**Followup Record - Qtrly Basic Information**

### Initial Information

**CLS/CSC Name:**

What is the name of the CLS who provided direct assistance to this consumer in the nursing home or in the community? If a CLS is conducting the follow up on behalf of another CLS, the name of the CLS actually completing the call will be documented in this field. If an administrative assistant is completing the follow up screen and/or phone call, the name of the CLS who provided the direct assistance should be indicated in this field. If this is a naturally occurring discharge, who is the client services center specialist conducting this follow up?

- Nancy Sandahl
- Deb Eiler
- Heather Pender
- Leslie Sauve
- Stephanie Larson
- Melanie Spencer
- Shelly Loney
- Denise Dickson-Whalen
- Kathy Vondrum
- Erin Lawrence
- Vicki French
- Pam Will
- Jennifer Warmka
- Jen Rooney
- Katelyn Kuechenmeister
- Connie Pelzer
- Sonia Rucks
- Wendy Galaniu
- Lori Wacek
- Jen McLaughlin
- Vicki Lawrence
- Jacqueline Portz
- Rita Pyan
- Bruce Kylonen
- Nicole Konz
- Brittany Perish
- Kylie Chandler
- Brenda Roemhildt
- Charlie Winship

**CLS/CSC AAA Region:**

What AAA office do you work at? This will auto-populate based on the CLS/CSC Name field.

### Actual Discharge Date/Support Plan Implementation Date

When did the consumer discharge from the nursing home? For those who were already in the community: What is the date the support plan was considered final?

### Type of Discharge

Who assisted the consumer with relocating from the nursing home to a community setting? If the consumer was already residing in the community and the CLS provided direct assistance, use CLS Assisted.

- CLS Assisted
- Naturally Occurring
- Moving Home Minnesota

### Date of Verbal Release

When did the consumer provide verbal permission to conduct the follow up call?

### Date of Written Release

When did the consumer sign the written release of information?
Initial Information

Who was the primary person who provided information during this check in?

- Adult Child
- Consumer
- Court Appointed Guardian
- Friend/Neighbor
- Grandchild
- Other Relative
- Paid Help
- Parent
- Sibling
- Spouse/Partner

Public Program Status:

- Alternative Care (AC)
- Brain Injury Waiver (BI)
- Community Alternative Care (CAC)
- Community Alternative for Disabled Individuals (CADI)
- Elderly Waiver (EW)
- Essential Community Supports (ECS)
- Medical Assistance
- Medical Assistance for Employed Persons with Disabilities (MA-EPD)
- Medical Assistance w/Spenddown
- MinnesotaCare
- None

Demographics

First Name: Hello, My name is _________________. I am calling on behalf from the Senior LinkAge Line® One Stop Shop for Minnesota Seniors. [If first interview - We are contacting you because you were recently discharged from a nursing home.] [If previously contacted - You have spoken previously with a Community Living Specialist regarding how you are doing at home after leaving the nursing home. I am following up to see how you are doing and to ask you a few questions.] We are gathering information in order to improve services for people who have returned to the community from a nursing home. We want to keep you and others successfully living at home for as long as you can. We are also calling because we would like to give you the opportunity to participate in research for the state of Minnesota. My questions will take about 30 minutes. Would you be willing to participate and answer a few questions for me?

If consumer answers yes, but has not yet signed a release form: Thank you, I need to mail you a release form that will need to be signed and mailed back to me; I will include a self-addressed stamped envelope for you to return the form. A release form is necessary because we will be collecting private data about you. You are welcome to call the Senior LinkAge Line® if you have questions about the release form once you receive it in the mail.

If consumer answers no: Thank you for your time. If you change your mind, please call the Senior LinkAge Line®. [End call and document in log notes.]

Is now a good time for you, or could I schedule a better time to call you back?

Before we get started, I just need to go over a few things. First of all, I want to let you know that your participation is strictly voluntary. You do not have to answer any of the questions or you can skip any questions you like at any time. If you'd like to stop the interview at any time, we can do that. I can always call you back to complete the interview or you can tell me that you are simply finished. May I get your first name?

Last Name: What is your last name?

Middle Name (RC): May I get your middle name?

Nickname: How do you prefer to be addressed?

Address

State: This is in Minnesota, correct?

Zip Code: So I can find services in your area, may I get your zip code?
### Address

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>City:</td>
<td>Script Your zip code shows that you are in (City), is this right?</td>
</tr>
<tr>
<td>County:</td>
<td>Script And that city is in (County) county?</td>
</tr>
<tr>
<td>Address 1:</td>
<td>Script I may need to send you some information. Please provide me with your mailing address.</td>
</tr>
<tr>
<td>Address 2:</td>
<td>Script Do you have an apartment or house number?</td>
</tr>
</tbody>
</table>

### TTY Phone Number:  

### Caller ID:  

### Home Phone:  

Script If you are calling from home, can I get your home telephone number?

### Cell Phone:  

Script If you are calling from a cell phone, may I get your cell phone number?

### E-Mail:  

Script I can send you information over email, can I get your email address?

### Other Data

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date:</td>
<td>Script Many programs are for people who are a certain age, may I get your date of birth?</td>
</tr>
<tr>
<td>Age:</td>
<td>Script Many programs are for people who are a certain age, can I get your age?</td>
</tr>
<tr>
<td>Social Security Number:</td>
<td>Script What is your Social Security number?</td>
</tr>
<tr>
<td>Resident Internal ID:</td>
<td>Script This number will auto populate when MDS profile names are uploaded to Web Referral.</td>
</tr>
<tr>
<td>Gender (RC):</td>
<td>Script We receive funds from many sources and they like to know a little about our callers, may I verify your gender?</td>
</tr>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>Transgender- Male to Female</td>
</tr>
<tr>
<td></td>
<td>Transgender- Female to Male</td>
</tr>
<tr>
<td>Marital Status:</td>
<td>Script What is the consumer's marital status?</td>
</tr>
<tr>
<td></td>
<td>Never married</td>
</tr>
<tr>
<td></td>
<td>Married</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
</tr>
<tr>
<td></td>
<td>Separated</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
</tr>
<tr>
<td></td>
<td>Partner/Significant Other</td>
</tr>
<tr>
<td>Veteran:</td>
<td>Script Are you a Veteran?</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Language Spoken (RC):</td>
<td>Script Choose the language the consumer speaks.</td>
</tr>
<tr>
<td></td>
<td>American Sign Language (ASL)</td>
</tr>
<tr>
<td></td>
<td>Amharic</td>
</tr>
<tr>
<td></td>
<td>Arabic</td>
</tr>
<tr>
<td></td>
<td>Chinese</td>
</tr>
<tr>
<td></td>
<td>English</td>
</tr>
<tr>
<td></td>
<td>Hmong</td>
</tr>
</tbody>
</table>
### Other Data

- Khmer (Cambodian)
- Laotian
- Oromo
- Other
- Russian
- Serbo-Croatian (Bosnian)
- Somali
- Spanish
- Vietnamese

### Language Spoken

**Other (RC):**

- Please indicate the other language the consumer speaks.

### Interpreter Used?

- Script: Were interpreter services used to complete the consumer/caregiver interview?

- Not Applicable
- Yes
- No

### Ethnicity

- Script: We receive funds from many sources and they like to know a little about our callers, may I ask your ethnicity?

- American Indian or Alaskan Native
- Asian Indian
- Black, African American
- Chinese
- Filipino
- Guamanian or Chamorro
- Hispanic, Latino or Spanish Origin
- Japanese
- Korean
- Native Hawaiian
- Not Collected
- Other Asian
- Other Pacific Islander
- Samoan
- Some Other Race/Ethnicity
- Vietnamese
- White, Non-Hispanic

### Highest level of education

- Script: What is the highest level of schooling you have completed?

- No Schooling
- 8th Grade or Less
- 9-12 Grades
- High School Graduate
- Technical or Trade School
- Some College
- Bachelor's Degree
- Graduate Degree

### Occupation

- Script: What did you do for a living or as your primary occupation?

### Emergency Contacts

- Script: Do you have someone we should contact in case of an emergency?

  **Name:**

- Script: What is the address for this person?

  **Address 1:**

- Script: Does this person have an apartment number?

  **Address 2:**
### Emergency Contacts

<table>
<thead>
<tr>
<th>Emergency Contact</th>
<th>Script</th>
<th>What states does this person live in?</th>
</tr>
</thead>
<tbody>
<tr>
<td>State:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact</th>
<th>Script</th>
<th>What is the ZIP code of this person?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zip Code:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact</th>
<th>Script</th>
<th>In which city does this person live?</th>
</tr>
</thead>
<tbody>
<tr>
<td>City:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact</th>
<th>Script</th>
<th>What is your relationship to your emergency contact; are they your son, daughter, friend?</th>
</tr>
</thead>
</table>
| Relationship:     |        | Adult Child
|                   |        | Friend/Neighbor
|                   |        | Grandchild
|                   |        | Other Relative
|                   |        | Paid Help
|                   |        | Parent
|                   |        | Sibling
|                   |        | Spouse/Partner

<table>
<thead>
<tr>
<th>Emergency Contact</th>
<th>Script</th>
<th>What is the home number for your emergency contact?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Phone:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact</th>
<th>Script</th>
<th>Does this person have a work phone number that we may put into our records?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work Phone:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact</th>
<th>Script</th>
<th>Can we record this person’s cell phone number?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell Phone:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact</th>
<th>Script</th>
<th>Does your emergency contact have an email address?</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-Mail:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact</th>
<th>Script</th>
<th>What type of authority does this person have?</th>
</tr>
</thead>
</table>
| Legal Authority:  |        | Conservator
|                   |        | Guardian
|                   |        | Health Care Proxy
|                   |        | Power of Attorney (Financial)
|                   |        | Unknown
|                   |        | None

<table>
<thead>
<tr>
<th>Emergency Contact</th>
<th>Script</th>
<th>What level of involvement does this person have according to the consumer?</th>
</tr>
</thead>
</table>
| Level of Involvement: |        | Primary
|                        |        | Secondary
|                        |        | None

### Advanced Directive Documentation

<table>
<thead>
<tr>
<th>Advanced Directive Documentation</th>
<th>Script</th>
<th>Do you have any of the following documents?</th>
</tr>
</thead>
</table>
|                                   |        | Do Not Hospitalize
|                                   |        | Physician Orders Life Sustaining Treatment (POLST)
|                                   |        | Do Not Resuscitate (DNR) or Do Not Intubate Order (DNI)
|                                   |        | Health Care Directive (living will, durable power of attorney for health care)
|                                   |        | Do Not Know
|                                   |        | None

### Follow-up Record - Quarterly Insurance & Recent Health Care Use

07/25/2016 10:47 AM
Medicare/Medical Assistance

Medicare or Railroad Retirement Number:  
Script  What is your Medicare or Railroad Retirement Number?

Person Master Index (PMI) number:  
Script  Do you know your Person Master Index (PMI) Number?

County Case Worker/Managed Care Coordinator

County Case Worker/Care Coordinator Name:  
Script  Do you know the name of your case worker/care coordinator?

County Case Worker/Care Coordinator Phone Number:  
Script  Do you have the phone number for your case worker/care coordinator?

Recent Nursing Facility Admission

Recent Nursing Facility Admission:  
Script  In the last 3 months, how many times have you been admitted to a nursing facility?

- 0
- 1
- 2
- 3
- 4+

Reason for Recent Nursing Facility Admission:  
Script  Why were you admitted to a nursing facility?

- Therapy services
- Respite care
- Hospice care
- Permanent placement
- Unsafe for care at home
- Other
- UK – Unknown

Other Reason for Recent Nursing Facility Admission:  
Script  What is the other reason the consumer was admitted to a nursing facility?

Recent Hospital Visit

Recent Hospital Visit:  
Script  In the last 3 months, how many times have you been in the hospital? This includes any visits that were considered observation. This does not include trips to the Emergency Room.

- 0
- 1
- 2
- 3
- 4+

Reason for Recent Hospital Visit:  
Script  Why were you in the hospital?

- Accident
- Blood Pressure Low/High
- Blood Sugars Low/High
- Chest Pain/Pressure
- Dizziness
- Fall
- Fall with Injury
- Head Injury
- Lack of Caregiver
Recent Hospital Visit

- Medication Interaction
- No Medications
- Planned Surgery
- Shortness of Breath
- Uncontrolled Pain
- Viral/Bacterial Infection (Pneumonia, Cold, Flu)
- Other

Other Reason for Recent Hospital Visit:

Script What is the other reason the consumer was in the hospital?

Recent Emergency Room/Urgent Care Visits

Recent ER/Urgent Care Visit:

Script In the last 3 months, how many times have you been to the emergency room or urgent care?

- 0
- 1
- 2
- 3
- 4+

Reason for Recent ER/Urgent Care Visit:

Script Why did you go to the emergency room or urgent care?

- Accident
- Blood Pressure Low/High
- Blood Sugars Low/High
- Chest Pain/ Pressure
- Dizziness
- Fall
- Fall with Injury
- Head Injury
- Lack of Caregiver
- Medication Interaction
- No Medications
- Planned Surgery
- Shortness of Breath
- Uncontrolled Pain
- Viral/Bacterial Infection (Pneumonia, Cold, Flu)
- Other

Other Reason for Recent ER/Urgent Care Visit:

Script What is the other reason the consumer went to the emergency room or urgent care?

Doctor Visits

Total Doctor Visits-Last 3 Months:

Script About how many times in the last 3 months have you seen any doctor (your regular doctor, a specialist, or another medical doctor)?

- 0
- 1
- 2
- 3
- 4+

Primary Care Doctor in Community

Primary Doctor Name:

Script What is the name of your primary or regular doctor in the community?

Primary Doctor Clinic Name:

Script What is the name of the clinic or health system your doctor is affiliated with?

Primary Doctor State:

Script This field auto populates.
Primary Care Doctor in Community

- Alabama
- Alaska
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Vermont
- Virginia
- Washington
- Washington, DC
- West Virginia
- Wisconsin
- Wyoming

Primary Doctor Zip Code: Script This field auto populates.

Primary Doctor City: Script This field auto populates.

Primary Doctor County: Script This field auto populates.
Primary Care Doctor in Community

Primary Doctor
Address 1:  

Primary Doctor Phone:  

Followup Record - Qtrly Health Conditions

Drug Allergies/Sensitivities

Drug Allergies/Sensitivities:

- Yes
- None
- Unknown

List Drug Allergies/Sensitivities:

Diagnoses

Cancer:

If first interview, What medical diagnoses do you have? If not first interview, state, The last time we talked you had these medical diagnoses. Has your health changed in the last 3 months? Has a doctor or other health professional told you that you have any other diagnoses? Have you been diagnosed with cancer?

- Cancer - with or without metastasis

Heart/Circulation:

Have you been diagnosed with any of the following heart or circulation conditions?

- Anemia (includes Aplastic, Iron Deficiency, Pernicious, and Sickle Cell)
- Atrial Fibrillation and other Dysrhythmias (includes Bradycardias, Tachyarrhythmias)
- Coronary Artery Disease (CAD) (includes Angina, Myocardial Infarction, Atherosclerotic Heart Disease (ASHD))
- Deep Venous Thrombosis (DVT)/Pulmonary Embolus (PE) or Pulmonary Thrombo-Embolism (PTE)
- Heart Failure (includes Congestive Heart Failure (CHF), Pulmonary Edema)
- Hypertension
- Ortho-Static Hypotension
- Peripheral Vascular Disease/Peripheral Arterial Disease

Gastrointestinal:

Have you been diagnosed with any of the following gastrointestinal conditions?

- Cirrhosis
- Gastroesophageal Reflux Disease (GERD)/Ulcer (includes Esophageal, Gastric, and Peptic Ulcers)
- Diverticulitis
- Ulcerative Colitis/Crohn's Disease/Inflammatory Bowel Disease

Genitourinary:

Do you currently have the diagnosis or condition of any of the following?

- Benign Prostatic Hyperplasia (BPH)
- Renal Insufficiency or Renal Failure/End-Stage Renal Disease (ESRD)
- Neurogenic Bladder
- Obstructive Uropathy

Infections:

Do you currently have the diagnosis or condition of any of the following?

- Multi-Drug Resistant Organism (MDRO)
- Tuberculosis
- Wound infection (other than foot)
- Urinary Tract Infection (UTI) (LAST 30 DAYS)
- Pneumonia
- Septicemia
- Viral Hepatitis (includes A, B, C, D, & E)

Metabolic:

Do you currently have the diagnosis or condition of any of the following?

- Diabetes Mellitus (DM) (includes Diabetic Retinopathy, Nephropathy, and Neuropathy)
- Thyroid Disorder (includes Hypothyroidism, Hyperthyroidism, and Hashimoto's Thyroiditis)
## Diagnoses

- Hyperlipidemia (includes Hypercholesterolemia)
- Hyponatremia
- Hyperkalemia

### Musculoskeletal:

**Script**

Do you currently have the diagnosis or condition of any of the following?

- Arthritis (Degenerative Joint Disease (DJD), Osteoarthritis, and Rheumatoid Arthritis (RA))
- Hip Fracture (includes any hip fracture that has a relationship to current status, treatments, monitoring. Includes Sub-Capital Fractures, Fractures of the Trochanter and Femoral Neck)
- Osteoporosis
- Other Fracture

### Neurological:

**Script**

Do you currently have the diagnosis or condition of any of the following?

- Alzheimer's disease
- Aphasia
- Cerebral Palsy
- Cerebrovascular Accident (CVA)/Transient Ischemic Attack (TIA)/Stroke
- Dementia (Non-Alzheimer's dementia, including Vascular or Multi-Infarct Dementia, Mixed Dementia, Frontal Temporal Dementia (e.g., Pick's Disease), and Dementia related to Stroke, Parkinson's or Creutzfeldt-Jakob diseases)
- Hemiplegia/Hemiparesis
- Huntington's disease
- Multiple Sclerosis
- Paraplegia
- Parkinson's Disease
- Quadriplegia
- Seizure Disorder
- Tourette's Syndrome
- Traumatic Brain Injury

### Nutritional:

**Script**

Do you currently have the diagnosis or condition of any of the following?

- Malnutrition (protein or calorie) or at risk of malnutrition

### Psychiatric/Mood Disorder:

**Script**

Do you currently have the diagnosis or condition of any of the following?

- Anxiety Disorder
- Psychotic Disorder (other than Schizophrenia)
- Post Traumatic Stress Disorder (PTSD)
- Depression (other than Bipolar)
- Manic Depression (Bipolar Disease)
- Schizophrenia (including Schizoaffective and Schizophreniform Disorders)

### Pulmonary:

**Script**

Do you currently have the diagnosis or condition of any of the following?

- Asthma/Chronic Obstructive Pulmonary Disease (COPD) or Chronic Lung Disease (includes chronic Bronchitis and Restrictive Lung diseases such as Asbestosis)
- Respiratory Failure

### Vision:

**Script**

Do you currently have the diagnosis or condition of any of the following?

- Cataracts, Glaucoma, or Macular Degeneration

## Additional Diagnosis

**Script**

Do you have any other diagnoses or conditions that we have not addressed?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>

## Medication Management

**Script**

Can you take your medications without help? This includes getting prescription refills, scheduling when you will take your medications, setting up your medications so you can take the proper dose, and taking the pills/liquids/injections.

- I manage my own medications without help from others
- I can obtain and set up my medication, but I need someone to remind me when it is time to take them
- I need someone to obtain and setup my medications, but I can take them on my own
- I need help with both medication set-up and reminders
- Someone else gives my medication to me
- I do not take any medications
### Medication Management

**Blood Sugar:**
- **Script** If you are diabetic, are you able to manage blood sugars on your own?
  - I am not diabetic
  - I do not need to manage my blood sugars
  - I manage my blood sugars on my own
  - I am unable to manage my blood sugars on my own

**Diabetic Medication:**
- **Script** If you are diabetic, are you able to manage your diabetic medications?
  - I am not diabetic
  - I manage sliding scale insulin and oral medications on my own
  - I manage scheduled daily insulin plus daily sliding scale on my own
  - I manage scheduled daily insulin on my own
  - I manage oral medications on my own
  - I am unable to manage my diabetic medications without assistance
  - I do not take insulin or oral medications, but I am on a diabetic diet

### Followup Record - Qtrly ADL/IADL/Environmental Review

#### ADLs

**Dressing:**
- **Script** When it is time to get dressed, in what ways, if any, do you need help getting dressed? By dressing, we mean laying out the clothes and putting them on, including shoes and socks, and fastening clothes. Can you get dressed without any help at all or only sometimes need help getting dressed? Do you need somebody to help you lay out clothes or give you reminders to get dressed? Or do you always need help getting dressed?
  - Dress without help from others
  - Sometimes needs help getting dressed
  - Always needs help getting dressed

**Dressing-Sometimes/Always:**
- **Script** If the consumer sometimes or always needs help getting dressed, indicate all levels of assistance needed.
  - Someone to help lay out clothes
  - Someone to give reminders
  - Someone to physically put on clothes

**Grooming:**
- **Script** How well are you able to manage grooming activities like combing your hair, putting on makeup, shaving, and brushing your teeth by yourself? Can you comb your hair, wash your face, shave, and brush your teeth without any help at all, or only sometimes need help? Do you need somebody to help you set up or watch you while doing these activities? Do you need somebody to give you reminders to complete your grooming activities? Or do you always need help to complete grooming activities?
  - Grooming without help from others
  - Sometimes needs help with grooming
  - Always needs help with grooming

**Grooming-Sometimes/Always:**
- **Script** If the consumer sometimes or always needs help with grooming, indicate all levels of assistance needed.
  - Someone to set up or watch grooming
  - Someone to give reminders to complete grooming activities
  - Someone to physically complete grooming activities

**Bathing/Showering:**
- **Script** How much help, if any, do you need to bathe or shower? Bathing or showering "yourself" means running the water, taking the bath or shower without any help, and washing all parts of the body, including your hair and face. Can you bathe or shower by yourself without any help at all, or do you only sometimes need help? Do you need somebody to help you get in and out of the bath or shower? Do you need somebody to help you set up or watch you while bathing or showering? Do you need somebody to give you reminders to bathe or shower? Or do you always need physical help (wash hair, feet, or bottom) to complete a bath or shower?
  - Bathing/showering without help from others
  - Sometimes needs help with bathing/showering
  - Always need help with bathing/showering

**Bathing/Showering-Sometimes/Always:**
- **Script** If the consumer sometimes or always needs help with bathing/showering indicate all levels of assistance needed.
  - Someone to help get in or out of the bath or shower
  - Someone to set up or watch bathing/showering
  - Someone to give reminders to bathe/shower
  - Someone to physically wash hair, feet, or bottom
### ADLs

#### Eating:

Script How well can you manage eating by yourself? Eating by yourself means drinking and eating without help from anybody else, but you can use special utensils and straws. It also means cutting most foods on your own. Can you eat by yourself without any help at all, or do you only sometimes need help? Do you need someone to cut your food, butter your bread, arrange your food, or put food on the utensil? Do you need somebody to set up or food or watch you while eating? Do you need somebody to give you reminders while eating? Or do you always need to be fed completely?

- N/A: Tube feeding or IV feeding
- Eating without help from others
- Sometimes needs help with eating
- Always needs help with eating
- Needs to be fed completely

#### Eating-Sometimes/Always:

Script If the consumer sometimes or always needs help with eating indicate all levels of assistance needed.

- Someone to help to cut food, butter bread, arrange food, or put food on the utensil
- Someone to set up or watch while eating
- Someone to give reminders to while eating

#### Bed Mobility:

Script How well can you manage sitting up or moving around in bed? Can you move in bed without any help at all, or do you only sometimes need help to sit up, turn over, or change positions in bed? Or do you always need help to sit up, be turned, or to change positions in bed?

- Moving in bed without help from others
- Sometimes needs help moving in bed
- Always needs help moving in bed

#### Movement out of Bed/Chair:

Script How well can you get in and out of a bed or chair? Can you get in and out of a bed or chair without any help? Do you only sometimes need help, or do you always need help? Do you need somebody to guide you, but you can move by yourself? Can you get in and out of a bed or chair but only with the help of one person? Do you need two people or a mechanical aid to move in or out of a bed or chair?

- N/A: Never gets out of bed or chair
- Moves in and out of bed/chair without help from others
- Sometimes needs help with moving in and out of bed/chair
- Always needs help with moving in and out of bed/chair

#### Movement out of Bed/Chair-Sometimes/Always:

Script If the consumer sometimes or always needs help with moving out of the bed or chair indicate all levels of assistance needed.

- Someone to help guide while moving in and out of bed/chair
- One person to help move in and out of bed/chair
- Two people or mechanical aid to move in and out of bed/chair

#### Walking:

Script How much help do you need to walk around? Walking refers to the ability to walk short distances around the house. This does not include climbing stairs. Can you walk around independently, or only sometimes need help? Can you walk without help from others, but need the help of a cane, walker, crutch, or push wheelchair? Do you always need help from one person to help you walk? Do you always need help from two people to help you walk?

- Never walks/cannot walk at all
- Walks without help from others
- Walks without help from others, but needs the help of a cane, walker, crutch, or push wheelchair
- Sometimes needs help walking
- Always needs help walking

#### Walking-Sometimes/Always:

Script If the consumer sometimes or always needs help with walking indicate all levels of assistance needed.

- One person to help walk
- Two people to help walk

#### Wheelchair:

Script Are you able to maneuver your wheelchair (manual or electric) by yourself, or do you only sometimes need help? Do you need help negotiating doorways, elevators, ramps, or locking and unlocking brakes? Or do you always need help using your wheelchair?

- N/A: Does not use a wheelchair
- Uses wheelchair without help from others
- Sometimes needs help using wheelchair
- Always needs help using wheelchair
### ADLs

#### Toilet Use:

**Script**
Now I want to ask you some sensitive questions regarding your personal hygiene. How well can you manage using the toilet? This includes adjusting clothing, getting to and on the toilet, and cleaning one's self. Can you use the toilet without help including adjusting clothing, or do you only sometimes need help? Do you need help getting to and on the toilet, adjusting your clothing, or cleaning after using the toilet? Do you need reminders to use the toilet? Or do you always need help getting to the toilet, adjusting clothing or cleaning yourself?

- Does not use the toilet
- Uses toilet without help from others
- Sometimes needs help using toilet
- Always needs help using toilet

#### Urine Incontinence:

**Script**
Do you ever dribble or leak urine? If yes, do you need assistance to clean and change yourself without help from others? How much assistance do you need- sometimes: no more than once a week, sometimes: more than once a week but not every day, or do you need assistance cleaning and changing after you dribble or leak urine every day?

- Does not dribble or leak urine
- Does not need assistance cleaning/changing
- Sometimes needs assistance cleaning/changing: no more than once per week
- Sometimes needs assistance cleaning/changing: more than once per week, but not every day
- Needs assistance cleaning/changing every day

#### Bowel Incontinence:

**Script**
Do you ever have smears of bowel in your underwear? If yes, do you need assistance to clean and change yourself without help from others? How much assistance do you need- sometimes: no more than once a week, sometimes: more than once a week but not every day, or do you need assistance cleaning and changing after you dribble or leak urine every day?

- Does not have bowel incontinence
- Does not need assistance cleaning/changing
- Sometimes needs assistance cleaning/changing: no more than once per week
- Sometimes needs assistance cleaning/changing: more than once per week, but not every day
- Needs assistance cleaning/changing every day

#### Catheter/Ostomy:

**Script**
If you have a catheter or ostomy, how often do you need assistance to manage it if any?

- N/A: Does not have a catheter or ostomy
- Does not need assistance
- Less than once a week
- More than once a week, but not daily
- Daily

### IADLs

#### Answer Telephone:

**Script**
How much help do you need to answer the telephone?

- I do not answer the telephone
- I answer the telephone without help
- I sometimes need help to answer the telephone
- I always need help to answer the telephone

#### Telephone Calling:

**Script**
How much help do you need to make telephone calls?

- I do not make telephone calls
- I can find a number and make a telephone call without help
- I sometimes need help to find a number or make a telephone call
- I always need help to find a number or make a telephone call

#### Shopping:

**Script**
How well do you manage shopping by yourself? Are you able to plan and complete shopping trips or do you sometimes need help?

- I do not participate in shopping
- I am able to plan and complete shopping trips without help
- I sometimes need help planning or completing my shopping trips
- I always need someone with me when I shop

#### Food Preparation:

**Script**
How well are you able to prepare meals? Do you sometimes need help or does someone always help you?

- N/A: Does not prepare meals (e.g., receives meal service)
- I can plan and prepare meals without help
- I sometimes need help planning or preparing my meals
- I always need someone with me while I am planning or preparing my meals

#### Light Housekeeping:

**Script**
How well are you able to manage light housekeeping tasks such as dusting, sweeping, dishes, or wiping surfaces? Do you sometimes need help or does someone always help you?
### IADLs
- N/A: Does not have light housekeeping tasks
- Do light housekeeping without help
- I sometimes need help to do light housekeeping
- I always need help to do light housekeeping

### Heavy Housekeeping: Script
How well are you able to manage heavy housekeeping tasks such as emptying the garbage, vacuuming, or cleaning the bathroom? Do you sometimes need help or does someone always help you?
- N/A: Does not have heavy housekeeping tasks
- Do heavy housekeeping without help
- I sometimes need help to do heavy housekeeping
- I always need help to do heavy housekeeping

### Laundry: Script
How well are you able to manage your laundry, including putting your clothes in the washer or dryer, starting and stopping the machine and removing and putting them away? Do you sometimes need help or do you always need help?
- N/A: Does not do laundry (e.g., laundry service)
- Do laundry without help
- I sometimes need help to do laundry
- I always need help to do laundry

### Money: Script
How well are you able to manage your money including receiving and paying bills, balancing your checkbook, and taking care of any issues that arise regarding your finances? Do you sometimes need help or does someone always help you?
- N/A: Does not manage money
- Do manage money without help
- I sometimes need someone to help me or check my work when I am managing my money and bills
- I always have someone help me with my money and bills

### Transportation: Script
How do you get to the places you need to go, such as places of worship, shopping, doctor’s appointments, or social activities?
- N/A: Does not travel within the community
- Drive myself
- Family members/friends drive me
- Public transportation (e.g., bus)
- Paid service transportation (e.g., taxi)
- Health related transportation service (e.g., ambulance)
- Other

### Other Transportation: Script
What other transportation do you use?

### Falls in Community
- Have you fallen in the last 3 months?
  - Yes
  - No
  - Not Applicable - Caregiver Completed

### Injury from Falls: Script
Were you injured when you fell?
- Yes
- No
- Not Applicable

### Balancing/Vertigo: Script
Does concern about your balance or falling affect what you do each day?
- Yes
- No

### Environmental Review
### Safety Concerns in the Home:
- Basement
- Bathroom/Bathtub
- Bedroom
- Entrance or Exit
- Kitchen
Environmental Review

- Laundry/Utility Room
- Stairs/Stairways
- No
- Other

If Other Areas Identified:

- Script What other areas of your home are you concerned about?

Maintenance/Weatherizing:

- No
- Arranging for household maintenance (plumber, electrician, etc.) when something breaks
- Arranging for weatherization, such as insulation, window covering
- Arranging for seasonal tasks, such as snow removal and lawn care
- Other

Other Maintenance/Weatherizing Needs:

- Script What other areas of maintenance or weatherization do you need help with?

Followup Record - Qtrly Medical Treatments

Medical Treatments/Therapies

- Script Do you regularly receive/need any of the following medical treatments?

Medical Treatments/Therapies Administered/Needed:

- Bedsores Treatment
- Catheter Care
- Colostomy Care
- Diabetes Education
- Dialysis at Home
- Dialysis Outpatient
- HIV Therapies
- Occupational Therapy
- Ostomy Care
- Oxygen
- Physical Therapy
- Respiratory Therapy
- Respiratory Treatment
- Restorative Therapy
- Speech Therapy
- Suctioning
- Urostomy
- Wound Care
- None
- Other

Other Treatments/Therapies Administered/Needed:

- Script If you use other treatments or therapies, could you please specify what these are?

Nutrition

Describe Significant Weight Change:

- Script Have you gained or lost 10 or more pounds in the last 6 months and why have you lost or gained this much weight? If the consumer has not had significant weight change, write, “no significant change”.

Problems with Eating:

- Script Do you have any problems that make eating difficult?

- None
- Dental Problems/Chewing Problems
### Nutrition
- Swallowing Problems
- Taste Problems
- Cannot Eat Certain Foods
- Food Allergies
- Other Problems with Eating

### Other Eating Problems:
- **Script**: Could you describe the other problems you are having with eating?

### Special Diets:
- **Script**: Are you on any of the following special diets? Such as calorie supplement, low fat, low sugar, etc.
  - Calorie Supplement
  - Gluten-Free
  - Lactose-Free
  - Low Fat, Low Carb
  - Low Salt
  - Low Sugar
  - Mechanical Soft
  - Pureed
  - Thickened Food
  - Thickened Liquids
  - None
  - Other

### Other Special Diets:
- **Script**: Can you describe the special diet you are on that I did not mention?

### Pain

#### Daily Rating of Pain:
- **Script**: Do you have pain that affects your daily activities? If yes, Please rate your worst pain during the last 7 days on a scale of 1 to 10; with 1 being least amount of pain and 10 being the worst pain you can imagine.
  - I do not have daily pain
  - 1
  - 2
  - 3
  - 4
  - 5
  - 6
  - 7
  - 8
  - 9
  - 10
  - Not Applicable-Caregiver Completed

#### Sleeping with Pain:
- **Script**: During the past 7 days, has pain made it hard for you to sleep?
  - I do not have pain
  - Yes
  - No
  - Do Not Know
  - Not Applicable-Caregiver Completed

#### Pain and Activities:
- **Script**: During the past 7 days, have you limited your activities because of pain?
  - I do not have pain
  - Yes
  - No
  - Do Not Know
  - Not Applicable-Caregiver Completed

#### Chest Pain:
- **Script**: Do you regularly have chest pain?
  - Yes
  - No
  - Not Applicable-Caregiver Completed
## Pain

<table>
<thead>
<tr>
<th>Swollen Ankles:</th>
<th>Script</th>
<th>Do you have swollen ankles?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Shortness of Breath:</th>
<th>Script</th>
<th>Do you have shortness of breath or have difficulty breathing (prompt: rest/exertion/pain)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dizziness:</th>
<th>Script</th>
<th>Do you have dizziness (periodic or consistent)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

## Emotional Health PHQ-9

### Interest or Pleasure:

<table>
<thead>
<tr>
<th>Script</th>
<th>In the last 2 weeks, have you had little interest or pleasure in doing things?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never or 1 Day</td>
</tr>
<tr>
<td></td>
<td>2-6 Days (Several Days)</td>
</tr>
<tr>
<td></td>
<td>7-11 Days (Half or More Days)</td>
</tr>
<tr>
<td></td>
<td>12-14 Days (Nearly Every Day)</td>
</tr>
<tr>
<td></td>
<td>Did Not Answer</td>
</tr>
<tr>
<td></td>
<td>Not Applicable-Caregiver Completed</td>
</tr>
</tbody>
</table>

### Feeling Down, Depressed, or Hopeless:

<table>
<thead>
<tr>
<th>Script</th>
<th>In the last 2 weeks, have you been feeling down, depressed or hopeless?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never or 1 Day</td>
</tr>
<tr>
<td></td>
<td>2-6 Days (Several Days)</td>
</tr>
<tr>
<td></td>
<td>7-11 Days (Half or More Days)</td>
</tr>
<tr>
<td></td>
<td>12-14 Days (Nearly Every Day)</td>
</tr>
<tr>
<td></td>
<td>Did Not Answer</td>
</tr>
<tr>
<td></td>
<td>Not Applicable-Caregiver Completed</td>
</tr>
</tbody>
</table>

## Followup Record - Qtrly Self-Evaluation/CG Supports

### Self Evaluation

<table>
<thead>
<tr>
<th>Rate Your Health:</th>
<th>Script</th>
<th>Overall, compared to others your age, how would you rate your health?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>I am in very good health compared to others my age</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I'm about as healthy as others my age</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I am in poor health compared to others my age</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No response</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not Applicable-Caregiver Completed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health/Finances/Daily Activities Help:</th>
<th>Script</th>
<th>How much help do you need to make decisions about your health, finances, or daily activities?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>I feel safe and confident making decisions without help from others</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I feel safe and confident making decisions in familiar situations, but need help in situations that are new or different</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I sometimes need someone to help me make decisions about my daily routine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I always need someone to help me make decisions about my daily routine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I need someone to make most decisions for me</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not Applicable-Caregiver Completed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Living Situation:</th>
<th>Script</th>
<th>Where are you currently living?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Live alone in own home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Live with family or other person(s) in consumer's own home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Live with family or other person(s) in their home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Live in congregate situation (e.g., assisted living)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Level of Assistance:</th>
<th>Script</th>
<th>How much help do you get with your personal care or daily living needs?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Around the clock</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Regular daytime</td>
</tr>
</tbody>
</table>
### Self Evaluation

- Regular nighttime
- Occasional/short-term assistance
- No assistance

### Who Are You Living With?:

Script: Who do you live with?

- Adult Child
- Alone
- Friend/Neighbor
- Grandchild
- Other Relative
- Paid Help
- Parent
- Sibling
- Spouse/Partner

### Satisfied Where You Live:

Script: In the community are you satisfied with where you live or is there somewhere else you would prefer to live?

- Satisfied with current community housing
- Prefer to live somewhere else
- Do Not Know
- Not Applicable—Caregiver Completed

### Communication with Others:

Script: Did you talk to friends, relatives, or others on the telephone as often as you would like in the past week (either they called you or you called them?) (Not applicable to paid helpers)

- Yes
- No
- Not Applicable—Caregiver Completed

### Socialization with Others:

Script: Did you spend some time with someone who does not live with you as often as you would want? That is, you went to see them or they came to visit you or you did things together?

- Yes
- No
- Not Applicable—Caregiver Completed

### Current Services in Community:

Script: What services are you currently receiving at home?

- Adult Day Service
- Caregiver Support Groups
- Chore Services
- Companion Services
- Congregate Dining
- Durable Medical Equipment
- Evidence Based Programs (Ex: Matter of Balance, Chronic Disease Self Mgmt.)
- Financial Assistance-Agency Referral
- Home Health Aides
- Home-Delivered Meals
- Homemaker Services
- Hospice
- Long-term Care Consultation
- Medication Management
- Personal Emergency Response System (PERS)
- Personal Care Assistant (PCA)
- Rehab Services (OT/PT/ST/RT)
- Respite Care
- Skilled Nursing
- Training for informal caregivers
- Transportation
- None

### Willing to Pay?:

Script: Are you willing to pay for services that may be needed?

- Yes
- No
## Self Evaluation

### Why Not?:

**Script** What would you not be willing to pay for?

### Monthly Income:

**Script** What is your monthly income? This will help me find services and supports that meet your budget.

- $0 - $950
- $951 - $1,300
- $1,301 - $2,100
- $2,101 - $3,000
- More than $3,001
- Refused to provide

### Total Assets:

**Script** How much do you have in assets? This will help us determine if you may be eligible for certain programs.

- $0 - $3,000
- $3,001 - $10,000
- $10,001 - $25,000
- $25,001 - $75,000
- $75,001 - $150,000
- $150,001 - $300,000
- $300,001 - $600,000
- $600,001 - $999,999
- More than $1,000,000
- Refused to provide
- Don't know

## Caregiver Supports

**Who Helps You the Most in the Community?**

**Script** Who would you say is the person who helps you the most with day to day activities, taking care of your home or yourself, running errands or other things?

- Adult Child
- Friend/Neighbor
- Grandchild
- No One
- Other Relative
- Paid Help
- Parent
- Sibling
- Spouse/Partner

**Primary Caregiver First and Last Name:**

**Script** What is the first and last name of the person who helps you the most?

## Followup Record - Qtrly Caregiver Information

### Primary Caregiver Information

**Primary Caregiver First and Last Name:**

**Script** The primary caregiver is the individual who assists the consumer with care or tasks that cannot be completed independently due to a disability or functional limitation. Cares or tasks could include nonmedical care such as help with bathing or dressing; medically necessary care such as assistance with medications or changing dressings; and/or assistance with instrumental activities such as transportation, appointment setting, or home cleaning/maintenance. This individual may be a relative, friend or neighbor.

The interview would NOT be conducted with a paid individual, whether a licensed professional or someone else employed by an agency, family or the consumer.

What is your name?

**Primary Caregiver Relationship to Consumer:**

- Adult Child
- Friend/Neighbor
- Grandchild
- Guardian
Primary Caregiver Information

- Parent
- Other Relative
- Sibling
- Spouse/Partner

Primary Caregiver Age:

Script How old are you?

Primary Caregiver Home Phone:

Script What is your telephone number?

Primary Caregiver Cell Phone:

Script What is your cell phone number?

Primary Caregiver Email:

Script What is your email?

Primary Caregiver Gender:

- Male
- Female
- Not Collected
- Transgender- Male to Female
- Transgender- Female to Male

Primary Caregiver Health:

Script How is your health?

- Good
- Fair
- Poor
- No Response

Primary Caregiver Employment:

Script Are you employed?

- Full Time
- Homemaker
- Part Time
- Retired
- Unemployed

Primary Caregiver Availability:

Script First, I'd like to ask you about helping out your [Relationship of consumer -- Mom/Dad/Spouse/Friend]. When are you primarily available to provide help?

- Morning
- Afternoon
- Night
- Weekdays
- Weekends

Primary Caregiver Marital Status:

Script Are you married (if not spouse of consumer)?

- Yes
- No
- Not Applicable (Spouse of Consumer)

Primary Caregiver Dependents:

Script Do you have minor children or other dependents living in your home?

- 0
- 1 to 3
- 4 to 5
- More than 5

Other People to Care For:

Script Are there others that you care for on a regular basis?
### Primary Caregiver Information

- [ ] Yes
- [ ] No

### Frequency of Care:

- [ ] Daily
- [ ] Less than once a week
- [ ] At least once a week
- [ ] Several times a week
- [ ] Several times a month

### Symptoms of Dementia - In the last 7 days, has the consumer had problems with:

#### Judgment or Decision Making:

- [ ] Yes
- [ ] No
- [ ] Do not know
- [ ] Refused to answer

#### Less Interest or Pleasure in Doing Things, Hobbies or Activities:

- [ ] Yes
- [ ] No
- [ ] Do not know
- [ ] Refused to answer

#### Repeating the Same Things Over and Over Such as Questions or Stories:

- [ ] Yes
- [ ] No
- [ ] Do not know
- [ ] Refused to answer

#### Learning How to use a Tool, Appliance, or Gadget:

- [ ] Yes
- [ ] No
- [ ] Do not know
- [ ] Refused to answer

#### Forgetting the Correct Month or Year:

- [ ] Yes
- [ ] No
- [ ] Do not know
- [ ] Refused to answer

#### Handling Complicated Financial Affairs Such as Balancing Checkbook & Paying Bills:

- [ ] Yes
- [ ] No
- [ ] Do not know
- [ ] Refused to answer

#### Remembering Appointments:

- [ ] Yes
- [ ] No
# Symptoms of Dementia - In the last 7 days, has the consumer had problems with:

- [ ] Do not know
- [ ] Refused to answer

## Thinking or Memory:

**Script**

In the last 7 days, has the consumer had problems with:

- [ ] Yes
- [ ] No
- [ ] Do not know
- [ ] Refused to answer

# Behavioral Symptoms - In the past 7 days, has the consumer had problems with:

## Mental Symptoms:

**Script**

For the next group of questions, please keep in mind that we are surveying many different people across the state. Some of these people have dementia or other conditions that can lead to behavior problems. We are asking everyone these questions so we know who does and does not have behavioral problems. Specialist: Based on caregiver responses, appropriate referrals need to be made to Adult Protection and Common Entry Point. Log notes should reflect the action steps.

In the last 7 days, has the consumer had any of the following? Choose all that apply.

- [ ] Hallucinations (perceptual experiences in the absence of real external sensory stimuli)
- [ ] Illusions (misperceptions in the presence of real external sensory stimuli)
- [ ] Delusions (misconceptions or beliefs that are firmly held, contrary to reality)
- [ ] None of the above
- [ ] Do not know
- [ ] Refused to answer

## Being Stubborn, Agitated, Aggressive or Resistive to Help from Others:

**Script**

In the last 7 days, has the consumer had problems with:

- [ ] Yes
- [ ] No
- [ ] Do not know
- [ ] Refused to answer

## Feeling Anxious, Nervous, Tense, Fearful or Panic:

**Script**

In the last 7 days, has the consumer had problems with:

- [ ] Yes
- [ ] No
- [ ] Do not know
- [ ] Refused to answer

## Believing Others are Stealing from Them or Planning to Harm Them:

**Script**

In the last 7 days, has the consumer had problems with:

- [ ] Yes
- [ ] No
- [ ] Do not know
- [ ] Refused to answer

## Acting Impulsively, Without Thinking Through the Consequences of Their Actions:

**Script**

In the last 7 days, has the consumer had problems with:

- [ ] Yes
- [ ] No
- [ ] Do not know
- [ ] Refused to answer

## Wandering, Pacing, or Doing Things Repeatedly:

**Script**

In the last 7 days, has the consumer had problems with:

- [ ] Yes
- [ ] No
- [ ] Do not know
- [ ] Refused to answer
### Types and Length of Care

#### Types of Care:

- [ ] Personal care (help with bathing, dressing, using the toilet, getting in and out of the bath, or help with eating)
- [ ] Housekeeping (such as help with meal preparation, cleaning and laundry)
- [ ] Transportation
- [ ] Supervision for Safety
- [ ] Shopping and Errands
- [ ] Money Management
- [ ] Medications (set up, pick up, administer)
- [ ] Other

#### If Other Types of Care, Specify:

If other types of care, specify:

<table>
<thead>
<tr>
<th>Script</th>
<th>What other type of care do you expect to provide?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Length of Care:

- [ ] Never Helped Before
- [ ] 1-6 Months
- [ ] 7-12 Months
- [ ] 1-2 Years
- [ ] 3-5 Years
- [ ] Over 5 Years

#### Will Others Help You With Caregiving?:

- [ ] Yes
- [ ] No

#### How Often Will They Help?:

- [ ] No One Will Help
- [ ] Daily
- [ ] At least once a week
- [ ] Less than once a week
- [ ] Several times a week

#### Current Caregiver Support Services:

- [ ] None
- [ ] Care Coordination
- [ ] Care Planning
- [ ] Coaching
- [ ] Information
- [ ] Respite
- [ ] Support Groups
- [ ] Training
- [ ] Other

#### Other Current Caregiver Support Services:

<table>
<thead>
<tr>
<th>Script</th>
<th>What other caregiving services/supports are you receiving?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

#### Would You Like to be Contacted about Additional Caregiver Supports?:

- [ ] No
- [ ] Care Coordination
- [ ] Care Planning
- [ ] Coaching

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Types and Length of Care

- Information
- Respite
- Support Groups
- Training
- Other

Other Additional Caregiver Supports:

Script What other supports would you find helpful?

Reason Caregiver Information Not Complete

Reason Why Caregiver Information Not Completed:

- No Primary Caregiver Identified
- Refused to Participate
- Unable to Reach
- Consumer Refused to Provide Contact Information
- Consumer Requests No Caregiver Contact
- Other

Other Reason Why Caregiver Information Not Completed:

Script If the Caregiver Information screen was not completed, indicate other reason why.

Followup Record - Qtrly Outcome of Check In

Qtrly Outcome of Check In

Services Offered to Consumer/Caregiver:

Script What services were offered to the consumer/caregiver when conducting follow-up in the community?

- Advanced Care Planning (Ex: Financial Planner, Elder Law Attorney)
- Adult Day Service
- Adult Protection
- Caregiver Support Groups
- Chore Services
- Companion Services
- Congregate Dining
- Durable Medical Equipment
- Evidence Based Programs (Ex: Matter of Balance, Chronic Disease Self Mgmt.)
- Financial Assistance-Agency Referral
- Food Support (Ex: SNAP)
- Home Health Aides
- Home-Delivered Meals
- Homemaker Services
- Hospice
- Long-term Care Consultation (LTCC)/MNChoices Referral
- Medication Set Up
- Memory Support Services (Ex: Alzheimer's Association)
- Personal Emergency Response System (PERS)
- Personal Care Assistant (PCA)
- Referral to County Case Worker/Managed Care Coordinator
- Rehab Services (OT/PT/ST/RT)
- Respite Care
- Skilled Nursing
- Training for Informal Caregivers
- Transportation
- Veterans/CVSO Referral
- Not Applicable
- None
Qtrly Outcome of Check In

Services Accepted by Consumer/Caregiver:
- Advanced Care Planning (Ex: Financial Planner, Elder Law Attorney)
- Adult Day Service
- Adult Protection
- Caregiver Support Groups
- Chore Services
- Companion Services
- Congregate Dining
- Durable Medical Equipment
- Evidence Based Programs (Ex: Matter of Balance, Chronic Disease Self Mgmt.)
- Financial Assistance-Agency Referral
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- Respite Care
- Skilled Nursing
- Training for Informal Caregivers
- Transportation
- Veterans/CVSO Referral
- Not Applicable
- None

Outcome of Check In:
- Check In Completed/Next Follow Up Scheduled
- Check In Completed/Consumer Moving Out of State
- Check In Completed/Consumer Declines Further Contact
- Check In Not Completed/Consumer Readmitted to Nursing Facility
- Check In Not Completed/Consumer Declined Contact
- Check In Not Completed/Consumer Passed Away
- Check In Not Completed/Next Follow Up Scheduled
- Check In Not Completed/Part of Sampling
- Unable to Reach-Letter Sent to Consumer/Caregiver
- Check In Not Completed/Consumer Moved Out of State