ☐ *Taste problems* ☐ *Can't eat certain foods* ☐ *Swallowing problems*
☐ *Food allergies* ☐ *Nausea* *Other (Describe)* _____

☐ ##9. Do you eat alone most of the time?
Yes (1) No (0)

☐ ##10a. Are you usually able to shop for yourself?
Yes (0) No (0.5)

☐ ##10b. Are you usually able to cook for yourself?
Yes (0) No (0.5)

☐ ##11. Are you usually able to eat without help?
Yes (0) No (1)

☐ ##12. Do you have enough money to buy the food you need?
Yes (0) No (4)

TOBACCO USE

##1. Do you smoke or use tobacco products? ☐ Yes (Y) ☐ No (N)

##2. Have you ever smoked or used tobacco? ☐ Yes (Y) ☐ No (N)
If yes, for how long? _____

##3. Do you live with others who smoke? ☐ Yes (Y) ☐ No (N)

ASSESSOR:
DOES THERE APPEAR TO BE A NEED FOR FOOD STAMPS? ☐ Yes (Y) ☐ No (N)

CURRENT HEIGHT: _____

CURRENT WEIGHT: _____

SUMMARY

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

(O) (C) E1. Health Conditions *YES (Y) or NO (N)*

- ##1. Arthritis (type) _____
- ##2. Bed sore(s) (Decubitus)
  Location _____
- ##3. Cancer
  Lung Skin Oral Other
- ##4. Dementia(Alz, OBS, etc.)
- ##5. Diabetes (IDDM/NIDDM)
- ##6. Emphysema/COPD
- ##7. Heart Problems (CHF, MI, etc.)
- ##8. Incontinence (Bladder/Bowel)
- ##9. Liver Problems (Cirrhosis, Hepatitis)
- ##10. Pneumonia
- ##11. Stroke (CVA, etc.)
- ##12. Osteoporosis
- ##13. Parkinson's Disease
- ##14. Other (from list below) _____

Others: *Yes(Y) or No (N)* Enter most problematic in #14 above

- Allergies (type) _____
- Amputation (site) _____
- Asthma (type) _____
- Bladder/Kidney Problems (UTI, etc.)
- Blood Pressure - High Low
- Broken Bones/Fractures
  Location _____
- Dehydration
- Dizziness
- Falls in past year
- Gallbladder Problems
- Hearing Problems
- Ostomy care (type) _____
- Pacemaker
- Paralysis (site) _____
- Seizure disorder
- Sleep Problems
- Thyroid Problems (Graves, Myxedema, etc.)
- Ulcers (type/site) _____
- Vision Problems (Cataracts, Glaucoma)
- Other _____

(O) (C) E2. Special Services

Yes or No, if yes, indicate frequency

- ##Physical Therapy _____
- ##Occupational Therapy _____
- ##Respiratory Therapy _____
- ##Other, from list on right _____

Others: *YES (Y) or NO (N)*

- Bowel/bladder rehab
- Bowel impaction therapy
- Catheter care (type) _____
- Dialysis
- Insulin therapy
- Lesion irrigation
- Oxygen therapy
- Oxygen treatment
- Skilled Nursing
- Speech therapy
- Suctioning
- Tube Feeding
- Wound care
- Other _____

F. Medications

(including refrigerated meds, non-prescription drugs, over the counter, herbal remedies, etc.)

Medication	Dosage	Administration Method	Frequency	Physician

1. **ASSESSOR:** Does consumer seem to be compliant with medications?
   Yes No Unsure

2. **ASSESSOR:** What interferes with medication compliance?
   Alcohol Interaction Drug Interaction Can't Afford Confused N/A
   Other: _____

3. Has consumer been hospitalized in the last 6 months?
   No Yes
   If yes, why? _____

3a. Has consumer visited the Emergency Room in the past 6 months?
   No Yes
   If yes, why? _____

4. Indicate consumer's status:

a. Vision (w/glasses if used) Good Fair Poor Blind

b. Hearing (w/ aid if used) Good Fair Poor Deaf

c. Speech Good Fair Poor Gestures Signs Unable

d. Walking (w/ device if used) Good Fair Poor Chairbound Bedbound

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

G. Caregiver Assessment

##1. HCE Caregiver? ☐ Yes (Y) ☐ No (N)

##2. Is caregiver new to the consumer? ☐ Yes (Y) ☐ No (N)

(O) ##3. Social Security Number: _____ - _____ - _____

(O) ##4. Name _____
First Middle Initial Last

(O) ##5. Relationship
☐ Spouse (SP) ☐ Parent (P) ☐ Child (CH) ☐ Grandchild (GC)
☐ Friend (FR) ☐ Other relative (OR) ☐ Other (OT)

##6. Physical Address

_____
Street

_____
City State ZIP County

(O) 7. Telephone ( ) _____

##8. Race ☐ White (W) ☐ Black (B) ☐ Native Amer. (N) ☐ Asian/ Pacific (A) ☐ Other (O)

##9. Ethnicity ☐ Hispanic (H) ☐ Other (O)

##9a. Primary Language _____

##10. Date of Birth _____
M M D D Y Y Y Y

##11. Sex ☐ Female (F) ☐ Male (M)

##12. Is caregiver employed outside the home? ☐ Full-time ☐ Part-time ☐ N/A

(O) ##13. How is your own health? **P**

☐ Excellent (1) ☐ Good (2) ☐ Fair (3) ☐ Poor (4)

##13a. How long have you been providing care?

☐ Less than 6 mon. ☐ 6 mon. - 1 year ☐ 1 - 2 years ☐ Over 2 years

##14. How likely is it that you will continue to provide care?

CAREGIVER: ☐ Very likely ☐ Somewhat likely ☐ Unlikely

(O) ##14a. How likely is it that you will have the ability to continue to provide care?

CAREGIVER:
P ASSESSOR:
☐ Very likely (1) ☐ Somewhat likely (2) ☐ Unlikely (3)

##15. If you were unable to provide care, who would?

☐ No One ☐ Friend/Neighbor ☐ Close Relative ☐ Other

##16. ☐ **INITIAL :**
Since you began providing care, have various aspects of your life become better, stayed the same, or worsened?

OR

☐ **REASSESSMENT:**
Since you began receiving services, have aspects of your life become better, stayed the same, or worsened?

How is /are:	Better (1)	Same (2)	Worse (3)
Your relationship w/ consumer	☐	☐	☐
Your relationships w/ other family members	☐	☐	☐
Your relationships w/ friends	☐	☐	☐
Your work (If applicable)	☐	☐	☐
##Your emotional well-being.	☐	☐	☐

ASSESSOR:

(O) ##17. Is the caregiver in crisis? ☐ Yes (Y) ☐ No (N) **P**

If yes, check all that apply:

##17a. ☐ Financial ☐ Emotional ☐ Physical

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

H. Social Resources

1. Does consumer live alone? ☐ Yes (6) ☐ No (0) If no, with whom? _____

##1a. Does consumer care for grandchildren on a permanent basis? ☐ Yes ☐ No

##2. If needed, could you stay with someone, or they stay with you? ☐ Yes (Complete below) (0) ☐ No (6)

Name: _____ Relationship to consumer: _____

Address: _____ Phone: _____

##3. Do you have someone you can talk to when you have a problem (other than caregiver)? ☐ Yes (0) ☐ No (4)

Name: _____ Relationship to consumer: _____

##4. About how many times do you talk to friends, relatives, telephone reassurance volunteers or others on the telephone in a week, either they call you or you call them?

☐ Once a day or more (0) ☐ 2-6 times a week (2) ☐ Once a week (2) ☐ Not at all (4) ☐ No phone (4)

##5. How many times during a week do you spend time with someone who does not live with you - you go see them, they come to visit, or you do things together? ☐ Once a day or more (0) ☐ 2-6 times a week (2) ☐ Once a week (2) ☐ Not at all (4)

6. Are you able to participate in activities such as day care, senior center, church or other interests that you enjoy? ☐ Yes ☐ No If no, why not? _____

7. Do you own a pet? ☐ Yes ☐ No If yes, specify _____

Can you feed your pet? ☐ Yes ☐ No Clean up after your pet? ☐ Yes ☐ No Exercise your pet? ☐ Yes ☐ No

8. If consumer is the caregiver/guardian of a grandchild or child, under 19 years old or disabled, (section A. #3a. & 3b.) complete information on the child:

Child's name: _____ Child's date of birth: ____ - ____ - _____

Child's relationship to the consumer: _____ Is child disabled? _____ (Yes or No)

SUMMARY

##I. Environmental Assessment (Enter Risk below in CIRTS)

Case Manager: Please indicate the specific area(s) where there are potential safety or accessibility problems for the client.

☐ Building in need of repairs	☐ Refrigerator not working	☐ Grab bars/handrails needed
☐ Furniture in need of repairs	☐ Telephone not working	☐ Bathtub/shower unsafe
☐ Inadequate/insufficient plumbing	☐ No telephone	☐ Commode unsafe
☐ No/insufficient heat	☐ Flooring/rugs loose	☐ Electrical hazards
☐ No/insufficient hot water	☐ Lighting inadequate	☐ Insect or other pests present
☐ No air conditioning	☐ Stairs/railings unsafe	☐ Unsanitary conditions or odors
☐ Stove not working	☐ Ramp needed/unavailable	☐ Other - specify in comments

COMMENTS:

☐ **No Risk:** The physical environment is generally well equipped and supportive. This includes building, neighborhood and necessary furnishings.

☐ **Low Risk:** The physical environment has few negative aspects. The few negative aspects are minor or within acceptable living standards and are not hazardous to the consumer's well-being.

☐ **Moderate Risk:** The physical environment is negative. Many aspects are substandard or hazardous. The consumer may not be able to remain in the current dwelling.

☐ **High Risk:** The physical environment is strongly negative or hazardous. The consumer should change dwellings or is very likely to need to change dwellings unless immediate corrective action is taken to address the negative or hazardous aspects.

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

ASSESSMENT SUMMARY

PROBLEMS	LIABILITIES/ CHALLENGES/BARRIERS	RESOURCES/ASSETS	GAPS WHICH NEED TO BE MET IN CARE PLAN
B. CONSUMER CONDITIONS			
D. NUTRITION			
E. HEALTH			
F. MEDICATIONS			
G. CAREGIVER			
H. SOCIAL RESOURCES			
I. ENVIRONMENTAL			