SECTION A. Identification Information

1. NAME

a. (First) b. (Middle Initial) c. (Last) d. (Jr./Sr.)

2. GENDER

1 Male **2** Female

3. BIRTHDATE

4. MARITAL STATUS

1 Never married
2 Married
3 Partner / Significant other
4 Widowed
5 Separated
6 Divorced

5. NATIONAL NUMERIC IDENTIFIER

a. Social Security number

b. Medicare number (or comparable railroad insurance number)

c. Medicaid number *[Note: "+" if pending, "N" if not a Medicaid recipient]*

6. FACILITY / AGENCY PROVIDER NUMBER

7. CURRENT PAYMENT SOURCES

[Note: Billing Office to indicate]

0 No **1** Yes

a. Medicaid
b. Medicare
c. Self or family pays for full cost
d. Medicare with Medicaid co-payment
e. Private insurance
f. Other per diem

8. REASON FOR ASSESSMENT

1 First assessment
2 Routine reassessment
3 Return assessment
4 Significant change in status reassessment
5 Discharge assessment, covers last 3 days of service
6 Discharge tracking only
7 Other - e.g., research

9. ASSESSMENT REFERENCE DATE

10. PERSON'S EXPRESSED GOALS OF CARE

Enter primary goal in box at bottom

11. POSTAL / ZIP CODE OF USUAL LIVING ARRANGEMENT

12. RESIDENTIAL / LIVING STATUS AT TIME OF ASSESSMENT

1 Private home / apartment / rented room
2 Board and care
3 Assisted living or semi-independent living
4 Mental health residence - e.g., psychiatric group home
5 Group home for persons with physical disability
6 Setting for persons with intellectual disability
7 Psychiatric hospital or unit
8 Homeless (with or without shelter)
9 Long-term care facility (nursing home)
10 Rehabilitation hospital / unit
11 Hospice facility / palliative care unit
12 Acute care hospital
13 Correctional facility
14 Other

13. LIVING ARRANGEMENT

a. Lives

1 Alone
2 With spouse / partner only
3 With spouse / partner and other(s)
4 With child (not spouse / partner)
5 With parent(s) or guardian(s)
6 With sibling(s)
7 With other relative(s)
8 With nonrelative(s)

b. As compared to 90 DAYS AGO (or since last assessment), person now lives with someone new - e.g., moved in with another person, other moved in

0 No **1** Yes

c. Person or relative feels that the person would be better off living elsewhere

0 No
1 Yes, other community residence
2 Yes, institution

14. TIME SINCE LAST HOSPITAL STAY

Code for most recent instance in LAST 90 DAYS

0 No hospitalization within 90 days
1 31 - 90 days ago
2 15 - 30 days ago
3 8 - 14 days ago
4 In the last 7 days
5 Now in the hospital

SECTION B. Intake and Initial History

1. DATE CASE OPENED (this agency)

2. ETHNICITY AND RACE

0 No **1** Yes

Ethnicity

a. Hispanic or Latino

Race

b. American Indian or Alaska Native
c. Asian
d. Black or African American
e. Native Hawaiian or other Pacific Islander
f. White

3. PRIMARY LANGUAGE

1 English **2** Spanish **3** French **4** Other

4. RESIDENTIAL HISTORY OVER THE LAST 5 YEARS

Code for all settings person lived in during 5 YEARS prior to date case opened (Item B1)

0 No **1** Yes

a. Long-term care facility - e.g., nursing home
b. Board and care home, assisted living
c. Mental health residence - e.g., psychiatric group home
d. Psychiatric hospital or unit
e. Setting for persons with intellectual disability

SECTION C. Cognition

1. COGNITIVE SKILLS FOR DAILY DECISION MAKING
Making decisions regarding tasks of daily life - e.g., when to get up or have meals, which clothes to wear or activities to do

- **0** **Independent** - Decisions consistent, reasonable, and safe
- **1** **Modified independence** - Some difficulty in new situations only
- **2** **Minimally impaired** - In specific recurring situations, decisions become poor or unsafe; cues / supervision necessary at those times
- **3** **Moderately impaired** - Decisions consistently poor or unsafe; cues / supervision required at all times
- **4** **Severely impaired** - Never or rarely makes decisions
- **5** **No discernable consciousness, coma** [Skip to Section G]

2. MEMORY / RECALL ABILITY
Code for recall of what was learned or known

- **0** Yes, memory OK
- **1** Memory problem

a. **Short-term memory OK** - Seems / appears to recall after 5 minutes
b. **Procedural memory OK** - Can perform all or almost all steps in a multitask sequence without cues
c. **Situational memory OK** - Both: recognizes caregivers' names / faces frequently encountered AND knows location of places regularly visited (bedroom, dining room, activity room, therapy room)

3. PERIODIC DISORDERED THINKING OR AWARENESS
[Note: Accurate assessment requires conversations with staff, family, or others who have direct knowledge of the person's behavior over this time]

- **0** Behavior not present
- **1** Behavior present, consistent with usual functioning
- **2** Behavior present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)

a. **Easily distracted** - e.g., episodes of difficulty paying attention; gets sidetracked
b. **Episodes of disorganized speech** - e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought
c. **Mental function varies over the course of the day** - e.g., sometimes better, sometimes worse

4. ACUTE CHANGE IN MENTAL STATUS FROM PERSON'S USUAL FUNCTIONING- *e.g., restlessness, lethargy, difficult to arouse, altered environmental perception*

0 No **1** Yes

5. CHANGE IN DECISION MAKING AS COMPARED TO 90 DAYS AGO (OR SINCE LAST ASSESSMENT)

- **0** Improved
- **1** No change
- **2** Declined
- **8** Uncertain

SECTION D. Communication and Vision

1. MAKING SELF UNDERSOOD (Expression)
Expressing information content - both verbal and nonverbal

- **0** **Understood** - Expresses ideas without difficulty
- **1** **Usually understood** - Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required
- **2** **Often understood** - Difficulty finding words or finishing thoughts AND prompting usually required
- **3** **Sometimes understood** - Ability is limited to making concrete requests
- **4** **Rarely or never understood**

2. ABILITY TO UNDERSTAND OTHERS (Comprehension)
Understanding verbal information content (however able; with hearing appliance normally used)

- **0** **Understands** - Clear comprehension
- **1** **Usually understands** - Misses some part / intent of message BUT comprehends most conversation
- **2** **Often understands** - Misses some part / intent of message BUT with repetition or explanation can often comprehend conversation
- **3** **Sometimes understands** - Responds adequately to simple, direct communication only
- **4** **Rarely or never understands**

3. HEARING - *Ability to hear (with hearing appliance normally used)*

- **0** **Adequate** - No difficulty in normal conversation, social interaction, listening to TV
- **1** **Minimal difficulty** - Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet (2 meters) away)
- **2** **Moderate difficulty** - Problem hearing normal conversation, requires quiet setting to hear well
- **3** **Severe difficulty** - Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
- **4** **No hearing**

4. VISION - *Ability to see in adequate light (with glasses or with other visual appliance normally used)*

- **0** **Adequate** - Sees fine detail, including regular print in newspapers/books
- **1** **Minimal difficulty** - Sees large print, but not regular print in newspapers/books
- **2** **Moderate difficulty** - Limited vision; not able to see newspaper headlines, but can identify objects
- **3** **Severe difficulty** - Object identification in question, but eyes appear to follow objects; sees only light, colors, shapes
- **4** **No vision**

SECTION E. Mood and Behavior

1. INDICATORS OF POSSIBLE DEPRESSED, ANXIOUS, OR SAD MOOD
Code for indicators observed in last 3 days, irrespective of the assumed cause [Note: Whenever possible, ask person]

- **0** Not present
- **1** Present but not exhibited in last 3 days
- **2** Exhibited on 1-2 of last 3 days
- **3** Exhibited daily in last 3 days

a. **Made negative statements** - e.g., "Nothing Matters"; "Would rather be dead"; "What's the use"; "Regret having lived so long"; "Let me die"
b. **Persistent anger with self or others** - e.g., easily annoyed, anger at care received
c. **Expressions, including nonverbal, of what appear to be unrealistic fears** - e.g., fear of being abandoned, being left alone, being with others; intense fear of specific objects or situations
d. **Repetitive health complaints -** e.g., persistently seeks medical attention, incessant concern with body functions
e. **Repetitive anxious complaints / concerns** (non-health related) - e.g., persistently seeks attention / reassurance regarding schedules,meals, laundry, clothing, relationships
f. **Sad, pained or worried facial expressions** - e.g., furrowed brow, constant frowning
g. **Crying, tearfulness**
h. **Recurrent statements that something terrible is about to happen** – believes he or she is about to die, have a heart attack
i. **Withdrawal from activities of interest** - e.g., long standing activities, being with family / friends
j. **Reduced social interactions**
k. **Expressions, including nonverbal, of a lack of pleasure in life (anhedonia) -** e.g., "I don't enjoy anything anymore"

2. SELF-REPORTED MOOD

0 Not in last 3 days
1 Not in last 3 days, but often feels that way
2 In 1-2 of last 3 days
3 Daily in the last 3 days
8 Person could not (would not) respond

Ask: "In the last 3 days, how often have you felt..."

a. Little interest or pleasure in things you normally enjoy? ☐
b. Anxious, restless, or uneasy? ☐
c. Sad, depressed, or hopeless? ☐

3. BEHAVIOR SYMPTOMS

Code for indicators observed, irrespective of the assumed cause

0 Not present
1 Present but not exhibited in last 3 days
2 Exhibited on 1-2 of last 3 days
3 Exhibited daily in last 3 days

a. **Wandering** - Moved with no rational purpose, seemingly oblivious to needs or safety ☐
b. **Verbal abuse** - e.g., others were threatened, screamed at, cursed at ☐
c. **Physical abuse** - e.g., others hit, shoved, scratched, sexually abused ☐
d. **Socially inappropriate or disruptive behavior** - e.g., made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through other's belongings ☐
e. **Inappropriate public sexual behavior or public disrobing** ☐
f. **Resists care** - e.g., taking medications/injections, ADL assistance, eating ☐

SECTION F. Psychosocial Well-Being

1. SOCIAL RELATIONSHIPS

[Note: Whenever possible, ask person]

0 Never
1 More than 30 days ago
2 8-30 days ago
3 4-7 days ago
4 In last 3 days
8 Unable to determine

a. Participation in social activities of long-standing interest ☐
b. Visit with a long-standing social relation or family member ☐
c. Other interaction with long-standing social relation or family member - e.g., telephone, e-mail ☐
d. Conflict or anger with family or friends ☐
e. Fearful of a family member or close acquaintance ☐
f. Neglected, abused, or mistreated ☐

2. LONELY ☐

Says or indicates that he / she is lonely

0 No **1** Yes

3. CHANGE IN SOCIAL ACTIVITIES IN LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO) ☐

Decline in level of participation in social, religious, occupational, or other preferred activities

IF THERE WAS A DECLINE, person is distressed by this fact

0 No decline **1** Decline, not distressed **2** Decline, distressed

4. LENGTH OF TIME ALONE DURING THE DAY (MORNING AND AFTERNOON) ☐

0 Less than 1 hour **1** 1-2 hours
2 More than 2 hours but less than 8 hours **3** 8 hours or more

5. MAJOR LIFE STRESSORS IN LAST 90 DAYS - e.g., episode of severe personal illness; death or severe illness of close family member / friend; loss of home; major loss of income / assets; victim of a crime such as robbery or assault; loss of driving license / car ☐

0 No **1** Yes

SECTION G. Functional Status

1. IADL SELF-PERFORMANCE AND CAPACITY

Code for PERFORMANCE in routine activities around the home or in the community during the LAST 3 DAYS

Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.

0 **Independent** - No help, setup, or supervision
1 **Setup help only**
2 **Supervision** - Oversight / cuing
3 **Limited assistance** - Help on some occasions
4 **Extensive assistance** - Help throughout task, but performs 50% or more of task on own
5 **Maximal assistance** - Help throughout task, but performs less than 50% of task on own
6 **Total dependence** - Full performance by others during entire period
8 **Activity did not occur** - During entire period
[DO NOT USE THIS CODE IN SCORING CAPACITY]

	Performance	Capacity
a. **Meal preparations** - How meals are prepared (e.g. planning meals, assembling ingredients, cooking, setting out food and utensils)	☐	☐
b. **Ordinary housework** - How ordinary work around the house is performed (e.g. doing dishes, dusting, making bed, tidying up, laundry)	☐	☐
c. **Managing finances** - How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored	☐	☐
d. **Managing medications** - How medications are managed (e.g., remembering to take medications, opening bottles, taking correct drug dosages, giving injections, applying ointments)	☐	☐
e. **Phone Use** - How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)	☐	☐
f. **Stairs** - How full flight of stairs is managed (12 - 14 stairs)	☐	☐
g. **Shopping** - How shopping is performed for food and household items (e.g., selecting items, paying money) - EXCLUDE TRANSPORTATION	☐	☐
h. **Transportation** - How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles)	☐	☐

2. ADL SELF-PERFORMANCE AND CAPACITY

Code for PERFORMANCE by considering all episodes over the LAST 3 DAYS.
If all episodes are performed at the same level, score ADL at that level. If any episodes at level 6, and other less dependent, score ADL as a 5.

Otherwise, focus on the three most dependent episodes [or all episodes if performed fewer than 3 times]. If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2-5.

Code for CAPACITY based on presumed ability to carry out activity as independently as possible.

- **0** **Independent** - No physical assistance, setup, or supervision in any episode
- **1** **Independent, setup help only** - Article or device provided or placed within reach, no physical assistance or supervision in any episode
- **2** **Supervision** - Oversight / cuing
- **3** **Limited assistance** - Guided maneuvering of limbs, physical guidance without taking weight
- **4** **Extensive assistance** - Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks
- **5** **Maximal assistance** - Weight-bearing support (including lifting limbs) by 2+ helpers - OR - Weight-bearing support for more than 50% of subtasks
- **6** **Total dependence** - Full performance by others during all episodes
- **8** **Activity did not occur during entire period** *[DO NOT USE THIS CODE IN SCORING CAPACITY EXCEPT FOR WALKING]*

	Performance	Capacity
a. **Bathing -** How takes a full-body bath / shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area - EXCLUDE WASHING OF BACK AND HAIR	☐	☐
b. **Personal hygiene -** How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS	☐	☐
c. **Dressing upper body -** How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.	☐	☐
d. **Dressing lower body -** How dresses and undresses (street clothes, underwear) from the waist down, including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.	☐	☐
e. **Walking -** How walks between locations on same floor indoors	☐	☐
f. **Locomotion** - How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair	☐	☐
g. **Transfer toilet -** How moves on and off toilet or commode	☐	☐
h. **Toilet use -** How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET	☐	☐
i. **Bed mobility -** How moves to and from lying position, turns from side to side, and positions body while in bed	☐	☐
j. **Eating -** How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	☐	☐
k. **Transfer** - How moves in and out of a bed or chair.	☐	☐

3. LOCOMOTION / WALKING

a. Primary mode of locomotion ☐

- **0** Walking, no assistive device
- **1** Walking, uses assistive device - e.g., cane, walker, crutch,Pushing wheelchair
- **2** Wheelchair, scooter
- **3** Bed-bound

b. Timed 4-meter (13-foot) walk ☐

Lay out a straight, unobstructed course. Have person stand in still position, feet just touching start line. ***Then say: "When I tell you begin to walk at a normal pace (with cane/walker if used). This is not a test of how fast you can walk. Stop when I tell you to stop, is this clear?"*** *Assessor may demonstrate test.* ***Then say: "Begin to walk now."*** *Start stopwatch (or can count seconds) when first foot falls. End count when foot falls beyond 4-meter mark.* ***Then say: "You may stop now."***

Enter time in seconds, up to 30 seconds

- **30** 30 or more seconds to walk 4 meters
- **77** Stopped before test complete
- **88** Refused to do the test
- **99** Not tested - e.g., does not walk on own

c. Distance walked - Farthest distance walked at one time without sitting down in the LAST 3 DAYS (with support as needed) ☐

- **0** Did not walk
- **1** Less than 15 feet (under 5 meters)
- **2** 15-149 feet (5-49 meters)
- **3** 150-299 feet (50-99 meters)
- **4** 300+ feet (100+ meters)
- **5** 1/2 mile or more(1+ kilometers)

d. Distance wheeled self - Farthest distance wheeled self at one time in the LAST 3 DAYS (includes independent use of motorized wheelchair) ☐

- **0** Wheeled by others
- **1** Used motorized wheelchair / scooter
- **2** Wheeled self less than 15 feet (under 5 meters)
- **3** Wheeled self 15-149 feet (5-49 meters)
- **4** Wheeled self 150-299 feet (50-99 meters)
- **5** Wheeled self 300+ feet (100+ meters)
- **8** Did not use wheelchair

4. ACTIVITY LEVEL

a. **Total hours of exercise or physical activity in LAST 3 DAYS** - e.g., walking ☐

- **0** None
- **1** Less than 1 hour
- **2** 1-2 hours
- **3** 3-4 hours
- **4** More than 4 hours

b. **In LAST 3 DAYS, number of days went out of the house or building in which he / she resides** (no matter how short the period) ☐

- **0** No days out
- **1** Did not go out in last 3 days, but usually goes out over a 3-day period
- **2** 1-2 days
- **3** 3 days

5. PHYSICAL FUNCTION IMPROVEMENT POTENTIAL

0 No **1** Yes

a. Person believes he / she is capable of improved performance in physical function ☐

b. Care professional believes person is capable of improved performance in physical function ☐

6. CHANGE IN ADL STATUS AS COMPARED TO 90 DAYS AGO, OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO ☐

- **0** Improved
- **1** No change
- **2** Declined
- **3** Uncertain

7. DRIVING

a. Drove car (vehicle) in the LAST 90 DAYS ☐

0 No **1** Yes

b. If drove in the LAST 90 DAYS, assessor is aware that someone has suggested that person limits OR stops driving ☐

0 No **1** Yes

SECTION H. Continence

1. BLADDER CONTINENCE

- **0** **Continent** - Complete control; DOES NOT USE any type of catheter or other urinary collection device
- **1** **Control with any catheter or ostomy** over last 3 days
- **2** **Infrequently incontinent** - Not incontinent over last 3 days, but does have incontinent episodes
- **3** **Occasionally incontinent** - Less than daily
- **4** **Frequently incontinent** - Daily, but some control present
- **5** **Incontinent** - No control present
- **8** Did not occur - No urine output from bladder in last 3 days

2. URINARY COLLECTION DEVICE [Exclude pads / briefs]

- **0** None
- **1** Condom catheter
- **2** Indwelling catheter
- **3** Cystostomy, nephrostomy, ureterostomy

3. BOWEL CONTINENCE

- **0** **Continent** - Complete control; DOES NOT USE any type of ostomy device
- **1** **Control with ostomy** - Control with ostomy device over last 3 days
- **2** **Infrequently incontinent** - Not incontinent over last 3 days, but does have incontinent episodes
- **3** **Occasionally incontinent** - Less than daily
- **4** **Frequently incontinent** - Daily, but some control present
- **5** **Incontinent** - No control present
- **8** **Did not occur** - No bowel movement in the last 3 days

4. PADS OR BRIEFS WORN

0 No **1** Yes

SECTION I. Disease Diagnoses

Disease code

- **0** Not present
- **1** Primary diagnosis/diagnoses for current stay
- **2** Diagnosis present, receiving active treatment
- **3** Diagnosis present, monitored but no active treatment

1. DISEASE DIAGNOSES

Musculoskeletal

a. Hip fracture during last 30 days (or since last assessment if less than 30 days)

b. Other fracture during last 30 days (or since last assessment if less than 30 days)

Neurological

c. Alzheimer's disease

d. Dementia other than Alzheimer's disease

e. Hemiplegia

f. Multiple sclerosis

g. Paraplegia

h. Parkinson's disease

i. Quadriplegia

j. Stroke / CVA

Cardiac or Pulmonary

k. Coronary heart disease

l. Chronic obstructive pulmonary disease

m. Congestive heart failure

Psychiatric

n. Anxiety

o. Bipolar disorder

p. Depression

q. Schizophrenia

Infections

r. Pneumonia

s. Urinary tract infection in last 30 days

Other

t. Cancer

u. Diabetes mellitus

2. DISEASE DIAGNOSES

Diagnosis	*Disease Code*	*ICD Code*
a. _____		
b. _____		
c. _____		
d. _____		
e. _____		
f. _____		
g. _____		
h. _____		
i. _____		
j. _____		

SECTION J. Health Conditions

1. FALLS

- **0** No fall in last 90 days
- **1** No fall in last 30 days, but fell 31-90 days ago
- **2** One fall in last 30 days
- **3** Two or more falls in last 30 days

2. RECENT FALLS

[Skip if last assessment is more than 30 days ago of if this is first assessment]

- **0** No
- **1** Yes
- [blank] Not applicable (first assessment, or more than 30 days since last assessment)

3. PROBLEM FREQUENCY

Code for presence in last 3 days

0 Not present
1 Present but not exhibited in last 3 days
2 Exhibited on 1 of last 3 days
3 Exhibited on 2 of last 3 days
4 Exhibited daily in last 3 days

Balance

a. Difficult or unable to move self to standing position unassisted
b. Difficult or unable to turn self around and face the opposite direction when standing
c. Dizziness
d. Unsteady gait

Cardiac or Pulmonary

e. Chest pain
f. Difficulty clearing airway secretions

Psychiatric

g. Abnormal thought process - e.g., loosening of associations, blocking, flight of ideas, tangentiality, circumstantiality
h. Delusions - Fixed false beliefs
i. Hallucinations - False sensory perceptions

Neurological

j. Aphasia

GI Status

k. Acid reflux - Regurgitation of acid from stomach to throat
l. Constipation - No bowel movement in 3 days or difficult passage of hard stool
m. Diarrhea
n. Vomiting

Sleep Problems

o. Difficulty falling asleep or staying asleep; waking up too early; restlessness; non-restful sleep
p. Too much sleep - Excessive amount of sleep that interferes with person's normal functioning

Other

q. Aspiration
r. Fever
s. GI or GU bleeding
t. Hygiene - Unusually poor hygiene, unkempt, disheveled
u. Peripheral edema

4. DYSPNEA (Shortness of breath)

0 Absence of symptom
1 Absent at rest, but present when performed moderate activities
2 Absent at rest, but present when performed day-to-day activities
3 Present at rest

5. FATIGUE - *Inability to complete normal daily activities - e.g., ADLs, IADLs*

0 **None**
1 **Minimal** - Diminished energy but completes normal day-to-day activities
2 **Moderate** - Due to diminished energy, UNABLE TO FINISH normal day-to-day activities
3 **Severe** - Due to diminished energy, UNABLE TO START SOME normal day-to-day activities
4 **Unable to commence any normal day-to-day activities** - Due to diminished energy

6. PAIN SYMPTOMS

[Note: Always ask the person about pain frequency, intensity, and control. Observe person and ask others who are in contact with the person.]

a. **Frequency with which person complains or shows evidence of pain** [including grimacing, teeth clenching, moaning, withdrawal when touched, or other nonverbal signs suggesting pain]

0 No pain
1 Present but not exhibited in last 3 days
2 Exhibited on 1-2 of last 3 days
3 Exhibited daily in last 3 days

b. **Intensity of highest level of pain present**

0 No pain
1 Mild
2 Moderate
3 Severe
4 Times when pain is horrible or excruciating

c. **Consistency of pain**

0 No pain
1 Single episode during last 3 days
2 Intermittent
3 Constant

d. **Breakthrough pain** - Times in LAST 3 DAYS when person experienced sudden, acute flare-ups of pain

0 No **1** Yes

e. **Pain Control** - Adequacy of current therapeutic regimen to control pain (from person's point of view)

0 No issue of pain
1 Pain intensity acceptable to person; no treatment regimen or change in regimen required
2 Controlled adequately by therapeutic regimen
3 Controlled when therapeutic regimen followed, but not always followed as ordered
4 Therapeutic regimen followed, but pain control not adequate
5 No therapeutic regimen being followed for pain; pain not adequately controlled

7. INSTABILITY OF CONDITIONS

0 No **1** Yes

a. **Conditions** / diseases make cognitive, ADL, mood, or behavior patterns unstable (fluctuating, precarious, or deteriorating)
b. **Experiencing** an acute episode, or a flare-up of a recurrent or chronic problem
c. **End-stage** disease, 6 or fewer months to live

8. SELF-REPORTED HEALTH

Ask: "In general, how would you rate your health?"

0 Excellent
1 Good
2 Fair
3 Poor
8 Could not (would not) respond

9. TOBACCO AND ALCOHOL

a. Smokes tobacco daily

0 No
1 Not in last 3 days, but is usually a daily smoker
2 Yes

b. Alcohol - Highest number of drinks in any "single sitting" in the LAST 14 DAYS

0 None **2** 2-4
5 1 **3** 5 or more

SECTION K. Oral and Nutritional Status

1. HEIGHT AND WEIGHT [INCHES AND POUNDS]

Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in LAST 30 DAYS.

a. **HT** (in.)
b. **WT** (lb).

2. NUTRITIONAL ISSUES

0 No **1 Yes**

a. Weight loss of 5% or more in LAST 30 DAYS or 10% or more in LAST 180 DAYS
b. Dehydrated or BUN / Cre ratio > 25
c. Fluid intake less than 1,000 cc per day (less than four 8 oz cups/day)
d. Fluid output exceeds input

3. MODE OF NUTRITIONAL INTAKE

- **0** **Normal** - Swallows all types of food
- **1** **Modified independent** - e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
- **2** **Requires diet modification to swallow solid food** - e.g., mechanical diet (e.g., puree, minced, etc.) or only able to ingest specific foods
- **3** **Requires modification to swallow liquids** - e.g., thickened liquids
- **4** **Can swallow only pureed solids** - AND - thickened liquids
- **5** **Combined oral and parenteral or tube feeding**
- **6** **Nasogastric tube feeding only**
- **7** **Abdominal feeding tube** - e.g., PEG tube
- **8** **Parenteral feeding only** - Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)
- **9** **Activity did not occur** - During entire period

4. DENTAL OR ORAL

0 No **1** Yes

a. **Wears** a denture (removable prosthesis)
b. Has **broken**, fragmented, loose, or otherwise non-intact natural teeth
c. **Reports** having dry mouth
d. **Reports** difficulty chewing

SECTION L. Skin Condition

1. MOST SEVERE PRESSURE ULCER

- **0** No pressure ulcer
- **1** Any area of persistent skin redness
- **2** Partial loss of skin layers
- **3** Deep craters in the skin
- **4** Breaks in skin exposing muscle or bone
- **5** Not codeable, e.g., necrotic eschar predominant

2. PRIOR PRESSURE ULCER

0 No **1** Yes

3. PRESENCE OF SKIN ULCER OTHER THAN PRESSURE ULCER - e.g., venous ulcer, arterial ulcer, mixed venous-arterial ulcer, diabetic foot ulcer

0 No **1** Yes

4. MAJOR SKIN PROBLEMS - e.g., lesions, 2nd - or 3rd-degree burns, healing surgical wounds

0 No **1** Yes

5. SKIN TEARS OR CUTS - Other than surgery

0 No **1** Yes

6. OTHER SKIN CONDITIONS OR CHANGES IN SKIN CONDITION - e.g., bruises, rashes, itching, mottling, herpes zoster, intertrigo, eczema

0 No **1** Yes

7. FOOT PROBLEMS - e.g., bunions, hammertoes, overlapping toes, structural problems, infections, ulcers

0 No **1** Yes

SECTION M. Medications

1. LIST OF ALL MEDICATIONS

List all active prescriptions, and any non-prescribed (over-the-counter) medications taken in the LAST 3 DAYS

[Note: Use computerized records if possible; hand enter only when absolutely necessary]

For each drug record:

a. **Name**

b. **Dose -** A positive number such as 0.5, 5, 150, 300.
[Note: Never write a zero by itself after a decimal point (X mg). Always use a zero before a decimal point (0.X mg).]

c. **Unit** - Code using the following list:

gtts (drops)	**mEq** (milli-equivalent)	**puffs**
gm (gram)	**mg** (milligram)	**%** (percent)
L (liters)	**ml** (milliliter)	**units**
Mcg (microgram)	**oz** (ounce)	**OTH** (other)

d. **Route of administration** - Code using the following list:

PO (by mouth/oral)	**REC** (rectal)	**ET** (enteral tube)
SL (sublingual)	**TOP** (topical)	**TD** (transdermal)
IM (intramuscular)	**IH** (inhalation)	**EYE** (eye)
IV (intravenous)	**NAS** (nasal)	**OTH** (other)
Sub-Q (subcutaneous)		

e. **Freq** - Code the number of times per day, week, or month the medication is administered using the following list:

Q1H (every hour)	**5D** (5 times daily)
Q2H (every 2 hours)	**Q2D** (every other day)
Q3H (every 3 hours)	**Q3D** (every 3 days)
Q4H (every 4 hours)	**Weekly**
Q6H (every 6 hours)	**2W** (2 times weekly)
Q8H (every 8 hours)	**3W** (3 times weekly)
Daily	**4W** (4 times weekly)
BED (at bedtime)	**5W** (5 times weekly)
BID (2 times daily) (includes every 12 hrs)	**6W** (6 times weekly)
TID (3 times daily)	**1M** (monthly)
QID (4 times daily)	**2M** (twice every month)
	OTH (other)

f. **PRN**

0 No **1** Yes

g. **Computer-entered drug code**

	a. Name	b. Dose	c. Unit	d. Route	e. Freq	f. PRN	g. ATC or NOC Code
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							

a. Name	b. Dose	c. Unit	d. Route	e. Freq	f. PRN	g. ATC or NOC Code
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						

2. ALLERGY TO ANY DRUG ☐
0 No known drug allergies **1** Yes

3. ADHERENT WITH MEDICATIONS PRESCRIBED BY PHYSICIAN ☐
0 Always adherent
1 Adherent 80% of time or more
2 Adherent less than 80% of time, including failure to purchase prescribed medications
8 No medications prescribed

SECTION N. Treatments and Procedures

1. PREVENTION
0 No **1** Yes

a. Blood pressure measured in LAST YEAR ☐
b. Colonoscopy test in LAST 5 YEARS ☐
c. Dental exam in LAST YEAR ☐
d. Eye exam in LAST YEAR ☐
e. Hearing exam in LAST 2 YEARS ☐
f. Influenza vaccine in LAST YEAR ☐
g. Mammogram or breast exam in LAST 2 YEARS (for women) ☐
h. Pneumovax vaccine in LAST 5 YEARS or after age 65 ☐

2. TREATMENTS AND PROGRAMS RECEIVED OR SCHEDULED IN THE LAST 3 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 3 DAYS)
0 Not ordered AND did not occur
1 Ordered, not implemented
2 1-2 of last 3 days
3 Daily in last 3 days

Treatments
a. Chemotherapy ☐
b. Dialysis ☐
c. Infection control - e.g., isolation, quarantine ☐
d. IV medication ☐
e. Oxygen therapy ☐
f. Radiation ☐
g. Suctioning ☐
h. Tracheostomy care ☐
i. Transfusion ☐
j. Ventilator or respirator ☐
k. Wound care ☐

Programs
l. Scheduled toileting program ☐
m. Palliative care program ☐
n. Turning / repositioning program ☐

3. FORMAL CARE
Days (A) and Total minutes (B) of care in the last 7 days
Extent of care/treatment in LAST 7 DAYS (or since last assessment or admission, if less than 7 days) involving:

	(A) # of Days	(B) Total Minutes In last week
a. Home health aides	☐	
b. Home nurse	☐	
c. Homemaking services	☐	
d. Meals	☐	
e. Physical therapy	☐	
f. Occupational therapy	☐	
g. Speech-language pathology and audiology services	☐	
h. Psychological therapy (by any licensed mental health professional)	☐	

4. HOSPITAL USE, EMERGENCY ROOM USE, PHYSICIAN VISIT
Code for number of times during the LAST 90 DAYS (or since last assessment if LESS THAN 90 DAYS)

a. Inpatient acute hospital with overnight stay ☐
b. Emergency room visit (not counting overnight stay) ☐
c. Physician visit (or authorized assistant or practitioner) ☐

5. PHYSICALLY RESTRAINED - Limbs restrained, used bed rails, restrained to chair when sitting ☐
0 No **1** Yes

SECTION O. Responsibility

1. LEGAL GUARDIAN
0 No **1 Yes** ☐

SECTION P. Social Supports

1. TWO KEY INFORMAL HELPERS

a. Relationship to person — Helper 1. ☐ 2. ☐

1 Child or child-in-law
2 Spouse
3 Partner/significant other
4 Parent/guardian
5 Sibling
6 Other relative
7 Friend
8 Neighbor
9 No informal helper

b. Lives with person ☐ ☐

0 No
1 Yes, 6 months or less
2 Yes, more than 6 months
8 No informal helper

Areas of Informal Help during Last 30 days

c. IADL help ☐ ☐
d. ADL help ☐ ☐

2. INFORMAL HELPER STATUS
0 No **1** Yes

a. Informal helper(s) is unable to continue caring activities - e.g., decline in health of helper makes it difficult to continue ☐
b. Primary informal helper expresses feelings of distress, anger, or depression ☐
c. Family or close friends report feeling overwhelmed by person's illness ☐

3. HOURS OF INFORMAL CARE AND ACTIVE MONITORING ☐

DURING LAST 3 DAYS

For instrumental and personal activities of daily living in the LAST 3 DAYS, indicate the total number of hours of help received from all family, friends, and neighbors

4. STRONG AND SUPPORTIVE RELATIONSHIP WITH FAMILY ☐

0 No **1** Yes

5. LOSS OF PRIMARY CAREGIVER IN THE PAST 6 MONTHS ☐

0 No **1** Yes

SECTION Q. Environmental Assessment

1. HOME ENVIRONMENT

Code for any of the following that make home environment hazardous or uninhabitable (if temporarily in institution, base assessment on home visit)

0 No **1** Yes

a. **Disrepair of the home** - e.g., hazardous clutter; inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors; holes in floor; leaking pipes ☐

b. **Squalid condition** - e.g., extremely dirty, infestation by rats or bugs ☐

c. **Inadequate heating or cooling** - e.g., too hot in summer, too cold in winter ☐

d. **Lack of personal safety** - e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street ☐

e. **Limited access to home or rooms in home** - e.g., difficulty entering or leaving home, unable to climb stairs, difficulty maneuvering within rooms, no railings although needed

2. LIVES IN APARTMENT OR HOUSE RE-ENGINEERED ACCESSIBLE FOR PERSON WITH DISABILITIES ☐

0 No **1** Yes

3. OUTSIDE ENVIRONMENT

0 No **1** Yes

a. **Availability of emergency assistance** - e.g., telephone, alarm, response system ☐

b. **Accessibility to grocery store without assistance** ☐

c. **Availability of home delivery of groceries** ☐

d. **Access to adequate transportation** ☐

4. FINANCES ☐

Because of limited funds, during the last 30 days made trade-offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heat or cooling; necessary health care

0 No **1** Yes

SECTION R. Discharge Potential and Overall Status

1. ONE OR MORE CARE GOALS MET IN THE LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS) ☐

0 No **1** Yes

2. OVERALL SELF-SUFFICIENCY HAS CHANGED SIGNIFICANTLY AS COMPARED TO STATUS OF 90 DAYS AGO (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS) ☐

0 Improved [Skip to Section S]
1 No change [Skip to Section S]
2 Deteriorated

CODE THE FOLLOWING THREE ITEMS IF "DETERIORATED" IN LAST 90 DAYS - *OTHERWISE* SKIP TO SECTION S

3. NUMBER OF 10 ADL AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION ☐

4. NUMBER OF 8 IADL AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION ☐

5. TIME OF ONSET OF THE PRECIPITATING EVENT OR PROBLEM RELATED TO DETERIORATION ☐

0 Within 7 days
1 8-14 days ago
2 15-30 days ago
3 31-60 days ago
4 More than 60 days ago
8 No clear precipitating event

SECTION S. Discharge

[Note: Complete Section S at Discharge only]

1. LAST DAY OF STAY ☐

2. RESIDENTIAL / LIVING STATUS AFTER DISCHARGE ☐

1 Private home / apartment / rented room
2 Board and care
3 Assisted living or semi-independent living
4 Mental health residence - e.g., psychiatric group home
5 Group home for persons with physical disability
6 Setting for persons with intellectual disability
7 Psychiatric hospital or unit
8 Homeless (with or without shelter)
9 Long-term care facility (nursing home)
10 Rehabilitation hospital / unit
11 Hospice facility / palliative care unit
12 Acute care hospital
13 Correctional facility
14 Other
15 Deceased

SECTION Supplemental, Skilled Level of Care

(See attached Narrative)

1. Seizure ☐

Is nursing level intervention required for the safe management of uncontrolled seizures?

0 No 1 Yes

a. What is the medical condition that is causing seizures (if known)?

b. Identify the frequency of seizures and how long they last.

c. What symptoms does the individual display when seizing? Including if the individual loses consciousness or sleeps for a long time after the seizure.

d. What is the seizure management plan?

e. Is medication administered if seizures last more than 3-5 minutes?

f. When was the last time medication was administered during a seizure?

g. Does the individual have a history of ER visits for seizures? And if so, what has been the outcome?

2. Medical Observation ☐

Is medical observation and physician assessment required at least every 30 days due to a changing, unstable physical condition (evidenced by changes in orders related to medications, diet, oxygen levels, other treatments, etc.)? Note: routine doctor visits/treatments does not mean the condition is unstable.

0 No **1** Yes

a. What is the unstable and changing medical impairment that justifies this need?

b. Does the individual require nursing intervention/observation until the condition stabilizes?

c. How long has the condition been considered unstable?

d. What dates in the past month did the individual visit/contact the doctor? (list dates, type of physician, reason for visit, and treatment provided)?

3. Acute Rehab

Is direct assistance from others required for special routines or prescribed treatments that must be followed at least five (5) days per week as part of acute rehabilitative Physical Therapy, Occupational Therapy, and/or Speech Therapy? General strengthening exercise programs and habilitation are excluded.

0 No 1 Yes

Acute Rehabilitation Condition means a recent medical injury or insult, onset occurring within the last six months, which results in impaired functioning. These conditions may include, but are not limited to, head injury, CVA (stroke), or hip fracture. The therapy must be of such complexity and sophistication and the condition of the individual must be such that the judgment, knowledge, and skills of a qualified therapist are required. This is as opposed to habilitative services which are provided to individuals with long term, chronic conditions (ICF/ID) and are intended to develop skills the individual never previously had.

a. List the type of therapy/therapies being performed and their frequency.

b. How long are the therapies expected to last?

4. Injections

Is direct assistance from others required to administer physician prescribed medicine (excluding vitamins) by intramuscular, intravenous, or subcutaneous injection more than one (1) time per day? (Note: other than insulin injections for an individual whose diabetes is under control)

0 No **1 Yes**

a. What medical condition requires injections?
b. What is the prescribed medication and its purpose?
c. How often are the injections required?
d. How are the injections administered?
e. Who provides this care?

5. Continuous Oxygen

Is nursing level intervention required for the safe management of continuous oxygen? **0 No** **1 Yes**

a. Why is this individual prescribed oxygen?
b. What is the liter flow?
c. Are oxygen sats required/monitored?
d. Are O2 sats unstable, requiring adjustments to the liter flow? (if the answer is no to c or d, note that this individual likely does not meet the qualifications of skilled care).

SECTION Supplemental, IC Level of Care

(See attached Narrative)

1. Fluids and Solids

Does the individual require daily recording of the kind and amounts of fluids and solids intake and output?

0 No 1 Yes

a. Is there a physician order for input and output?
b. How often is it ordered?
c. Why is monitoring required?
d. Who is monitoring?

2. Passive ROM

Does the individual require assistance with passive range of motion exercise on a daily basis per medical plan of care?

0 No **1** Yes

a. What is the medical impairment justifying this need?
b. How often is passive ROM completed?
c. Who provides this assistance?

3. Nursing 24/7 monitoring

To maintain a stable medical condition, does the individual require monitoring of his or her health care plan on a 24 hour a day, seven day a week basis by a licensed nurse?

0 No **1** Yes

a. What is the stable medical impairment that justifies this need?

b. Who is monitoring?

4. Significant Deterioration

The person has experienced a significant deterioration in overall condition of health in the last six (6) months. Assessor must document reason this is required. (Example: significant weight loss, unstable blood sugar, fluid restriction).

Note: Assessor must document the specifics, including time frames and dates.

0 No **1** Yes

a. Identify the significant deterioration in overall health in the last 6 months from date CM is assessing?

b. What caused the significant deterioration in overall health in the last 6 months from date CM is assessing?

c. When did this occur?

d. How has this affected the individual and their ability to complete ADLs?

e. Is this deterioration expected to be prolonged, permanent, or temporary?

5. Oxygen

The person requires direct assistance with the administration of oxygen (either continuous or as needed) for a chronic or stable condition.

0 No **1** Yes

Performance Capacity

a. Score for the individual's actual performance of and capacity to administer their oxygen

0 Independent - No physical assistance, setup, or supervision in any episode
1 Independent, setup help only - Article or device provided or placed within reach, no physical assistance or supervision in any episode
2 Supervision - Oversight / cuing
3 Limited assistance - Guided maneuvering of limbs, physical guidance without taking weight
4 Extensive assistance - Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks
5 Maximal assistance - Weight-bearing support (including lifting limbs) by 2+ helpers - OR - Weight-bearing support for more than 50% of subtasks
6 Total dependence - Full performance by others during all episodes

b. What is the medical impairment which creates the need for assistance?

c. Who provides this assistance?

SECTION T. Assessment Information

(See attached Narrative)

1. General Comments

2. Preliminary Care Plan Comments

3. SIGNATURE OF PERSON COORDINATING / COMPLETING THE ASSESSMENT

4. Date assessment signed as complete