

Agency Name: _____

Applicant Name: _____

Provider-Assessor #

Social Security #

Assessment Date

SECTION C. COGNITION	
1.	<p>MEMORY (Recall of what was learned or known) 0-Memory OK 1-Memory problems</p> <p>a. Short-term memory — seems/appears to recall after 5 minutes <input type="text"/></p> <p>b. Long-term memory — seems/appears to recall long past <input type="text"/></p>
2.	<p>MEMORY/ RECALL ABILITY (Check all that person normally able to recall during last 7 days; 24-48 hrs. if in hospital)</p> <p>a. Current season <input type="text"/></p> <p>b. Location of own room <input type="text"/></p> <p>c. Names/faces <input type="text"/></p> <p>d. Where he/she is <input type="text"/></p> <p>e. None of the above were recalled <input type="text"/></p>
3.	<p>COGNITIVE SKILLS FOR DAILY DECISION - MAKING Made decisions regarding tasks of daily life.</p> <p>0. Independent — decisions consistent/reasonable</p> <p>1. Modified independence — some difficulty in new situations only <input type="text"/></p> <p>2. Moderately impaired — decisions poor; cues/supervision required</p> <p>3. Severely impaired — never/rarely made decisions</p>
4A.	<p>Is professional nursing assessment, observation and management required at least 3 days/week to manage all the above cognitive patterns?</p> <p>0 - NO 1 - YES <input type="text"/></p> <p>If 4A = 1 (YES), proceed to 5. If 4A = 0 (NO) and person meets the cognitive impairment threshold as defined in Chapter II, Section 67 of the MaineCare Benefits Manual, then go to page 2A and complete Section C.4B of the Supplemental Screening Tool.</p>
5.	<p>Is professional nursing assessment, observation and management required once a month to manage all the above cognitive patterns?</p> <p>0 -NO 1 - YES <input type="text"/></p>

SECTION D. PROBLEM BEHAVIOR																						
1.	<p>Column A Codes: Code for the frequency of behavior in last 7 days</p> <p>0. Behavior not exhibited in last 7 days</p> <p>1. Behavior of this type occurred 1 to 3 days in last 7 days</p> <p>2. Behavior of this type occurred 4 - 6 days, but less than daily</p> <p>3. Behavior of this type occurred daily</p> <p>Column B Codes: Alterability of behavioral symptoms</p> <p>0. Not present or easily altered</p> <p>1. Behavior not easily altered</p> <table border="1"> <thead> <tr> <th></th> <th>A</th> <th>B</th> </tr> <tr> <th></th> <th>FREQUENCY</th> <th>ALTERABILITY</th> </tr> </thead> <tbody> <tr> <td>a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)</td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>b. VERBALLY ABUSIVE (others were threatened, screamed at, cursed at)</td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>c. PHYSICALLY ABUSIVE (others were hit, shoved, scratched, sexually abused)</td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIOR (made disruptive sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)</td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>e. RESISTS CARE (resisted taking medications/injections, ADL assistance or eating)</td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </tbody> </table>		A	B		FREQUENCY	ALTERABILITY	a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	<input type="text"/>	<input type="text"/>	b. VERBALLY ABUSIVE (others were threatened, screamed at, cursed at)	<input type="text"/>	<input type="text"/>	c. PHYSICALLY ABUSIVE (others were hit, shoved, scratched, sexually abused)	<input type="text"/>	<input type="text"/>	d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIOR (made disruptive sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)	<input type="text"/>	<input type="text"/>	e. RESISTS CARE (resisted taking medications/injections, ADL assistance or eating)	<input type="text"/>	<input type="text"/>
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2A.	<p>Is professional nursing assessment, observation and management required at least 3 days/week to manage the behavior problems—items a-d?</p> <p>0 - NO 1 - YES <input type="text"/></p> <p>If 2A = 1 (YES), proceed to 3. If 2A = 0 (NO) and person meets the behavioral impairment threshold as defined in Chapter II, Section 67 of the MaineCare Benefits Manual, then go to page 2A and complete Section D.2B of the Supplemental Screening Tool.</p>																					
3.	<p>Is professional nursing assessment, observation and management required once a month to manage the above behavior problems?</p> <p>0 -NO 1 - YES <input type="text"/></p>																					

SECTION E. PHYSICAL FUNCTIONING/STRUCTURAL PROBLEMS			
<p>1. ADL SELF-PERFORMANCE (Code for PERFORMANCE during last 7 days (24-48 hrs. if in hospital) – not including setup.)</p> <p>0. INDEPENDENT — No help or oversight — OR — Help/oversight provided only 1 or 2 times during last 7 days.</p> <p>1. SUPERVISION — Oversight, encouragement or cueing provided 3+ times during last 7 days — OR — Supervision plus nonweight-bearing physical assistance provided only 1 or 2 times during last 7 days.</p> <p>2. LIMITED ASSISTANCE — Person highly involved in activity; received physical help in guided maneuvering of limbs, or other nonweight-bearing assistance 3+ times — OR — Limited assistance (as just described) plus weight-bearing support 1 or 2 times during the last 7 days.</p> <p>3. EXTENSIVE ASSISTANCE — While person performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: — Weight-bearing support — Full staff/caregiver performance during part (but not all) of last 7 days.</p> <p>4. TOTAL DEPENDENCE — Full staff/caregiver performance of activity during ENTIRE 7 days.</p> <p>5. CUEING — Spoken instructions or physical guidance which serves as a signal to do an activity are required 7 days a week. Cueing is typically used when caring for individuals who are cognitively impaired.</p> <p>8. ACTIVITY DID NOT OCCUR during entire 7 days.</p>			
<p>2. ADL SUPPORT PROVIDED — (Code for MOST SUPPORT PROVIDED OVER EACH 24 HOUR PERIOD during last 7 days (24-48 hours if person is in hospital); code regardless of person's self-performance classification.)</p> <p>0. No setup or physical help from staff</p> <p>1. Setup help only</p> <p>2. One-person physical assist</p> <p>3. Two+ persons physical assist</p> <p>5. CUEING-Cueing support required 7 days a week</p> <p>8. Activity did not occur during entire 7 days.</p>		1	2
		SELF-PERFORMANCE	SUPPORT
a. BED MOBILITY	How person moves to and from lying position, turns side to side, and positions body while in bed	<input type="text"/>	<input type="text"/>
b. TRANSFER	How person moves between surfaces — to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet, dressing)	<input type="text"/>	<input type="text"/>
c. LOCOMOTION	How person moves between locations in his/her room and other areas on same floor. If in wheelchair, self-sufficiency once in chair	<input type="text"/>	<input type="text"/>
d. DRESSING	How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis	<input type="text"/>	<input type="text"/>
e. EATING	How person eats and drinks (regardless of skill)	<input type="text"/>	<input type="text"/>
f. TOILET USE	How person uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	<input type="text"/>	<input type="text"/>
9. PERSONAL HYGIENE	How person maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)	<input type="text"/>	<input type="text"/>
3. WALKING	a. How person walks for exercise only b. How person walks around own room c. How person walks within home d. How person walks outside	<input type="text"/>	<input type="text"/>
4. BATHING	How person takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair). (Code for most dependent in self performance and support. Bathing Self-Performance codes appear below.) <p>0. Independent—No help provided</p> <p>1. Supervision—Oversight help only</p> <p>2. Physical help limited to transfer only</p> <p>3. Physical help in part of bathing activity</p> <p>4. Total dependence</p> <p>5. CUEING—Cueing support required 7 days a week</p> <p>8. Activity did not occur during entire 7 days.</p>	1	2
		SELF-PERFORMANCE	SUPPORT

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SECTION C.4B. COGNITION

Enter the code that most accurately describes the person's cognition for the last 7 days.

1. MEMORY FOR EVENTS:

- 0 Can recall details and sequences of recent experiences and remember names of meaningful acquaintances.
- 1 Cannot recall details or sequences of recent events or remember names of meaningful acquaintances.
- 2 Cannot recall entire events (e.g. recent outings, visits of relatives or friends) or names of close friends or relatives without prompting.
- 3 Cannot recall entire events or name of spouse or other living partner even with prompting.

2. MEMORY AND USE OF INFORMATION:

- 0 Does not have difficulty remembering and using information. Does not require directions or reminding from others.
- 1 Has minimal difficulty remembering and using information. Requires direction and reminding from others one to three times per day. Can follow simple written instructions.
- 3 Has difficulty remembering and using information. Requires direction and reminding from others four or more times per day. Cannot follow written instructions.
- 4 Cannot remember or use information. Requires continual verbal reminding.

3. GLOBAL CONFUSION:

- 0 Appropriately responsive to environment.
- 1 Nocturnal confusion on awakening.
- 2 Periodic confusion during daytime.
- 3 Nearly always confused.

4. SPATIAL ORIENTATION:

- 0 Oriented, able to find and keep his/her bearings.
- 1 Spatial confusion when driving or riding in local community.
- 2 Gets lost when walking neighborhood.
- 3 Gets lost in own home or present environment.

5. VERBAL COMMUNICATION:

- 0 Speaks normally.
- 1 Minor difficulty with speech or word-finding difficulties.
- 2 Able to carry out only simple conversations.
- 3 Unable to speak coherently or make needs known.

C.4B TOTAL COGNITIVE SCORE

Return to Section C5 on page 2.

SECTION D.2B. BEHAVIOR

Enter the code that most accurately describes the person's behavior for the last 7 days.

1. SLEEP PATTERNS:

- 0 Unchanged from "normal" for the consumer.
- 1 Sleeps noticeably more or less than "normal."
- 3 Restless, nightmares, disturbed sleep, increased awakenings.
- 4 Up wandering for all or most of the night, inability to sleep.

2. WANDERING:

- 0 Does not wander.
- 1 Does not wander. Is chair bound or bed bound.
- 2 Wanders within the facility or residence and may wander outside, but does not jeopardize health and safety.
- 3 Wanders within the facility or residence. May wander outside, health and safety may be jeopardized. Does not have history of getting lost and is not combative about returning.
- 4 Wanders outside and leaves grounds. Has a consistent history of leaving grounds, getting lost or being combative about returning. Requires a treatment plan that may include the use of psychotropic drugs for management and safety.

3. BEHAVIORAL DEMANDS ON OTHERS:

- 0 Attitudes, habits and emotional states do not limit the individual's type of living arrangement and companions.
- 1 Attitudes, habits and emotional states limit the individual's type of living arrangement and companions.
- 3 Attitudes, disturbances and emotional states create consistent difficulties that are modifiable to manageable levels. The consumer's behavior can be changed to reach the desired outcome through respite, in-home services, or existing facility staffing.
- 4 Attitudes, disturbances and emotional states create consistent difficulties that are not modifiable to manageable levels. The consumer's behavior cannot be changed to reach the desired outcome through respite, in-home services, or existing facility staffing even given training for the caregiver.

4. DANGER TO SELF AND OTHERS:

- 0 Is not disruptive or aggressive, and is not dangerous.
- 1 Is not capable of harming self or others because of mobility limitations (is bed bound or chair bound).
- 2 Is sometimes (1 to 3 times in the last 7 days) disruptive or aggressive, either physically or verbally, or is sometimes extremely agitated or anxious, even after proper evaluation and treatment.
- 3 Is frequently (4 or more times during the last 7 days) disruptive or aggressive, or is frequently extremely agitated or anxious; and professional judgment is required to determine when to administer prescribed medication.
- 5 Is dangerous or physically abusive, and even with proper evaluation and treatment may require physician's orders for appropriate intervention.

5. AWARENESS OF NEEDS/JUDGMENT:

- 0 Understands those needs that must be met to maintain self care.
- 1 Sometimes (1 to 3 times in the last 7 days) has difficulty understanding those needs that must be met but will cooperate when given direction or explanation.
- 2 Frequently (4 or more times during the last 7 days) has difficulty understanding those needs that must be met but will cooperate when given direction or explanation.
- 3 Does not understand those needs that must be met for self care and will not cooperate even though given direction or explanation.

D.2B TOTAL BEHAVIOR SCORE

Return to Section D3 on page 2.

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SECTION I. COMMUNICATION/HEARING PATTERNS	
1. HEARING <i>(Choose only one.)</i>	<p><i>(With hearing appliance, if used)</i></p> <p>0. HEARS ADEQUATELY—normal talk, TV, phone</p> <p>1. MINIMAL DIFFICULTY when not in quiet setting <input type="checkbox"/></p> <p>2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly</p> <p>3. HIGHLY IMPAIRED—absence of useful hearing</p>
2. COMMUNICATION DEVICES/TECHNIQUES	<p><i>(Check all that apply during last 7 days.)</i></p> <p><input type="checkbox"/> a. Hearing aid, present and used</p> <p><input type="checkbox"/> b. Hearing aid, present and not used regularly</p> <p><input type="checkbox"/> c. Other receptive communication techniques used (e.g., lip reading)</p> <p><input type="checkbox"/> d. NONE OF ABOVE</p>
3. MAKING SELF UNDERSTOOD <i>(Choose only one.)</i>	<p><i>(Expressing information content—however able)</i></p> <p>0. UNDERSTOOD</p> <p>1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts <input type="checkbox"/></p> <p>2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests</p> <p>3. RARELY/NEVER UNDERSTOOD</p>
4. ABILITY TO UNDERSTAND OTHERS <i>(Choose only one.)</i>	<p><i>(Understanding information content—however able)</i></p> <p>0. UNDERSTANDS</p> <p>1. USUALLY UNDERSTANDS—may miss some part/intent of message <input type="checkbox"/></p> <p>2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication</p> <p>3. RARELY/NEVER UNDERSTANDS</p>

SECTION J. VISION PATTERNS	
1. VISION <i>(Choose only one.)</i>	<p><i>(Ability to see in adequate light and with glasses if used)</i></p> <p>0. ADEQUATE—sees fine detail, including regular print in newspapers/books</p> <p>1. IMPAIRED—sees large print, but not regular print in newspapers/books <input type="checkbox"/></p> <p>2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects</p> <p>3. HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects</p> <p>4. SEVERELY IMPAIRED—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects</p>
2. VISUAL APPLIANCES	<p>a. Glasses, contact lenses 0 - NO 1 - YES <input type="checkbox"/></p> <p>b. Artificial eye 0 - NO 1 - YES <input type="checkbox"/></p>

SECTION K. NUTRITIONAL STATUS	
1. WEIGHT <i>(Optional if info is not available.)</i>	<p>Record weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard practice (e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes) WT (lb.) <input type="text"/> <input type="text"/> <input type="text"/></p>
2. WEIGHT CHANGE <i>(Optional if info is not available.)</i>	<p>0. No weight change <input type="checkbox"/></p> <p>1. Unintended weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days <input type="checkbox"/></p> <p>2. Unintended weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days <input type="checkbox"/></p>
3. NUTRITIONAL PROBLEMS OR APPROACHES <i>(Check all that apply)</i>	<p><input type="checkbox"/> a. Chewing or swallowing problem</p> <p><input type="checkbox"/> b. Complains about the taste of many foods</p> <p><input type="checkbox"/> c. Regular or repetitive complaints of hunger</p> <p><input type="checkbox"/> d. Leaves 25% or more of food uneaten at most meals</p> <p><input type="checkbox"/> e. Therapeutic diet</p> <p><input type="checkbox"/> f. Mechanically altered (or pureed) diet</p> <p><input type="checkbox"/> g. Noncompliance with diet</p> <p><input type="checkbox"/> h. Food Allergies (<i>specify</i>) _____</p> <p><input type="checkbox"/> i. Restrictions (<i>specify</i>) _____</p> <p><input type="checkbox"/> j. NONE OF ABOVE</p>

SECTION L. CONTINENCE IN LAST 14 DAYS	
1. BLADDER CONTINENCE <i>(Choose only one.)</i>	<p>Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants) with appliances if used (e.g., pads or incontinence program employed) in last 14 days</p> <p>0. CONTINENT—Complete control</p> <p>1. USUALLY CONTINENT—Incontinent episodes once a week or less <input type="checkbox"/></p> <p>2. OCCASIONALLY INCONTINENT—2 or more times a week but not daily</p> <p>3. FREQUENTLY INCONTINENT—tended to be incontinent daily, but some control present</p> <p>4. INCONTINENT—Bladder incontinent all (or almost all) of the time</p>
2. BOWEL CONTINENCE <i>(Choose only one.)</i>	<p>In last 14 days, control of bowel movement (with appliance or bowel continence programs if employed)</p> <p>0. CONTINENT—Complete control</p> <p>1. USUALLY CONTINENT—Bowel incontinent episodes less than weekly <input type="checkbox"/></p> <p>2. OCCASIONALLY INCONTINENT—Bowel incontinent episode once a week</p> <p>3. FREQUENTLY INCONTINENT—Bowel incontinent episodes 2-3 times a week</p> <p>4. INCONTINENT—Bowel incontinent all (or almost all) of the time</p>
3. APPLIANCES/PROGRAMS <i>(Check all that apply.)</i>	<p><input type="checkbox"/> a. External (condom) catheter</p> <p><input type="checkbox"/> b. Indwelling catheter</p> <p><input type="checkbox"/> c. Pads/briefs used</p> <p><input type="checkbox"/> d. Ostomy present</p> <p><input type="checkbox"/> e. Scheduled toileting/other program</p> <p><input type="checkbox"/> f. NONE OF ABOVE</p>

SECTION M. BALANCE	
1. ACCIDENTS <i>(Check all that apply)</i>	<p><input type="checkbox"/> a. Fell in past 30 days</p> <p><input type="checkbox"/> b. Fell in past 31-180 days</p> <p><input type="checkbox"/> c. Hip fracture in last 180 days</p> <p><input type="checkbox"/> d. Other fracture in last 180 days</p> <p><input type="checkbox"/> e. NONE OF ABOVE</p>
2. DANGER OF FALL <i>(Check all that apply)</i>	<p><input type="checkbox"/> a. Has unsteady gait</p> <p><input type="checkbox"/> b. Has balance problems when standing</p> <p><input type="checkbox"/> c. Limits activities because person or family fearful of person falling</p> <p><input type="checkbox"/> d. NONE OF ABOVE</p>

SECTION N. ORAL/DENTAL STATUS	
1. ORAL STATUS AND DISEASE PREVENTION <i>(Check all that apply)</i>	<p><input type="checkbox"/> a. Has dentures or removable bridge</p> <p><input type="checkbox"/> b. Some/all natural teeth lost—does not have or does not use dentures (or partial plates)</p> <p><input type="checkbox"/> c. Broken, loose, or carious teeth</p> <p><input type="checkbox"/> d. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes</p> <p><input type="checkbox"/> e. NONE OF ABOVE</p>

SECTION O. SKIN CONDITIONS	
1. SKIN PROBLEMS <i>(Check all that apply)</i>	<p>Any troubling skin conditions or changes in the last 180 days?</p> <p><input type="checkbox"/> a. Abrasions (scrapes) or cuts</p> <p><input type="checkbox"/> b. Burns</p> <p><input type="checkbox"/> c. Bruises</p> <p><input type="checkbox"/> d. Rashes, itchiness, body lice, scabies</p> <p><input type="checkbox"/> e. Open sores or lesions</p> <p><input type="checkbox"/> f. NONE OF ABOVE</p>
2. PRESSURE ULCERS	<p>Presence of an ulcer anywhere on the body? This would include an area of persistent skin redness (Stage 1), partial loss of skin layers (Stage 2), deep craters in the skin (Stage 3), and breaks in the skin exposing muscle or bone (Stage 4).</p> <p>0 - NO 1 - YES <input type="checkbox"/></p>
3. FOOT PROBLEMS	<p>a. Person or someone else inspects person's feet on a regular basis?</p> <p>0 - NO 1 - YES <input type="checkbox"/></p> <p>b. One or more foot problems or infections such as corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems, gangrene toe, foot fungus, onychomycosis?</p> <p>0 - NO 1 - YES <input type="checkbox"/></p>

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SECTION P. INSTRUMENTAL ACTIVITIES OF DAILY LIVING

1. IADL SELF-PERFORMANCE CODES:
 0. INDEPENDENT: (with/without assistive devices)—No help provided.
 1. INDEPENDENT WITH DIFFICULTY: Person performed task, but did so with difficulty or took a great amount of time to do so.
 2. ASSISTANCE/DONE WITH HELP: Person involved in activity but help (including supervision, reminders, and/or physical "hands-on" help) was provided.
 3. DEPENDENT/DONE BY OTHERS:
 Full performance of the activity was done by others. The person was not involved at all each time the activity was performed.
 8. Activity did not occur.

2. IADL SUPPORT CODES:
 0. No support provided.
 1. Supervision/cueing provided.
 2. Set-up help only.
 3. Physical assistance was provided.
 4. Total dependence—the person was not involved at all when the activity was performed.
 8. Activity did not occur.

		1		2	
		SELF-PERFORMANCE		SUPPORT	
1.	DAILY INSTRUMENTAL ACTIVITIES <i>Code for level of independence based on person's involvement in the activity in the last 7 days</i>	a. Meal Preparation: Prepared breakfast and light meals.			
		b. Main Meal Preparation: Prepared or received main meal <input type="checkbox"/> Meals on Wheels _____ times per week			
		c. Telephone: Used telephone as necessary, e.g., able to contact people in an emergency.			
		d. Light Housework: Did light housework such as dishes, dusting (on daily basis), making own bed.			
2.	OTHER INSTRUMENTAL ACTIVITIES OF DAILY LIVING <i>Code for level of independence based on person's involvement in the activity in the last 14 days</i>	a. Managing Finances: Managed own finances, including banking, handling checkbook, paying bills.			
		b. Routine Housework: Did routine housework such as vacuuming, cleaning floors, trash removal, cleaning bathroom, as needed.			
		c. Grocery Shopping: Did grocery shopping as needed (excluding transportation).			
		d. Laundry: Indicate: <input type="checkbox"/> in home <input type="checkbox"/> out of home Did laundry in home or at laundry facility (excluding transportation).			
3.	TRANSPORTATION <i>Check all that apply for level of independence based on person's involvement in the last 30 days.</i>	<input type="checkbox"/> a. Person drove self or used public transportation independently to get to medical, dental appointments, necessary engagements, or other activities. <input type="checkbox"/> b. Person needed arrangement for transportation to medical, dental appointments, necessary engagements, or other activities. <input type="checkbox"/> c. Person needed transportation to medical, dental appointments, necessary engagements, or other activities. <input type="checkbox"/> d. Person needed escort to medical, dental appointments, necessary engagements, or other activities. <input type="checkbox"/> e. Activity did not occur.			
4.	PRIMARY MODES OF LOCOMOTION <i>Code for the primary mode of locomotion for (a) indoors and (b) outdoors from the following list:</i> 0. No assistive device 1. Cane 2. Walker/crutch 3. Scooter (e.g. Amigo) 4. Wheelchair 5. Activity does not occur			a. Indoors	b. Outdoors

SECTION IR. AT RISK

1. **RISK OF HARM OR DETERIORATION**
(Check all that apply)
 Person at risk of harm or deterioration due to:
 a. Medical Risk
 b. Cognitive/Behavioral Risk
 c. Community Risk
 d. NONE OF THE ABOVE

SECTION Q. ENVIRONMENTAL ASSESSMENT

1.	If person resides in a facility such as a NF, RCF, or hospital, check here and proceed to Section R.		
2.	HOME ENVIRONMENT <i>(Check any of the following that makes home environment hazardous or uninhabitable. If none apply, check NONE OF ABOVE. If temporarily in institution, base assessment on home visit)</i>	a. Lighting (including adequacy of lighting, exposed wiring) b. Flooring and carpeting (e.g., holes in floor, electric wires where client walks, scatter rugs) c. Bathroom and toiletroom environment (e.g., non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet) d. Kitchen environment (e.g., dangerous stove, inoperative refrigerator, infestation by rats or bugs) e. Heating and cooling (e.g., too hot in summer, too cold in winter, wood stove in a home with an asthmatic) f. Personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street) g. Access to home (e.g., difficulty entering/leaving home) h. NONE OF ABOVE	a. b. c. d. e. f. g. h.
3.	TRADE OFFS <i>Check all that apply.</i>	Because of limited funds, during the last month, person made trade-offs in purchasing the following: <input type="checkbox"/> a. home heat <input type="checkbox"/> b. adequate food <input type="checkbox"/> c. necessary physician care <input type="checkbox"/> d. prescribed medications <input type="checkbox"/> e. home care. <input type="checkbox"/> f. NONE OF ABOVE	

SECTION R. MOOD

1. **INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD**
Code for behavior in last 30 days irrespective of the assumed cause.
 0. Indicator not exhibited
 1. Indicator of this type exhibited up to 5 days a week
 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

VERBAL EXPRESSIONS OF DISTRESS		SLEEP-CYCLE ISSUES	
a.	Person made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die."	h.	Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions
b.	Repetitive questions—e.g., "Where do I go? What do I do?"	i.	Repetitive anxious complaints/concerns (non-health related)—e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues
c.	Repetitive verbalizations—e.g., calling out for help. ("God help me.")	j.	Unpleasant mood in morning
d.	Persistent anger with self or others—e.g., easily annoyed; anger at placement in nursing home; anger at care received	k.	Insomnia/change in usual sleep pattern
e.	Self-deprecation—e.g., "I am nothing; I am of no use to anyone."	l.	Sad, pained, worried facial expressions—e.g., furrowed brows
f.	Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others	m.	Crying, tearfulness
g.	Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack	n.	Repetitive physical movements—e.g., pacing, hand-wringing, restlessness, fidgeting, picking
		o.	Withdrawal from activities of interest—e.g., no interest in longstanding activities or being with family/friends
		p.	Reduced social interaction

2.	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up," console or reassure the person over the last 7 days. 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	
3.	MOOD	Person's current mood status compared to person's status 180 days ago. 0. No change 1. Improved 2. Declined	