PARK COUNTY SENIOR COALITION CLIENT ASSESSMENT

A. CLIENT IDENTIFICATION: County: PARK Date of Assessment: _____ **Assessed by**_____ **New/Update Client Phone**: (_____) _____

Last Name: _____ **First**: _____ **M.I.**____ **Birthdate:** _____

AKA: _____ **Gender:** ____ **Age:** _____

Do you consider yourself Hispanic or Latino? Yes/No **Race:** _____

Primary Language: _____Other Language: _____

Mailing Address:

Add: _____Town: _____ ST _____ Zip _____

Residential Address:

Add: _____Town: _____ ST _____ Zip _____

Years in Park County ----------

NAPIS Related: For Office Use Only
All Park County residents are RURAL & Geographically Isolated

E-mail address: _____
Please circle the best description of your use:
Avid Daily Infrequent Timid

Current Residence: **check one**

____ Owns Home ____ Rents
____ Family member's residence
____ Homeless ____ Other

B. EMERGENCY CONTACT INFORMATION:

Power of Attorney_____ Tel (Home) _____ Tel (Work)_____

Type of POA_____ Relationship to client of person with POA_____

Primary Physician _____ Tel (Home) _____ Tel (Work) _____

Primary Contact _____ Tel (Home) _____ Tel (Work) _____
(Relation to Client) _____
Caregiver _____ Tel _____ Relationship to Client _____

C. DIRECTIONS TO HOME:

D. NOTES & LINKED PARTNER/FAMILY RECORD(S): can use back of form if more room is needed

E. **HOUSEHOLD ANNUAL INCOME:**

Marital Status: Married/ Single/ Domestic Partner/Widowed/_____

What is your monthly income range?

- $ 1,063 or less 100%
- $ 1,064- $1,327 125%
- $ 1,328- $1,965
- $1,966 or more 185%

What is you and your spouse's? Monthly married income range?

- $1,437 or less 100%
- $1,438-$1,796 125%
- $1,797-$2,658
- $2,659 or more 185%

Employed? _____ (note whether FT, PT, Temp, or NO)
Lives: Alone/With Spouse/With Extended Family/With Non-Relatives

F. COMMON QUALITIES: (Y, N, or D/K)

____ Veteran
____ Veteran Spouse
____Abused/Neglected/Exploited
____# of persons in household
____# of children in household
____ MEDICARE
_____MEDICAID ELIGIBLE?
_____ Receive Soc. Security
____Homebound
Why? _____

ACKNOWLEDGEMENTS: ***(initial** Y or N)*

I am aware that information I am submitting may be used for substantiation of eligibility and expenses and may be provided to the state or funders for that purpose. ____Y ____N

I have been informed that donations & contributions are requested, are voluntary, & that no eligible person shall be denied a service based on their inability and/or choice not to contribute. ____Y ____N

I have received a copy of the Park County Senior Coalition complaint/grievance procedure and am aware of my right to appeal. ____Y ____N

I give permission for PCSC to discuss my health & services with my Dr./contacts. ____Y ____N

I give permission for PCSC to provide my health and contact information in an emergency (evacuation, fire, etc.) ____Y ____N

_____
CLIENT SIGNATURE

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G) ACTIVITIES OF DAILY LIVING (ADL's) (check Y or N)

	Y	N
I can eat without help		
I can dress myself without help		
I can bathe myself without help		
I can use the toilet without help		
Do you use incontinence supplies?		
I can get in & out of the bed/chairs without help		
I can get around in my home without help		
TOTAL ADL's (do not count incontinence supply question)		

H) Instrumental Activities of Daily Living (IADL's) (check Y or N)

	Y	N
I can manage money without help		
I can take care of shopping without help		
I can take my medication without help		
I can prepare meals without help		
I can do ordinary housework without help		
I can use the telephone without help		
I can access/use public transportation w/o help		
TOTAL IADL's		

Are you currently receiving assistance with IADL's or ADL's from anyone?
___Y __N

If yes, from whom are you receiving assistance with IADL's or ADL's?

Do you have a Doctor's order for a Home Health Aide?

I) NUTRITION CHECKLIST: (Circle the answers)

	Y	N
a. I have an illness or condition that changes the kind and/or amount of food that I eat.	2	0
b. I eat fewer than 2 meals per day	3	0
c. I eat few fruits or vegetables or milk products	2	0
d. I have 3 or more drinks of beer, liquor, or wine almost every day.	2	0
e. I have tooth or mouth problems that make it hard for me to eat.	2	0
f. I don't always have enough money to buy the food I need.	4	0
g. I eat alone most of the time	1	0
h. I take 3 or more different prescribed or over-the-counter drugs a day	1	0
i. Without wanting to, I have lost or gained 10 lbs. in the last 6 mo.	2	0
j. I am not always physically able to shop, cook, and/or feed myself.	2	0
k. Do you smoke?	Y	N
l. Would you like to speak to a Dietician?	Y	N
TOTALS		

If your Combined Total is: **TOTAL SCORE: _____**

0-2 GOOD! Recheck Nutritional Status in 6 months.

3-5 Moderate nutritional risk. Recheck in 3 months. See what can be done to improve your eating habits. Your local Health Dept., Dietitian or Dr. can help.

6 or more High nutritional risk. Ask for help to improve your nutritional health the next time you see your Dr./ Dietitian/ other Health Professional. Ask your Dr. about Ensure Products or other meal supplements.

HOME CONDITION & PETS:

Can the client perform chore/heavy housework, carry wood, clean a chimney, and shovel snow without assistance? Y__N__ IF NO, describe the tasks the client can't perform below:

_____

_____

Why can't the client perform these tasks?

_____

_____

Is your home in need of repair? __Y__N If YES, describe below:

_____

_____

Do these home repair needs cause safety or health concerns?

_____

_____

Do you have pets? ___Y___N How many? (List below, attach additional paperwork if needed).

Name	Type of Pet	Age	Friendly?

J) MOBILITY & HEALTH CONDITIONS: Please Answer Y or N — Comments — Please Answer Y or N

a) I am able and willing to drive my own vehicle			g) My vision is impaired and cannot be corrected With lenses.	
b) I have a current driver's license			h) I wear glasses/contacts.	
c) I easily get on/off a van unassisted.			i) I use oxygen at night.	
d) I load/unload my own groceries (from car/ van)			j) I travel with oxygen.	
e) I easily shop & write a check unassisted			k) My hearing is impaired.	
f) I use help from following mobility devices:			l) I wear hearing aids.	
no help from mobility devices			m) I have been diagnosed as being diabetic.	
a cane			n) I require supervision.	
crutches			o) I have been diagnosed with autism.	
an electric scooter			p) I have epilepsy or another seizure disorder.	
a walker			q) I have an intellectual disability	
a wheelchair			**For office use only**	
Other			Is the client Frail based on the A and/or B below ?	
			A) Unable to perform at least two activities of daily living (ADL's) without substantial human assistance	
			B) Due to cognitive/mental impairment, requires substantial supervision because of behaving in a manner that poses a serious safety threat to themselves or others	

Do You Have Any Difficulty in the Following Areas? (Mark Y or N)

a) self-care		f) self-direction/act independently	
b) understanding / communication		g) living independently	
c) speaking		h) responding to direction	
d) learning		i) managing emotions	
e) moving/mobility		TOTAL (a-i)	

(Mark Y or N)

Memory		If Yes, circle the appropriate level of impairment/difficulty, below.		
Have you been diagnosed with a memory impairment?		Mild	Moderate	Severe
Have you been diagnosed with a cognitive impairment?		Mild	Moderate	Severe
Do you have difficulty remembering appointments, family occasions, holidays, and medications?		Mild	Moderate	Severe
Do you have difficulty assembling tax records, business affairs, or other papers?		Mild	Moderate	Severe

Are you interested in volunteering for the Coalition? Y or N **Which volunteer opportunities interest you**
(If "yes", provide information to the Program Coordinator)

ADDITIONAL RESOURCES

Volunteer Opportunities By Program	Time Commitment	Description
Transportation	4 hr. initial training, +1x per 3 month minimum: 3 x per week maximum.	Volunteer Driver - drive seniors to medical appointments in your own car Trip Assistant- Attend scheduled trips and provide support/ assistance the driver and to participating seniors.
Homemaker	8 hr. initial training, + 2 hours, 1x per week	Clean seniors' homes to provide a healthy and safe living environment.
Handyman	2 hr. initial training, 1 x per yr, minimum: 3 x per year maximum	Provide health and safety-related minor repairs to senior homes.
Rural Area Meals Program (RAMP)	1 day per month.	Deliver meals to rural/homebound seniors.
Office	Variable	Newsletter: Desktop publishing or mailing preparation.
	Professional Skills welcome	Answering phones
		Website updates
		Press Release

✓ If Provided Referral	How did you hear about our services?
	AAA Brochure/Flyer
	AAA Newsletter
	(TV) Channel 9 Senior Source
	Congregate Meal Site
	From a Current Client
	Friend/Relative
	Senior Information Fair
	Walk-In
	Website
*	**Other**

***Describe If "Other"**

If Requested Referral ↘	Would you like information for other services? Provided Referral **(write in name of agency referred to)**	Information or Referral Category
		Dental
		Financial
		Food
		Fuel
		Information/ Referral
		Legal
		Medical
		Personal Care
		Respite
		Shelter / Housing
		Tax
		Transportation
		Utilities
		Vision

Agreement to be contacted does not obligate you to participate ↓ Initial for release	On occasion, Park County Senior Coalition is asked to recommend seniors for the following services. Do you want to Park County Senior Coalition to give out your name and contact information for the following offers?
	Holiday Food Baskets Provided through the Sheriff's Office
	Holiday Food Baskets Provided through a community Food Bank
	Holiday Food Baskets Provided through a local youth group
	Community Service/Wood Provided through a church
	Community Service/Wood Provided through a local youth group
	Community Service/Wood Provided through a local individual
	If initialing above, you acknowledge that this listing of services does not indicate PCSC endorsement.

Household information:

Number in Household____

NAME _____ BIRTH YR. _____GENDER____

NAME _____ BIRTH YR. _____GENDER____

NAME _____ BIRTH YR. _____GENDER____

NAME _____ BIRTH YR. _____GENDER____