

**THE GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH CARE FINANCE**

ASSESSMENT INSTRUMENT

I. NAME AND VITAL INFORMATION

Ia. Last Name:		Ib. First Name:	
Ic. Primary phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Id. Medicaid No.:	
Ie. Other insurance coverage:			
If. Addl phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Ig. Email:	
Ih. Medicare No.:		Ii. SSN:	
Ij. Street Address:			
Ik. City:	Il. State:		Im. ZIP:
In. Date of Birth:		Io. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	
Ip. Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Unknown			
Iq. Preferred language:		Ir. Interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is. Race / ethnicity:			
It. Lifetime occupation:			

I. NAME AND VITAL INFORMATION, CONT'D

Iaa. Individuals providing information for assessment		<input type="checkbox"/> Individual If not individual, please write name(s) of any and all individual(s) contributing information and their relationship to the individual assessed:
Iab. Name:	Iac. Phone:	Iad. Email:
Iae. Relationship: <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Non-minor child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling or other relative <input type="checkbox"/> Unrelated person providing informal care <input type="checkbox"/> Unrelated person familiar with individual prior to assessment <input type="checkbox"/> Physician / Clinician familiar with individual prior to assessment <input type="checkbox"/> Physician / Clinician not familiar with individual prior to assessment		
Iaf. Name:	Iag. Phone:	Iah. Email:
Iai. Relationship: <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Non-minor child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling or other relative <input type="checkbox"/> Unrelated person providing informal care <input type="checkbox"/> Unrelated person familiar with individual prior to assessment <input type="checkbox"/> Physician / Clinician familiar with individual prior to assessment <input type="checkbox"/> Physician / Clinician not familiar with individual prior to assessment		
Iaj. Name:	Iak. Phone:	Ial. Email:
Iam. Relationship: <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Non-minor child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling or other relative <input type="checkbox"/> Unrelated person providing informal care <input type="checkbox"/> Unrelated person familiar with individual prior to assessment <input type="checkbox"/> Physician / Clinician familiar with individual prior to assessment <input type="checkbox"/> Physician / Clinician not familiar with individual prior to assessment		
Ian. Name:	Iao. Phone:	Iap. Email:
Iaq. Relationship: <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Non-minor child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling or other relative <input type="checkbox"/> Unrelated person providing informal care <input type="checkbox"/> Unrelated person familiar with individual prior to assessment <input type="checkbox"/> Physician / Clinician familiar with individual prior to assessment <input type="checkbox"/> Physician / Clinician not familiar with individual prior to assessment		
Please ensure this information is completed for all sections of the assessment.		

II. EMERGENCY POINTS OF CONTACT AND PHYSICIANS

Primary Emergency Contact			
2a. Full Name:		2b. Relationship:	
2c. Address:		2d. City, State, ZIP:	
2e. Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		2f. Secondary Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
2g. Email:			
Other Emergency Contact			
2h. Full Name:		2i. Relationship:	
2j. Address:		2k. City, State, ZIP:	
2l. Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		2m. Secondary Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
2n. Email:			
Primary Care Physician			
2o. Full Name:			
2p. Address:		2q. City, State, ZIP:	
2r. Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Work		2s. Fax:	2t. Email:
Other or Specialty Physician			
2u. Full Name:			
2v. Address:		2w. City, State, ZIP:	
2x. Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Work		2y. Fax:	2z. Email:
Social Worker / Case Manager			
2aa. Full Name:		2ab. Clinician Affiliation:	
2ac. Address:		2ad. City, State, ZIP:	
2ae. Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Work		2af. Fax:	2ag. Email:
2ah. Individuals providing information for assessment <input type="checkbox"/> Individual <input type="checkbox"/> Other respondent (select name from list provided in Section I)			
Please ensure this information is completed for all sections of the assessment.			

III. INITIAL CONTACT / REFERRAL

Definitions to include in rollover / pop-up boxes:

- Referral source

3a. Referral Source:		3b. Relationship to Individual:	
3c. Reason for Referral:		3d. Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
3e. Assessment conducted in	<input type="checkbox"/> Individual's home	<input type="checkbox"/> Other community setting	<input type="checkbox"/> Nursing facility <input type="checkbox"/> Other health care setting
	<input type="checkbox"/> Hospital (indicate specialty if relevant: <input type="checkbox"/> Psychiatric <input type="checkbox"/> Rehab)		
3f. Assessment conducted by	<input type="checkbox"/> licensed nurse	<input type="checkbox"/> licensed social worker	<input type="checkbox"/> Other clinician
3g. Assessor Name:	3h. Phone:	3i. Email:	
3j. Individuals present for assessment	<input type="checkbox"/> Individual <input type="checkbox"/> Individual's family members or legal guardian <input type="checkbox"/> Clinicians currently providing care to individual		

3k. Individuals providing information for assessment	<input type="checkbox"/> Individual <input type="checkbox"/> Other respondent (select name from list provided in Section I)
<p>Please ensure this information is completed for all sections of the assessment.</p>	

IV. CURRENT SERVICES

Please complete the following section to describe any services accessed by the individual within the last 30 days. For frequency, please provide information based on a typical day or week under ordinary circumstances.

Definitions to include in rollover / pop-up boxes:

- Currently: within the last 30 days
- Personal care aide
- In-home nursing and/or therapy
- Adult day health care
- Home-delivered meals
- Congregate meals / senior center
- Financial management or counseling
- Legal services
- Housing assistance
- Mental health services
- Substance abuse services
- Adult protective services
- Vocational rehabilitation / Job help
- Transportation
- Other Medicaid HCBS waiver services
- SNAP, commodity foods or nutritional assistance
- Case management / social worker
- PERS

Indicate Any Services Currently Received by Individual			
Service	Currently Received?	If Yes, Indicate Provider Name	If Yes, Indicate Frequency
4aa – 4af. Personal Care Aide	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
4ba – 4bf. In-Home Nursing and/or Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
4ca – 4cf. Adult Day Health Care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
4da – 4df. Home-Delivered Meals	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
4ea – 4ef. Congregate Meals / Senior Center	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
4fa – 4ff. Financial Management or Counseling	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
4ga – 4gf. Legal Services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
4ha – 4hf. Housing Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
4ia – 4if. Mental Health Services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
4ja – 4jf. Substance Abuse Services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
4ka – 4kf. Adult Protective Services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
4la – 4lf. Vocational Rehabilitation / Job Help	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
4ma – 4mf. Transportation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:

Indicate Any Services Currently Received by Individual			
4na – 4nf. Other Medicaid HCBS waiver services not listed above (EPD or ID/DD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
4oa – 4of. SNAP, Commodity Foods or other nutritional assistance not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
4pa – 4pg. Case management / Social worker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
	Clinician affiliation (check only one): <input type="checkbox"/> DMH <input type="checkbox"/> DDS <input type="checkbox"/> Medicaid <input type="checkbox"/> Other		
4qa – 4qf. PERS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
4ra – 4rf. Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:

4s. Individuals providing information for assessment Individual
 Other respondent (select name from list provided in Section I)

Please ensure this information is completed for all sections of the assessment.

V. GUARDIANSHIP AND POWER OF ATTORNEY

Definitions to include in rollover / pop-up boxes:

- Legal guardian
- Power of attorney
- Representative payee
- Advance directives
- Living will

Does anyone cash checks, pay bills, or otherwise manage financial affairs for the individual?			
5aa – 5ac. Legal Guardian	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name:	Phone:
5ba – 5bc. Power of Attorney	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name:	Phone:
5ca – 5cc. Representative Payee	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name:	Phone:
5da – 5dc. Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name:	Phone:
5e. Would you like someone to help with these activities? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does anyone assist in making medical decisions for the individual?			
5fa – 5fc. Legal Guardian	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name:	Phone:
5ga – 5gc. Power of Attorney	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name:	Phone:
5ha – 5hc. Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name:	Phone:
5i. Would you like someone to help with these activities? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Does the individual have any advanced directives?		
5ja – 5jb. Living Will	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Location held:
5ka – 5kb. Do-Not-Resuscitate orders	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Location held:
5la – 5lb. Comfort Care orders	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Location held:
5ma – 5mb. Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Location held:
<p>5n. If yes is checked for any of the four items in this section, please ask individual or another respondent to attest they are able to provide documentation for any and all advanced directives.</p> <p><input type="checkbox"/> Yes, they so attest <input type="checkbox"/> No, they do not so attest</p>		

5o. Individuals providing information for assessment Individual
 Other respondent (select name from list provided in Section I)

Please ensure this information is completed for all sections of the assessment.

Indicate and describe any problems that apply to the physical space where the individual resides.		
6ea – 6eb. Home is accessible to individual	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If no, describe:
6fa – 6fb. Electrical hazards	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, describe:
6ga – 6gb. Adequate fire safety devices	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If no, describe:
6ha – 6hb. Adequate heat / AC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If no, describe:
6ia – 6ib. Adequate water / hot water	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If no, describe:
6ja – 6jb. Adequate toilet facilities	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If no, describe:
6ka – 6kb. Operable kitchen appliances	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If no, describe:
6la – 6lb. Operable laundry appliances	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If no, describe:
6ma – 6mb. Furniture in good condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If no, describe:
6na – 6nb. Adequate bathing facilities	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If no, describe:
6oa – 6ob. Structural problems	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, describe:
6pa – 6pb. Operable telephone	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If no, describe:
6qa – 6qb. Adequate lighting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If no, describe:
6ra – 6rb. Unsanitary conditions, including rodent or insect infestation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, describe:
6sa – 6sb. Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Describe:

6t. Individuals providing information for assessment	<input type="checkbox"/> Individual <input type="checkbox"/> Other respondent (select name from list provided in Section I)
Please ensure this information is completed for all sections of the assessment.	

VII. FUNCTIONAL ASSESSMENT

Describe the type of assistance and the frequency of assistance required for the individual for each activity based on typical experience under ordinary circumstances within the last seven days prior to assessment. Use the frequency to indicate variations within a week (e.g., for a person whose needs vary by the location where they reside, use “sometimes” to indicate needs they have only in a location where they reside only a minority of the time). Minutes per occurrence, times per day, and days per week information will be used in developing a care plan. Base these responses on typical experience under ordinary circumstances. Check only one box within each activity.

DRAFT definitions to include in rollover / pop-up boxes:

Type of assistance required

- Cueing or supervision: the individual can physically perform the task alone but requires another individual to provide cueing or supervisory guidance in order to complete the task.
- Mechanical assistance only: the individual can physically perform the task alone, provided the individual has access to a piece of necessary equipment, such as a rolling shower, a wheelchair, cane or walker, or other adaptive equipment.
- One-to-one physical assistance: the person cannot perform the task alone, but may complete the task with physical assistance from another person, such as assistance with lifting, movement, or physical guidance. This individual requires *assistance* with the activity and is not totally dependent on others for the performance of the task.
- Two-to-one physical assistance: the person cannot perform the task alone, but may complete the task with physical assistance from two other persons, such as assistance with lifting, movement, or physical guidance. This individual requires *assistance* with the activity and is not totally dependent on others for the performance of the task.
- Totally dependent on another person: this person is unable to perform or assist in the performance of the task and the task must be completed in whole by another person or persons.

Frequency of assistance:

- Never: The individual never requires assistance, whether mechanical or from another person
- Sometimes: The individual requires assistance, whether mechanical or from another person, occasionally or in limited circumstances
- Usually: The individual generally requires assistance, whether mechanical or from another person, under routine or normal circumstances, but in limited circumstances may not require such assistance
- Always: The individual does not perform the task without assistance, whether mechanical or from another person; the task would not be completed without such assistance

VII. FUNCTIONAL ASSESSMENT, CONTINUED

Describe the type of assistance of frequency of assistance required for the individual for each activity. Check only one box within each activity.

I. BATHING					
7aa – 7ad. How frequently is this activity required and for what duration?		Minutes per occurrence		=	minutes per week
		Times per day			
		Days per week			
7ba. Type of assistance required	Required Frequency of Assistance				Bathing Score (7bb):
	Never	Sometimes	Usually	Always	
Cueing or supervision	(0)	(0)	(1)	(2)	
Mechanical assistance only	(0)	(0)	(1)	(1)	
One-to-one 1:1 person physical assist	(0)	(1)	(2)	(3)	
Totally dependent on another person	(0)	(2)	(3)	(4)	
7c. Observations:					

2. DRESSING					
7da – 7dd. How frequently is this activity required and for what duration?		Minutes per occurrence		=	minutes per week
		Times per day			
		Days per week			
7ea. Type of assistance required	Required Frequency of Assistance				Dressing Score (7eb):
	Never	Sometimes	Usually	Always	
Cueing or supervision	(0)	(0)	(1)	(2)	
Mechanical assistance only	(0)	(0)	(1)	(1)	
1:1 person physical assist	(0)	(1)	(2)	(3)	
Totally dependent on another person	(0)	(2)	(3)	(4)	

7f. Observations:

VII. FUNCTIONAL ASSESSMENT, CONTINUED

3. EATING / FEEDING					
7ga – 7gd. How frequently is this activity required and for what duration?		Minutes per occurrence		=	minutes per week
		Times per day			
		Days per week			
7ha. Type of assistance required	Required Frequency of Assistance				Eating Score (7hb):
	Never	Sometimes	Usually	Always	
Cueing or supervision	(0)	(0)	(1)	(3)	
Mechanical assistance only	(0)	(0)	(1)	(1)	
1:1 person physical assist	(0)	(1)	(3)	(4)	
Totally dependent on another person	(0)	(1)	(4)	(4)	
7i. Observations:					

VIII. FUNCTIONAL ASSESSMENT, CONTINUED

4. TRANSFER						
7ja – 7jd. How frequently are these activities (#4-5) required and for what duration?		Minutes per occurrence			= minutes per week	
		Times per day				
		Days per week				
7ka. Type of assistance required	Required Frequency of Assistance				Highest of Transfer or Mobility Scores (7kc):	
	Never	Sometimes	Usually	Always		
Cueing or supervision	(0)	(0)	(1)	(3)		
Mechanical assistance only	(0)	(0)	(1)	(1)		
1:1 person physical assist	(0)	(1)	(3)	(4)		
2:1 -person physical assist	(0)	(1)	(3)	(4)		
Totally dependent on another person	(0)	(1)	(4)	(4)		
5. MOBILITY						
7kb. Type of assistance required	Required Frequency of Assistance					Highest of Transfer or Mobility Scores (7kc):
	Never	Sometimes	Usually	Always		
Cueing or supervision	(0)	(0)	(1)	(2)		
Mechanical assistance only	(0)	(0)	(1)	(1)		
1:1 -person physical assist	(0)	(1)	(2)	(3)		
2:1 -person physical assist	(0)	(1)	(2)	(3)		
Totally dependent on another person	(0)	(2)	(3)	(4)		
7l. Observations:						

VII. FUNCTIONAL ASSESSMENT, CONTINUED

6. MANAGEMENT OF MEDICATIONS					
7ma – 7md. How frequently is this activity required and for what duration?		Minutes per occurrence		=	minutes per week
		Times per day			
		Days per week			
7na. Type of assistance required	Required Frequency of Assistance				Med Score (7nb):
	Never	Sometimes	Usually	Always	
Cueing or supervision	(0)	(0)	(1)	(2)	
Self-manages but requires assistance with administration	(0)	(1)	(2)	(3)	
Another person assists with management and administration	(0)	(1)	(2)	(3)	
Totally dependent on another person	(0)	(2)	(3)	(3)	
7o. Observations:					

VII. FUNCTIONAL ASSESSMENT, CONTINUED

7. TOILETS INDEPENDENTLY				
7pa – 7pd. How frequently are these activities (#5-7) required and for what duration?		Minutes per occurrence		= minutes per week
		Times per day		
		Days per week		
7qa. Type of assistance required	Required Frequency of Assistance			
	Never	Sometimes	Usually	Always
Cueing or supervision	(0)	(0)	(1)	(1)
Mechanical assistance only	(0)	(1)	(1)	(1)
1:1 person physical assist	(0)	(1)	(2)	(3)
2:1-person physical assist	(0)	(2)	(3)	(4)
8. URINARY CONTINENCE AND CATHETER CARE				
7qb. Type of assistance required	Required Frequency of Assistance			
	Never	Sometimes	Usually	Always
Individual is urinary-continent	(0)	(0)	(0)	(0)
Cueing or supervision	(0)	(0)	(1)	(1)
1:1 person assist	(0)	(1)	(2)	(3)
2:1 -person physical assist	(0)	(2)	(3)	(3)
Totally dependent on another person	(0)	(3)	(3)	(4)
9. BOWEL CONTINENCE AND OSTOMY CARE				
7qc. Type of assistance required	Required Frequency of Assistance			
	Never	Sometimes	Usually	Always
Individual is bowel-continent	(0)	(0)	(0)	(0)
Cueing or supervision	(0)	(0)	(1)	(2)
1:1 -person assist	(0)	(1)	(2)	(3)
2:1 -person physical assist	(0)	(2)	(3)	(3)
Totally dependent on another person	(0)	(3)	(3)	(4)

Toilet Score (7qd):

7r. Observations:

VII. FUNCTIONAL ASSESSMENT, CONTINUED

7s. Individuals providing information for assessment

Individual

Other respondent (select name from list provided in Section I)

Please ensure this information is completed for all sections of the assessment.

VIII. PHYSICAL ASSESSMENT

Recent Professional / Hospital Care			
8aa-8ae.	Name of Doctor or Facility: Provider is a <input type="checkbox"/> Physician <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing facility		Date of last visit:
	Phone:	Reason for visit:	
8ba-8be.	Name of Doctor or Facility: Provider is a <input type="checkbox"/> Physician <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing facility		Date of last visit:
	Phone:	Reason for visit:	
8ca-8ce.	Name of Doctor or Facility: Provider is a <input type="checkbox"/> Physician <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing facility		Date of last visit:
	Phone:	Reason for visit:	
8da-8de.	Name of Doctor or Facility: Provider is a <input type="checkbox"/> Physician <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing facility		Date of last visit:
	Phone:	Reason for visit:	
8ea-8ee.	Name of Doctor or Facility: Provider is a <input type="checkbox"/> Physician <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing facility		Date of last visit:
	Phone:	Reason for visit:	

VIII. PHYSICAL ASSESSMENT, CONTINUED

Individual's Diagnosis Profile (include all diagnoses, including mental health or ID/DD diagnoses)			
	Diagnosis	Currently See a Provider for Care of this Condition	Date of Onset
8fa. – 8fc.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
8ga. – 8gc.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
8ha. – 8hc.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
8fi. – 8ic.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
8ja. – 8jc.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
8ka. – 8kc.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
8la. – 8lc.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
8ma. – 8mc.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
8na. – 8nc.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
8oa. – 8oc.		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Individual's Medication Profile (include all medications, irrespective of condition treated)					
	Medication Name	Reason Prescribed	Dose	Frequency	Route
8pa. – 8pc.					
8qa. – 8qc.					
8ra. – 8rc.					
8sa. – 8sc.					
8ta. – 8tc.					
8ua. – 8uc.					
8va. – 8vc.					
8wa. – 8wc.					

8xa. – 8xc.					
8ya. – 8yc.					

VIII. PHYSICAL ASSESSMENT, CONTINUED

8z. Individuals providing information for assessment

Individual

Other respondent (select name from list provided in Section I)

Please ensure this information is completed for all sections of the assessment.

VIII. PHYSICAL ASSESSMENT, CONTINUED

Vital signs			
8aaa. Blood Pressure:	/	mm Hg	8aab. Pulse: bpm
8aac. Pulse saturation:			%
8aad. Temperature:	° F	8aae. Respiratory rate:	8aaf. Blood sugar: mg/dL

Allergies			
8aba – 8abd. Food allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Please list allergens:	
8aca – 8acd. Medication allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Please list allergens:	
8ada – 8add. Environmental allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Please list allergens:	

Nutritional assessment		
8aea. Est. Height (inches):	8aeb. Weight (lbs.):	8aec. Recent weight gain / loss: <input type="checkbox"/> Yes <input type="checkbox"/> No
8aed – 8aem. Special diet	<input type="checkbox"/> None <input type="checkbox"/> Low fat / cholesterol <input type="checkbox"/> No / low salt <input type="checkbox"/> No / low sugar <input type="checkbox"/> No meat / no pork / no beef <input type="checkbox"/> Vegetarian diet <input type="checkbox"/> Liquid or soft diet only <input type="checkbox"/> Doctor-recommended caloric intake <input type="checkbox"/> Combination of the above <input type="checkbox"/> Other (specify)	
8aen. Dietary supplements	<input type="checkbox"/> None <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily, not primary source <input type="checkbox"/> Daily, primary source <input type="checkbox"/> Daily, sole source	
8aeo – 8aet. Other dietary considerations	<input type="checkbox"/> Inadequate food <input type="checkbox"/> Nausea / vomiting / diarrhea <input type="checkbox"/> Taste problems <input type="checkbox"/> Problems swallowing <input type="checkbox"/> Tooth or mouth problems <input type="checkbox"/> Problems following special diet	

VIII. PHYSICAL ASSESSMENT, CONTINUED

Hearing and vision assessment	
Hearing	8afa. Ability to hear (with aid or device if normally used): <input type="checkbox"/> Adequate <input type="checkbox"/> Minimal difficulty <input type="checkbox"/> Moderate difficulty <input type="checkbox"/> Highly impaired
	8afb. Hearing aid or other appliance required: <input type="checkbox"/> Yes <input type="checkbox"/> No
Vision	8afc. Ability to see in adequate light (with glasses or other appliance if normally used): <input type="checkbox"/> Adequate <input type="checkbox"/> Impaired <input type="checkbox"/> Moderately impaired <input type="checkbox"/> Highly impaired <input type="checkbox"/> Severely impaired
	8afd. Corrective lenses (glasses, contacts, or magnifying lens) used: <input type="checkbox"/> Yes <input type="checkbox"/> No

Does the individual have any paralysis, joint or bone problems, amputated or missing limbs?	
8aga. Joint motion	<input type="checkbox"/> Normal or correctable <input type="checkbox"/> Limited motion <input type="checkbox"/> Immobile or uncorrected instability
8agb – 8age. Paralysis / Paresis	<input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Total Onset: <input type="checkbox"/> 1 year or less <input type="checkbox"/> More than 1 year Describe paralysis / paresis: Previous rehabilitation: <input type="checkbox"/> Yes <input type="checkbox"/> No / Not completed
8agf – 8agh. Amputated or Missing Limbs	<input type="checkbox"/> None <input type="checkbox"/> Fingers / Toes <input type="checkbox"/> Arm(s) <input type="checkbox"/> Leg(s) <input type="checkbox"/> Combination Date of Amputation / Loss: <input type="checkbox"/> 1 year or less <input type="checkbox"/> More than 1 year Previous rehabilitation: <input type="checkbox"/> Yes <input type="checkbox"/> No / Not completed

Does the individual experience any pain?			
8aha. <input type="checkbox"/> No pain reported <input type="checkbox"/> Pain reported on scale from 1 to 10 (please describe below) <input type="checkbox"/> Pain reported by non-verbal individual (describe below and indicate scale used)			
	Location of pain	Individual's rating of pain	Length of time experienced
8ahb – 8ahd.			
8ahe – 8ahg.			
8ahh – 8ahj.			
8ahk. Scale used for non-verbal reporting:			

VIII. PHYSICAL ASSESSMENT, CONTINUED

8aia. Individuals providing information for assessment

Individual

Other respondent (select name from list provided in Section I)

Please ensure this information is completed for all sections of the assessment.

IX. SKILLED CARE ASSESSMENT

Notes / Definitions to include in rollover / pop-up boxes:

- Distinctions between levels of complexity for wound care
- 30-day information will be used for informational purposes; 7-day info for scoring

Detailed skilled nursing and therapies required by individual (please identify in prior section regarding existing services first)			
Service	Currently received	If Yes, Indicate Provider Name	If Yes, Indicate Frequency
9aa – 9af. Occupational therapy (1-2)	<input type="checkbox"/> Yes, within last 7 days <input type="checkbox"/> Yes, within last 30 days <input type="checkbox"/> No / Not known		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
9ba – 9bf. Physical therapy (1-2)	<input type="checkbox"/> Yes, within last 7 days <input type="checkbox"/> Yes, within last 30 days <input type="checkbox"/> No / Not known		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
9ca – 9cf. Respiratory therapy (1-2)	<input type="checkbox"/> Yes, within last 7 days <input type="checkbox"/> Yes, within last 30 days <input type="checkbox"/> No / Not known		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
9da – 9df. Speech therapy (1-2)	<input type="checkbox"/> Yes, within last 7 days <input type="checkbox"/> Yes, within last 30 days <input type="checkbox"/> No / Not known		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
9ea – 9ef. Ventilator care (5)	<input type="checkbox"/> Yes, within last 7 days <input type="checkbox"/> Yes, within last 30 days <input type="checkbox"/> No / Not known		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
9fa – 9ff. Tracheal suctioning or tracheostomy care (3-4)	<input type="checkbox"/> Yes, within last 7 days <input type="checkbox"/> Yes, within last 30 days <input type="checkbox"/> No / Not known		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
9ga – 9gf. Total parenteral nutrition (3)	<input type="checkbox"/> Yes, within last 7 days <input type="checkbox"/> Yes, within last 30 days <input type="checkbox"/> No / Not known		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
9ha – 9hf. Complex wound care (3)	<input type="checkbox"/> Yes, within last 7 days <input type="checkbox"/> Yes, within last 30 days <input type="checkbox"/> No / Not known		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
9ia – 9if. Wound care, moderate complexity (2)	<input type="checkbox"/> Yes, within last 7 days <input type="checkbox"/> Yes, within last 30 days <input type="checkbox"/> No / Not known		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:

Detailed skilled nursing and therapies required by individual (please identify in prior section regarding existing services first)			
9ja – 9jf. Wound care, early or preventive (1)	<input type="checkbox"/> Yes, within last 7 days <input type="checkbox"/> Yes, within last 30 days <input type="checkbox"/> No / Not known		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
9ka – 9kf. Hemodialysis (2)	<input type="checkbox"/> Yes, within last 7 days <input type="checkbox"/> Yes, within last 30 days <input type="checkbox"/> No / Not known		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
9la – 9lf. Peritoneal dialysis (2)	<input type="checkbox"/> Yes, within last 7 days <input type="checkbox"/> Yes, within last 30 days <input type="checkbox"/> No / Not known		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
9ma – 9mf. Enteral tube feeding (2)	<input type="checkbox"/> Yes, within last 7 days <input type="checkbox"/> Yes, within last 30 days <input type="checkbox"/> No / Not known		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
9na – 9nf. IV fluid or medication administration (1-2)	<input type="checkbox"/> Yes, within last 7 days <input type="checkbox"/> Yes, within last 30 days <input type="checkbox"/> No / Not known		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
9oa – 9of. Intramuscular or subcutaneous injections (1-2)	<input type="checkbox"/> Yes, within last 7 days <input type="checkbox"/> Yes, within last 30 days <input type="checkbox"/> No / Not known		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
9pa – 9pf. Isolation precautions (1)	<input type="checkbox"/> Yes, within last 7 days <input type="checkbox"/> Yes, within last 30 days <input type="checkbox"/> No / Not known		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:
9qa – 9qf. PCA pump (1)	<input type="checkbox"/> Yes, within last 7 days <input type="checkbox"/> Yes, within last 30 days <input type="checkbox"/> No / Not known		<input type="checkbox"/> Hours or <input type="checkbox"/> Times per day: <input type="checkbox"/> Days or <input type="checkbox"/> Times per week:

9r. Individuals providing information for assessment Individual
 Other respondent (select name from list provided in Section I)

Please ensure this information is completed for all sections of the assessment.

X. COGNITIVE AND BEHAVIORAL ASSESSMENT

Definitions to include in rollover / pop-up boxes:

- Types of screens considered (validated, reliable)
- Serious mental illness
- Always understood
- Usually understood / understood with prompts or time
- Sometimes understood
- Rarely or never understood

Previously identified SMI / ID/DD	
I0a. Has the individual been evaluated by another screen and determined to have a serious mental illness or intellectual disability?	<input type="checkbox"/> No such screen completed <input type="checkbox"/> Screening performed, SMI identified <input type="checkbox"/> Screening performed, no such determination <input type="checkbox"/> Screening performed, ID/DD identified
Receptive and expressive communication	
I0b. Ability to make self understood (expressive communication)	<input type="checkbox"/> Always understood (0) <input type="checkbox"/> Sometimes understood (1) <input type="checkbox"/> Usually understood / understood with prompts or time (0) <input type="checkbox"/> Rarely or never understood (2)
I0c. Speech clarity	<input type="checkbox"/> Clear speech: distinct, intelligible words (0) <input type="checkbox"/> Unclear speech: slurred or mumbled words (1) <input type="checkbox"/> No speech: absence of spoken words, aphasia (2)
I0d. Ability to understand others (receptive communication)	<input type="checkbox"/> Understands / clear comprehension (0) <input type="checkbox"/> Usually understands / misses some parts but comprehends most conversation (0) <input type="checkbox"/> Sometimes understands / responds to direct communication only (1) <input type="checkbox"/> Rarely or never understands (2)

I0e. Individuals providing information for assessment

Individual
 Other respondent (select name from list provided in Section I)

Please ensure this information is completed for all sections of the assessment.

X. COGNITIVE AND BEHAVIORAL ASSESSMENT, CONTINUED

Definitions to include in rollover / pop-up boxes:

- Significant risk
- Interfere significantly with care
- Disrupt the care of others

Behavior and behavioral symptoms					
10f. Does the individual have any of the following?	<input type="checkbox"/> Hallucinations <input type="checkbox"/> Delusions <input type="checkbox"/> None of these				
Does the individual exhibit any of the following behaviors?	10g. Physical behavioral symptoms directed toward others (hitting, kicking, pushing, grabbing, sexual abuse of others, etc.) <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Behavior not exhibited (0)</td> <td style="border: none;"><input type="checkbox"/> Behavior exhibited 1 to 3 days per week (1)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Behavior exhibited 4 to 6 days per week (2)</td> <td style="border: none;"><input type="checkbox"/> Behavior exhibited daily (3)</td> </tr> </table>	<input type="checkbox"/> Behavior not exhibited (0)	<input type="checkbox"/> Behavior exhibited 1 to 3 days per week (1)	<input type="checkbox"/> Behavior exhibited 4 to 6 days per week (2)	<input type="checkbox"/> Behavior exhibited daily (3)
	<input type="checkbox"/> Behavior not exhibited (0)	<input type="checkbox"/> Behavior exhibited 1 to 3 days per week (1)			
	<input type="checkbox"/> Behavior exhibited 4 to 6 days per week (2)	<input type="checkbox"/> Behavior exhibited daily (3)			
10h. Verbal behavioral symptoms directed toward others (threatening, screaming, cursing at others) <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Behavior not exhibited (0)</td> <td style="border: none;"><input type="checkbox"/> Behavior exhibited 1 to 3 days per week (0)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Behavior exhibited 4 to 6 days per week (1)</td> <td style="border: none;"><input type="checkbox"/> Behavior exhibited daily (2)</td> </tr> </table>	<input type="checkbox"/> Behavior not exhibited (0)	<input type="checkbox"/> Behavior exhibited 1 to 3 days per week (0)	<input type="checkbox"/> Behavior exhibited 4 to 6 days per week (1)	<input type="checkbox"/> Behavior exhibited daily (2)	
<input type="checkbox"/> Behavior not exhibited (0)	<input type="checkbox"/> Behavior exhibited 1 to 3 days per week (0)				
<input type="checkbox"/> Behavior exhibited 4 to 6 days per week (1)	<input type="checkbox"/> Behavior exhibited daily (2)				
10i. Other physical behaviors not directed toward others (self-injury, pacing, public sexual acts, disrobing in public, throwing food or waste, etc.) <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Behavior not exhibited (0)</td> <td style="border: none;"><input type="checkbox"/> Behavior exhibited 1 to 3 days per week (1)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Behavior exhibited 4 to 6 days per week (2)</td> <td style="border: none;"><input type="checkbox"/> Behavior exhibited daily (2)</td> </tr> </table>	<input type="checkbox"/> Behavior not exhibited (0)	<input type="checkbox"/> Behavior exhibited 1 to 3 days per week (1)	<input type="checkbox"/> Behavior exhibited 4 to 6 days per week (2)	<input type="checkbox"/> Behavior exhibited daily (2)	
<input type="checkbox"/> Behavior not exhibited (0)	<input type="checkbox"/> Behavior exhibited 1 to 3 days per week (1)				
<input type="checkbox"/> Behavior exhibited 4 to 6 days per week (2)	<input type="checkbox"/> Behavior exhibited daily (2)				
10j. If any of the above behaviors were exhibited, please indicate if the behaviors did any of the following:	<input type="checkbox"/> Put the resident at significant risk of injury or illness (3) <input type="checkbox"/> Interfere significantly with care (2) <input type="checkbox"/> Interfere significantly with his/her activities or social interactions (1) <input type="checkbox"/> Does not interfere significantly with activities or interactions (0)				
10k. If any of the above behaviors were exhibited, please indicate if the behaviors did any of the following:	<input type="checkbox"/> Put others at significant risk of injury or illness (3) <input type="checkbox"/> Interfere significantly with the privacy or activities of others (1) <input type="checkbox"/> Disrupt the care or living environment for others (1) <input type="checkbox"/> Does not disrupt the care or living environment for others (0)				

Behavior and behavioral symptoms	
I0l. Did the individual reject assessment or health care, except in cases where that decision is supported by individual's or family goals or preferences?	<input type="checkbox"/> Behavior not exhibited (0) <input type="checkbox"/> Behavior exhibited 1 to 3 days per week (0) <input type="checkbox"/> Behavior exhibited 4 to 6 days per week (1) <input type="checkbox"/> Behavior exhibited daily (2)
I0m. Does the person have a history of eloping or wandering?	<input type="checkbox"/> Behavior not exhibited (0) <input type="checkbox"/> Behavior exhibited 1 to 3 days per week (1) <input type="checkbox"/> Behavior exhibited 4 to 6 days per week (2) <input type="checkbox"/> Behavior exhibited daily (3)
I0n. Indicate if the individual's wandering has done any of the following:	<input type="checkbox"/> Put the resident at significant risk of entering a dangerous place (3) <input type="checkbox"/> Intruded on the privacy of others (1) <input type="checkbox"/> Wandering has not put individual or others at risk (0)

I0o. Individuals providing information for assessment

Individual
 Other respondent (select name from list provided in Section I)

Please ensure this information is completed for all sections of the assessment.

XI. INDIVIDUAL ACTIVITIES, ROUTINES, AND PREFERENCES

Daily routines (to be answered by the individual being assessed)	
I Ia. When do you normally rise from bed?	<input type="checkbox"/> Before 6 a.m. <input type="checkbox"/> 6 – 8 a.m. <input type="checkbox"/> 8 – 10 a.m. <input type="checkbox"/> After 10 a.m.
I Ib. How many meals do you eat per day?	<input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> More than three
I Ic. When do you usually eat for the first time each day?	<input type="checkbox"/> Before 6 a.m. <input type="checkbox"/> 6 – 8 a.m. <input type="checkbox"/> 8 – 10 a.m. <input type="checkbox"/> After 10 a.m.
I Id. When do you typically eat again following your first meal?	<input type="checkbox"/> I typically only eat one full meal per day <input type="checkbox"/> 9 – 11 a.m. <input type="checkbox"/> 11 a.m. – 1 p.m. <input type="checkbox"/> 1 – 3 p.m. <input type="checkbox"/> After 3 p.m.
I Ie. When do you typically eat a third meal?	<input type="checkbox"/> I typically only eat one or two full meals per day <input type="checkbox"/> Before 3 p.m. <input type="checkbox"/> 3 – 5 p.m. <input type="checkbox"/> 5 – 7 p.m. <input type="checkbox"/> After 7 p.m.
I If. When do you typically bathe?	<input type="checkbox"/> Before 8 a.m. <input type="checkbox"/> 8 a.m. – 12 p.m. <input type="checkbox"/> 12 - 4 p.m. <input type="checkbox"/> After 4 p.m.
I Ig. When do you typically get dressed or brush your teeth after rising for the day?	<input type="checkbox"/> Before 6 a.m. <input type="checkbox"/> 6 – 8 a.m. <input type="checkbox"/> 8 – 10 a.m. <input type="checkbox"/> After 10 a.m.
I Ih. When do you typically brush your teeth or change clothes before bed?	<input type="checkbox"/> Before 7 p.m. <input type="checkbox"/> 7 – 9 p.m. <input type="checkbox"/> 9 – 11 p.m. <input type="checkbox"/> After 11 p.m.
I Ii. When do you normally go to bed in the evening?	<input type="checkbox"/> Before 8 p.m. <input type="checkbox"/> 8 – 10 p.m. <input type="checkbox"/> 10 p.m. to 12 a.m. <input type="checkbox"/> After 12 a.m.
I Ij. Do you frequently leave your home or residence for employment or leisure activities?	<input type="checkbox"/> Yes, for both work and leisure <input type="checkbox"/> Yes, for leisure <input type="checkbox"/> No, I leave my home only infrequently or only for medical care

I Ik. Individuals providing information for assessment

Individual

Other respondent (select name from list provided in Section I)

Please ensure this information is completed for all sections of the assessment.

XII. INFORMAL SUPPORTS

Informal supports provided by a family member or other individual	
<p>I2a. Does the individual have a family or other person providing informal care?</p>	<p><input type="checkbox"/> No informal care provided <input type="checkbox"/> Yes, a family member (provide details below) <input type="checkbox"/> Yes, another (unrelated) person (provide details below)</p>
<p>I2b. Where does the person described above reside?</p>	<p><input type="checkbox"/> With the individual <input type="checkbox"/> Near the individual (e.g., a neighbor) <input type="checkbox"/> Not within walking distance</p>
<p>I2ca – I2cc. How often and for how long does this person provide care? <i>Please limit to hours spent providing care only.</i></p>	<p>Daily: ___ Hours per day x ___ days per week Weekly: ___ Hours per weekly visit</p>
<p>I2da – I2dd. With what types of tasks does this person assist?</p>	<p><input type="checkbox"/> Activities of daily living (bathing, dressing, eating, transferring, mobility, etc.) <input type="checkbox"/> Instrumental activities (shopping, medication management, money management) <input type="checkbox"/> Other activities (household chores, etc.) <input type="checkbox"/> Skilled care (injections, infusion therapy, etc.)</p>

<p>I2o. Individuals providing information for assessment</p>	<p><input type="checkbox"/> Individual <input type="checkbox"/> Other respondent (select name from list provided in Section I)</p>
<p>Please ensure this information is completed for all sections of the assessment.</p>	