

COMPREHENSIVE OPTIONS ASSESSMENT FORM (COAF)

Consumer Name: _____ Social Security #: _____

Address: _____

ID #: _____ Phone #: _____ Birthdate: _____

Current Living Arrangements: Alone With Spouse With Children With Relatives Facility Other

Referred by: _____ Veteran? Yes No

Communication aid needed? Yes No Type _____ Language Spoken: _____

Emergency Contact:

Name (last, first, middle initial)

Relationship to Consumer

Address (street, city, state and zip code)

Day and Evening Telephone Number (including area code)

Request: _____ NF _____ DC/PCH _____ CS _____ FCSP _____ PDA Waiver _____ BRIDGE

Assessed by: _____ Date: _____

Location of Interview:

Present for Interview: Consumer Other (relationship): _____

Names: _____

Class of Assessment Completed: Comprehensive OBRA Nursing Facility Clinically Eligible: Yes No

ASSESSMENT OUTCOME:

- Nursing Facility
- CS
- FCSP
- DC/PCH
- PDA Waiver
- BRIDGE

FUNCTIONAL NEEDS MEASUREMENT:

I.	Physical Health _____
II.	Functional Ability ADLS _____ Mobility _____ IADLs _____
III.	Mental Health/Cognitive Cognitive Function _____ Emotional Behavior _____
IV.	Caregiver/Informal Support Availability/Capability _____ CG Burden _____ CG Stress _____ Respite Availability _____
V.	Physical Environment _____
VI.	Financial Resources _____
	TOTAL _____

Time for completion of Assessment Form:

SECTION 1: PHYSICAL HEALTH

USE OF MEDICAL SERVICES	Yes	No	NARRATIVE									
1. Does consumer have a family physician?	<input type="checkbox"/>	<input type="checkbox"/>										
Name: _____ Phone: _____												
Address (optional) : _____												
2. Other physicians (specialists)												
a. Name: _____ Phone: _____												
b. Name: _____ Phone: _____												
3. How often usually see physician? _____												
Date of last visit(as best remembered): _____												
Reason for visit? _____												
4. Do you seek health care from any other practitioner (s) in addition to or instead of a doctor? e.g. acupuncturist, chiropractor, herbalist, masseur, etc.	<input type="checkbox"/>	<input type="checkbox"/>										
Name: _____												
Type of Practitioner: _____												
Address: _____ Phone: _____												
Name: _____												
Type of Practitioner: _____												
Address: _____ Phone: _____												
5. Hospitalized in past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how many times? (Dates as best remembered)												
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">Where</th> <th style="width:30%;">What For</th> <th style="width:40%;">Dates</th> </tr> </thead> <tbody> <tr> <td>a. _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>b. _____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Where	What For	Dates	a. _____	_____	_____	b. _____	_____	_____			
Where	What For	Dates										
a. _____	_____	_____										
b. _____	_____	_____										
6. In nursing facility &/or PCH in past year? (Dates as best remembered)	<input type="checkbox"/>	<input type="checkbox"/>										
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Where	What For	Dates										
a. _____	_____	_____										
b. _____	_____	_____										

ILLNESSES AND HEALTH CONDITIONS

Verify all information on the MA-51 or other appropriate medical information documents (hospital records, etc.)

Prompting questions were added to assist you in further explaining illnesses/conditions/symptoms during the assessment. Untreated illnesses/conditions/symptoms should be reported by the applicant to their physician.

Do you have any of the following illnesses or health conditions? If yes, are you currently being treated for this (past 3 months)

- a) **EYES** - Glaucoma, cataracts, macular degeneration? or other eye problems? How is your eyesight (with glasses or contacts) good, fair, or poor. Can you read your medicine bottle labels? Watch TV?
- b) **EARS** - How is your hearing . . . good, . . . fair, . . . or poor? Can you hear the telephone ring? Talk on the telephone? Other ear problems like wax buildup or ringing in the ears.
- d) **THROAT** - Any problems swallowing? Frequent sore throats? Cancer? Laryngectomy?
- e) **MOUTH** - Do you have any missing teeth? Partial or full dentures? Do you wear them to eat? Any problems with gum disease or other mouth sores?
- g) Any difficulties breathing (dyspnea)? Shortness of breath? Do you have to sit up to breath (orthopnea) more easily? Have you ever suffered sleep apnea? (transient loss of breath while sleeping)
- h) Any heart problems? Angina? Previous heart attack? High blood pressure?
- i) Any circulation problems? Do you ever get much swelling? Especially in your ankles? Pain or discoloration in your feet? Varicose veins? Blood clots (thrombus = stationary; embolus = moving)?
- j) Ever any swelling or lumps under arms, in neck or groin?
- k) Any paralysis or effects of a stroke?
- l) Any stomach or bowel problem? Ever any regurgitation of food or heartburn? Ever black or bloody stool?
- n) Enlarged prostate? Cancer? Surgery? Any other male problems? Testicular Cancer?

List all identified unmet needs and problems.

ILLNESSES AND HEALTH CONDITIONS

7. Does consumer have any of the following illnesses or health conditions:	If yes, currently being treated?				NARRATIVE: List diagnosis/condition, and symptoms and medical need(s) created by Dx, complications, severity, effects on function, problems, treatments and who provides,
	Yes	No	Yes	No	
a) Eyes - Glaucoma/Cataracts/macular degeneration Sight: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Blind <input type="checkbox"/> Aid					
b) Ears -Hearing: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Deaf <input type="checkbox"/> Aid					
c) Nose - Deviated Septum, Polyps, nose bleed					
d) Throat - Speech: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Aphasic					
e) Mouth - Dentition: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Dentures					
f) Breasts - Cysts, Lumps/Nodules					
g) Lungs/Breathing Problems -TB, Asthma, Pneumonia, Chronic Obstructive Pulmonary Disease (Bronchitis, Emphysema), Allergies, Orthopnea, Dyspnea					
h) Heart - Angina, Irregular Heart Rate, Congestive Heart Failure, High Blood Pressure, Heart Attack					
i) Circulation - Leg Ulcers,Edema (swelling) Varicosities, Peripheral Vascular Disease, Cerebral Insufficiency, Thrombus, Embolus					
j) Lymph Nodes - Enlargement					
k) Extremities - Paralysis, Missing Limbs, Weakness					
l) Gastrointestinal - Ulcer, Bleeding, Colitis, Intestinal Problems, Diverticulosis, Jaundice, Gall Bladder Disease Gastro-Esophageal Reflux Disorder (GERD), bowel incontinence					
m) Hernia					
n) Prostate Problems (males only)					

- o) Ever any vaginal discharge or bleeding? or any other gynecological (female) problems?
- p) Ever any rectal bleeding? Hemorrhoids (piles)? Abscesses?
- q) Ever any fractures - hip, arm, etc.? Any residual effects? Any arthritis or pain in your joints? How are your feet? Any trouble with bunions, corns, circulation?
- r) Any skin problems like rashes or pressure sores? Any open wounds? Draining? Weeping?
- s) Have you ever had a stroke (CVA)? Any residual effects? Mini-strokes (TIAs)? Any tremors? Do you have seizures? How frequently?
- t) Have you ever been told you have "low blood" (anemia)? Do you take iron?
- u) Are you diabetic? For how long? Do you take insulin? Are you on a special diet? Do you or does someone do accuchecks or monitor your blood sugar regularly? As instructed by your physician? Do you have a thyroid problem? Do you take thyroid medicine?
- v) Do you have kidney and/or bladder problems? Ever any blood in your urine, frequent burning or itching? Ever any bladder or urinary tract infection? How often? Urine retention or frequent urination?
- w) Has anyone ever told you, you had tumors or cancer? What kind? Where? Did you receive treatment?
- x.i) This question should be checked yes only if the person has been medically tested and interviewer has access to the results or results have been confirmed by physician or other reliable informant. Examples of reversible conditions that can produce cognitive impairment are adverse drug reactions, thyroid dysfunction, malnutrition, recent stroke and other acute and chronic illnesses.
- y) Has anyone told you or diagnosed you as having a communicable disease, e.g., tuberculosis, hepatitis or any illness that is contagious?
- z) Other health problems that I haven't mentioned?
- aa) Have you had out-patient surgery in the past year? What kind? When was that?
- bb) Do you drink alcohol? How much?
Do you smoke? How much?
Do you take any drugs not prescribed by your doctor other than over-the-counter drugs?

Route:	
<hr/>	
IM = Intramuscular	PO = Oral
IN = Inhalant	SL = Sub-lingual
IV = Intravenous	Sub Q = Subcutaneous injection
OP = Ophthalmic	Sup = Suppository (Vaginal or Rectal)
Patch = Transdermal	Top = Topical

9., 10 & 11. Medications/herbs/other remedies

What are you taking now?

May I see what your taking and copy the names off of the bottles?

Are there any other medications/herbs.other remedies . . . some you keep in the refrigerator, for instance, or something like eye drops or skin creams?

Are there any non-prescription medications that you take regularly, like vitamins, laxatives, aspirin/Tylenol or cold remedies?

Do you usually take all your medications/herbs/other remedies the way your've been directed to do?

12. When was the last time you and your doctor discussed your medications? When was the last time he/she reviewed your medications with you so that he/she is aware of everything you are taking?

13. Do you need any help taking your medications? Who helps? What kind of help? Has your doctor ordered any type of monitoring regarding your medications? (e.g. blood levels, observation of effects etc.) Who does it? How often? Etc.

14. Do you know if you're allergic to any medication? If yes, what and what is your reaction?

15. Knowing who consumer's pharmacist is and where to reach him/her is very useful information. If consumer doesn't know this information it can be obtained from medication bottles/family/other collateral resources, if needed. (Optional)

CURRENT MEDICATIONS

Current Medications **If None, Skip to Question 14.**

List all (if institutionalized, include and specify meds to be taken after discharge.)	Dose/Freq/Route (Use codes)	NARRATIVE: Describe problems; note any changes or <u>discrepancies</u> in medications ordered/being taken.
9. Prescription (use and attach additional paper if necessary)		
10. OTC (if used regularly, note if ordered by physician)		
11. Herbs or other remedies (give name, dosage, why used & if on own or recommendation of another)		

12. If not in a hospital or nursing facility: Date of last medication review by doctor (optional) _____

13. Type of help needed with medications (check all that apply) If applicable, who is presently assisting? _____

- | | | |
|---------------------------------|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Administration | <input type="checkbox"/> Verbal reminding |
| <input type="checkbox"/> Set up | <input type="checkbox"/> Information | <input type="checkbox"/> Regular monitoring of effects |

14. Does consumer report drug allergy? No Yes

If yes, specify medication and type of reaction _____

15. Consumer's pharmac(y)(ist) Name: _____
(OPTIONAL)

Address: _____

Phone: _____

GENERAL ADL QUESTIONS

Do you _____ by yourself or does someone usually help you? Who helps? How does she/he help? Do you feel you need more help than you usually have? Do you need any special equipment to help you? _____

1. **Bathing** - Do you take a bath by yourself or does someone usually help you? How do you usually bathe . . . in a tub or shower . . . at the sink . . . bed baths? How often? Do you have safety equipment, such as grab bars to hold on to . . . a non-slip mat . . . or a tub seat?
2. **Dressing/undressing** - Do you get dressed by yourself or does someone usually help you? Do you usually get dressed for the day or do you sometimes stay in night clothes? Can you get the clothes from drawers and closets? Would adaptive clothing (with different fasteners like Velcro) make dressing easier?
3. **Grooming** - What about brushing your teeth, and brushing your hair (and shaving, putting on make-up) . . . do you do these by yourself or does someone usually help?
4. **Eating** - Do you eat without help or does someone usually help you? Do you use special utensils or dishes to help?
5. **Transferring in and out of bed or a chair** - Do you get in and out of bed by yourself or does someone usually help you? Do they lift you out or just give you a hand? What about out of a chair? (If uses a wheelchair), do you transfer from your bed to the wheelchair by yourself or does someone usually help you? Do you use any equipment like a sliding board or a trapeze to help you in and out?
6. **Toileting** - How do you usually go to the toilet, by yourself or with help? Do you use the bathroom . . . a bedside commode . . . a bedpan or urinal? What do you use during the night? Do you have safety equipment such as grab bars to hold on to or a raised toilet seat?
7. **Bladder management** - How often do you urinate? How often do you get up to urinate during the night? Do you have any bladder trouble? Have a weak bladder? Do you ever leak any urine when you laugh, cough or sneeze? Did you ever lose urine on the way to the bathroom because you couldn't get there in time? How often does this happen? Do you wear perennal pads for protection? Protection from what? How many pads do you use in a day? Do you have a urinary catheter? Do you take care of it by yourself or do you usually have help to care for it.
8. **Bowel movement** - Do you have any problems with your bowels . . . constipation . . . diarrhea . . . accidents? How often? What do you usually do to manage your bowels? Do you have a colostomy or ileostomy? Do you manage it yourself or does someone usually help you.
9. **Additional Relevant Information** - e.g. Do you have any other personal care needs such as help with nail care? Does your doctor ever restrict you from doing any of the activities we've been talking about because of a medical problem? Document any other information relevant to ADL's.

SECTION 2: ACTIVITIES OF DAILY LIVING

Select codes representing what consumer does with reasonable safety.

CODES for level of ADL functioning	CODES for bowel and bladder management
1. Independent. Performs safely without assistance 2. Uses assistive device, takes long time, or does with great difficulty. 3. Does with some help a. Does with supervision, set-up, cueing or coaxing only. b. Does with hands-on help. 4. Does with maximum help or does not do at all. Helper does more than half of all of the activity.	1. Independent. a. No accidents b. Infrequent accidents 2. Self care of devices or ostomy/no accidents. 3. Does with some help a. Does with supervision, set-up, cueing or coaxing/assist with equipment/infrequent accidents. b. Does with hands-on help and/or accidents less than daily. 4. Does with maximum help and/or daily accidents.

Questions 1 - 8: Describe the consumer's ability to perform the following activities.

ACTIVITIES OF DAILY LIVING	Code for level of functioning	If coded 2-4, describe how consumer currently manages	Describe additional help needed
1. Bathing			
2. Dressing/Undressing			
3. Grooming			
4. Eating			
5. Transferring In and Out of Bed or Chair			
6. Toileting			
7. Bladder Management			
8. Bowel Management			

9. Comments/additional relevant information

MOBILITY

Note: Bedbound means can't get out of bed or chair without assistance of another person. Without help, the consumer would remain in the bed or chair. Non-ambulatory means consumer, after rising from bed either assisted or nonassisted cannot walk independently unassisted by another person.

2. **Walk indoors** - How do you usually get around indoors? Do you use . . . a walker . . . cane . . . quad cane . . . wheelchair . . . hold onto the furniture? How difficult is it? Who helps you get around indoors?
3. **Walk outdoors** - How do you usually get around outdoors? Do you walk as far as one city block?
4. **Climb stairs** - Do you usually go up and down a flight of stairs? Do you go up and down a few stairs? Who helps you? How difficult is it? Do you have hand rails on both sides of the stairs?
5. **Wheel in a wheelchair** - Do you usually wheel in the chair by yourself or with help? Who helps you? Do you wheel up curbs and over thresholds? When did you start using the wheelchair? Why? Did you have physical therapy to show you how to use it safely?
7. **Fallen recently** - Have you fallen during the past six months? How often? Where did you fall? What were you doing at the time? Did you faint or lose consciousness? Were you injured in the fall(s)? Could you get back up by yourself? Were you seen by your doctor or did you go to an emergency room to be checked out after your fall? Do you do anything special to prevent falling?
8. **Additional Relevant Information** - e.g. Does your doctor ever restrict you from doing any of the activities discussed because of a medical problem. Is there an unmet need or potential for use of assistive device(s)?

SECTION 3: MOBILITY

1. Is consumer bedbound and non-ambulatory? _____ Yes. Skip to Question 5 _____ No. Continue . . .

SELECT CODES representing what consumer does with reasonable safety.

CODES for level of mobility functioning
—
1. Independent. Performs safely without assistance.
2. Uses assistive device, takes long time, or does with great difficulty.
3. Does with some help <ul style="list-style-type: none"> a. Does with supervision, set-up, cueing or coaxing only b. Does with hands-on help
4. Does with maximum help or does not do at all. Helper does more than half of all of the activity.

Questions 2 - 5: Describe the consumer's ability to perform the following activities.

MOBILITY	Code for level of functioning	If coded 2-4, describe how consumer currently manages	Describe additional help needed
2. Walk indoors			
3. Walk outdoors			
4. Climb stairs			
5. Wheel in Chair	NA if not applicable		

6. Consumer at risk of falling? _____ No _____ Yes

If yes, describe risk factor.

7. Has consumer fallen recently? _____ No _____ Yes, describe circumstances.

8. Comments/additional relevant information

GENERAL QUESTIONS FOR INSTRUMENTAL ACTIVITIES

Do you usually _____ by yourself, with some help, or don't you usually _____ at all? (If institutionalized) Are you able to _____? Who usually helps you? Do you need more help (than you currently have)? (If by self) is it very difficult for you?

1. **Preparing Meals** - Do you prepare light meals and snacks? Do you prepare whole meals? Do you have trouble using any of your kitchen appliances?
2. **Housework** - Do you do light housework, such as washing dishes or straightening up? Do you do heavy housework, such as cleaning floors?
3. **Laundry** - How do you usually do your laundry? Where do you do it?
4. **Shopping** - How do you usually do your grocery shopping? Other shopping?
5. **Transportation** - What kind of transportation do you usually use? Do you drive? Own a car? Can you travel in a car, van or taxi if someone goes with you? (If consumer says he/she never goes out, ask:) How do you get to the doctor?
6. **Managing money** - Do you usually manage your own money or does someone help you? Do you write checks and pay bills?
7. **Using the telephone** - Do you answer the telephone yourself? . . . Can you call the operator? . . . Do you use any special equipment on your phone? . . . Need any?
8. **Chores** - Do you usually do the chores, such as taking out the garbage? Do you do minor repairs around the house? . . . Yard work or gardening?

SECTION 4: INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Select codes representing what consumer does with reasonable safety.

CODES for IADLs
1. Independent.
2. Independent but with great difficulty or with mechanical help.
3. With the assistance of a helper.
4. Unable/helper does

Questions 1 - 8: Describe the consumer's ability to perform the following activities.

INSTRUMENTAL ACTIVITIES	Code for level of functioning	If coded 2-4, describe how consumer currently manages	Describe additional help needed
1. Preparing Meals			
2. Doing Housework			
3. Doing Laundry			
4. Shopping			
5. Using Transportation			
6. Managing Money			
7. Using Telephone			
8. Home Maintenance (chores and repairs)			

9. Comments

NUTRITION

1. How is your appetite, in general? How many meals do you usually eat each day?
2. What do you usually eat for breakfast . . . for lunch . . . for dinner? (OPTIONAL)
(Note any comments/concerns re: consumers' eating habits)
3. If consumer is aware of food allergies, specify the food and document the allergic reaction.
7. Do you know how much you weigh? How tall you are?
8. Has your weight gone up or down in the past 6 months, or has it stayed about the same? Do you know why it has gone up?
Down?

SECTION 5: NUTRITION

Does consumer	Yes	No	Specify when problematic
1. Generally have a good appetite?			
2. Usually eat three meals a day?			

(Following information on typical meals is OPTIONAL)

Describe typical breakfast _____

Describe typical lunch _____

Describe typical dinner _____

Are there any foods you do not eat because of religious practices/cultural norms? Yes No What are they? _____

Do you use dietary supplements or aids that have been recommended to you by someone who provides alternative medical care?
Yes No Who recommended them and what are they?

Is Consumer . . .	Yes	No	Specify when problematic
3. Aware of any food allergies			
4. On a special diet?			
a. Able to follow this diet?			
5. Able to chew without problems?			
6. Able to swallow without problems?			

7. Height: _____ Weight: _____

8. Weight changes in the past 6 months? No Yes

If yes, _____ Pounds, Gain Loss Reason: _____

9. Do you have access to adequate food? _____ No _____ Yes. Other nutritional concerns?

SOCIAL PARTICIPATION

OPTIONAL:

2. **Current employment status** - Are you currently employed? (If yes) Where do you work? Doing what? (If not) Are you retired, looking for work (i.e. unemployed), or on disability?

3. **Religious affiliation** - Do you belong to a congregation? Would you say you are very involved in religious affiliation activities?

SECTION 6: SOCIAL PARTICIPATION

1. Is the consumer satisfied with current level of socialization?

No Yes, Explain: _____

OPTIONAL:

2. Current employment status? Occupation? _____

3. Religious affiliation: _____

If relevant: Place of worship: _____

Clergy: _____

Phone: _____

4. Comments

COGNITIVE FUNCTIONING

(Questions may be asked of consumer and caregiver or, with rewording, of others who know the consumer and caregiver. Information from earlier in the interview may also be used. If this is a NF application, complete for consumer only.)

In general how is your memory?

- 2a. **Orientation** - Do you usually know the day of the week . . . the month . . . the season? Do you usually recognize people you know . . . remember their names?
- 2b. **Recent memory** - Do you remember what you had for breakfast?
- 2c. **Distant memory** - (Answers to the SPMSQ may be used, or ask the consumer/caregiver a question about his/her history.) e.g. Where were you born? Where did you grow up? How many siblings did you have? Did your parents have any health problems? How long have you been in the United States? How long have you lived here?

(Based on the rest of the interview:)

- 2d. **Understanding directions** - (Can the person read and understand labels on medicine bottles? Can the person respond appropriately to verbal instructions?)
- 2e. **Communicate needs** - (Has the person been able to identify and verbalize or otherwise communicate his/her needs during this interview?)
- 2f. **Safety judgment** - (Does the person show awareness of danger; e.g. use door locks appropriately, know that food spoils, do common sense things to prevent accidents?)
- 2g. **Understand consequences** - (Can the person identify potential risks and respond to negative consequences of his/her actions.) (About a particular decision or course of action . . .) Do you understand what kinds of things might happen? What would you think about that? . . . or, then what would you do?

OPTIONAL SPMSQ

The Short Portable Mental Status Questionnaire is intended to serve as a screen to help identify those persons whose cognitive status should be further evaluated. The SPMSQ should be used: whenever there is **any question** about a person's cognitive functioning; when a consumer will be making non-trivial care decisions; and consumers who are not regularly observed (e.g., those who live alone) should be screened. If you decide to skip the SPMSQ at this point, consider returning to it near the end of the assessment.

Instructions for scoring SPMSQ questions as "correct" or "incorrect"

1. Date today: Score correct only when the exact month, day and year are given correctly.
3. Name of this place: Score correct if any correct description of the location is given: "My home," accurate name of town, city or name of residence, hospital, or institution (if subject is institutionalized) are all acceptable.
4. If none, see 4a.

Telephone number: Score correct when the correct number can be verified or when subject can repeat the same number at another point in questions.
5. Age: Score correct when stated age corresponds to date of birth.
6. Birthdate: Score correct only when exact month, date and year are all given.
7. Current President: Only last name of President is required.
8. President before him: Only last name of previous President required.
9. Mother's maiden name: Does not need to be verified. Score correct if last name other than subject's last name is given.
10. Subtract 3 from 20: The entire series must be performed correctly in order to be scored correct. Any error in series or unwillingness to attempt series is scored as incorrect.

NOTE: Ask consumer what is highest grade completed in school.

SPMSQ SCORING, ADJUSTMENT FACTORS

- a. **Subtract 1** from the total number of errors (opposite page) if person has completed an 8th grade education or less. Record result in **ADJUSTED SCORE**.
- b. **Add 1** to total number of errors (opposite page) if person has had education beyond high school. Record result in **ADJUSTED SCORE**.

Meaning of SPMSQ Scores

- 0 - 2 errors** = intact intellectual functioning
- 3 - 4 errors** = mild intellectual impairment
- 5 - 7 errors** = moderate intellectual impairment
- 8 - 10 errors** = severe intellectual impairment

Please note: This scoring is provided as a guideline for the assessor's use. However, the SPMSQ should not be used as the sole basis in making a judgment about the person's cognitive functioning.

Section 7: **OPTIONAL - for consumer and/or caregiver (for NF Application, consider consumer only)**

SHORT PORTABLE MENTAL STATUS QUESTIONNAIRE (SPMSQ) by Eric Pfeiffer, MD

Instructions: Ask Questions 1-10, record answer, & check appropriate column (correct/error). All responses, to be scored correct, must be given by person without reference to calendar, newspaper, birth certificate or other memory aid. Ask only consumer/caregiver. Do not skip any questions. **Read to Person:** Sometimes people have trouble remembering things. If you do not know the answers to some of the next questions, that's okay. It's very normal. If you do know the answers, the questions may seem obvious.

	Correct	Incorrect	Not Answered
1. What is the date today? Month/Day/Year (Cons.) _____ (CG) _____			
2. What day of the week is it? (Cons.) _____ (CG) _____			
3. What is the name of this place? (Cons.) _____ (CG) _____			
Probe: This hospital? This nursing facility? (Cons.) _____ (CG) _____			
4. What is your telephone number?(Cons.) _____ (CG) _____			
a. What is your street address? (Ask only if subject does not have telephone.)(Cons.) _____ (CG) _____			
5. How old are you? (Cons.) _____ (CG) _____			
6. When were you born? Month/Day/Year (Cons.) _____ (CG) _____			
7. Who is the President of the United States now? (Cons.) _____ (CG) _____			
8. Who was the President before him? (Cons.) _____ (CG) _____			
9. What was your mother's maiden name? (Cons.) _____ (CG) _____			
10. Subtract 3 from 20 and keep subtracting 3 from each new number all the way down. (Cons.) _____ (CG) _____			
	17	14	11
	8	5	2

What was the highest grade completed in school? (Cons.) _____	Total Number Errors (Cons.) _____	_____
(CG) _____	Total Number Errors (CG) _____	_____
	Adjusted Score (Cons.) _____	_____
	Adjusted Score (CG) _____	_____

EMOTIONAL STATUS AND BEHAVIOR

(Answers may be based on asking the consumer, on observation, asking caregivers or others, or using information obtained at earlier points in the interview. **Do not** assume you know answers in the absence of evidence or information.)

1. **General questions:**

Would you say you feel _____?

Do you do anything special when you feel _____?

d. **Withdrawn** - Do you feel like you don't want to be around other people?

e. **Abusive** - (Ask a caregiver, if possible.) (If asking consumer . . .) Do you ever feel like shouting at someone or striking them? Do you ever do it?

g. **Depression** - Are you in good spirits most of the time? How often do you feel down or blue? Do you feel you have lost interest in things? How long have you been feeling like that?

2a. **Hallucinations** - Do you ever see or hear things that other people don't? What kind of things?

2b. **Suicidal thoughts/behavior** - Do you ever think that life isn't worth living? Have you ever had thoughts about suicide? . . . ever made any plans for suicide? How do you feel about that now?

2d. **Sleep disturbances** - Do you ever have trouble falling asleep or staying asleep? How often does that happen? Is there anything that you do about that?

4. If answered yes, continue. If answered no, consider the following

- ◆ Optimally the safety question should be asked of every consumer in private rather than in the presence of family or caregiver who could be an abuser.
- ◆ Understand fully the dynamics of how such privacy is achieved and the possible implications concerning the reaction of a potential abuser (e.g. suspicion, anger, resentment or increased risk of abuse)
- ◆ Avoid blaming the victim

If the reason for "feeling unsafe" is not related to abuse/domestic violence (e.g. gangs, substandard housing, pest or rodent infestation etc.) make the appropriate referrals.

If the reason for "feeling unsafe" is related to abuse/domestic violence, ask questions such as:

- ◆ Would you like to talk to someone at the domestic violence program?
- ◆ Would you like to talk to a protective services worker?
- ◆ Are you afraid to stay here?
- ◆ Are there weapons present?
- ◆ Do you need a safe place?
- ◆ Do you want help from the police?

SECTION 8: EMOTIONAL STATUS AND BEHAVIOR

Unable to assess any of the below ____ yes (provide comments i.e. why etc. then skip to # 4) ____ no (Continue)

1. Ask consumer if possible is the consumer . . . ?	YES	NO	Describe behavior and how it is being managed.
a. Worried, anxious			
b. Irritable, easily upset			
c. Lonely			
d. Withdrawn, lethargic			
e. Abusive verbally/physically			
f. Fearful, suspicious			
g. Depressed, very sad, hopeless			

2. Does the consumer have?	YES	NO	Describe behavior and how it is being managed
a. Hallucinations, Delusions			
b. Suicidal Thoughts/Behavior			
c. Problem with Wandering			
d. Sleep Disturbances			
e. Other Unusual Behavior			

3. When you are worried, anxious or sad, to whom do you go to for advice or counsel? Name:

4. Do you feel safe in your current living situation? ____yes ____no

5. Have you had a recent psychiatric hospitalization? ____yes (fill in below) ____no

When _____ Physician _____

Diagnosis _____ Hospital _____

6. Check sources of information for emotional status section. Consumer Record Observation
 Family Provider Other

7. Comments.

INFORMAL SUPPORTS

Ask about the helpers who have been mentioned during the interview.

2. Who help you the most?

(For each) Where does _____ live?
Are there any other people who help you (and are not paid)?

3. Do you think your caregiver has any special problems?

(Ask of the primary caregiver): OPTIONAL

9. Can you continue to provide help at the current level? If not, why not?

10. Overall, are the arrangements between you and _____ (consumer) satisfactory to you, or are some things difficult for you to deal with? What things are difficult? How stressed do you feel caring for _____, . . . not stressed . . . somewhat stressed . . . very stressed?

11. If you could have help with some tasks, which would you most like help with? Can you think of something that might make your caregiving easier? What would that be?

NOTE: Questions 2, 3, 4, 5, 6, 7, 8 & 9 should be helpful in scoring caregiver burden in the FNM.

Questions 5, 9, 10, 11, 12, 13, 14, 15, 16, 17, & 18 should be helpful in scoring caregiver stress in the FNM.

Questions 2 & 12 should be helpful in scoring respite care availability in the FNM.

SECTION 9: INFORMAL SUPPORTS

1. Does consumer have any informal supports?

No, Skip to page 17, Section 10, Question 1.

Yes, continue . . .

2. List Informal Supports Name/Location/Phone	Relationship P = Primary caregiver	Age (estimated)	NARRATIVE: Help Provided

3. Check limitations or constraints on primary caregiver.

- No particular constraints
- Poor health, disabled, frail
- Employed
- Lacks knowledge, skills
- Providing care to others
- Not reliable

- Poor relationship with consumer
- Lives at a distance
- Alcohol, drug abuse
- Financial strain
- Dependent on consumer for housing, money or other

PRIMARY CAREGIVER INFORMATION (Required when considering FCSP. If not considering FCSP skip to Section 10)

4. Current employment status? (full/part time) _____

5. Have your caregiving and social life and/or employment affected each other? How? _____

6. Do you have any other caregiving responsibilities? (children, other adults, etc.) _____

7. How many hours a day do you have available to provide care to this consumer? _____

8. How many hours a day do you usually spend providing care to this consumer? _____

9. Describe problems with continued caregiving (if any). _____

10. Overall, how stressed do you feel in caring for the consumer? (Optional caregiver stress interview may be completed at this point in the assessment - see pg. 25)

- Not stressed Somewhat stressed Very stressed

11. Do you desire service or support?

No Yes, Describe needs _____

PRIMARY CAREGIVER INFORMATION (Continued)

12. Is anyone available to provide respite (relief) when you are unable to provide care? ____ Yes ____ No If yes, is such assistance available on short notice? ____ Yes ____ No
13. In the past six months, have there been any significant changes or events in your life? ____ Yes ____ No Explain:
14. Are you currently experiencing any emotional concerns or difficulties? ____ Yes ____ No Explain:
15. Are you currently receiving any assistance to deal with your emotional concerns or difficulties? ____ Yes ____ No Explain:
16. Do you participate in a support or discussion group where you can discuss your feelings? ____ Yes ____ No What type of support group/frequency of attendance?
17. Have you ever been so upset that you did something to your relative (consumer) that you now regret? ____ Yes ____ No Explain:
18. Has your relative (consumer) ever done these kinds of things to you? ____ Yes ____ No Explain:
19. Consumable Caregiving Supplies

Item Description	Total Average Monthly Costs	Who Pays

20. What is the average monthly cost TO THE FAMILY OR CONSUMER for consumable supplies?

21. Comments (If considering FCSP, summarize **total** household financial situation)

FORMAL SERVICES

What services are you currently receiving from an agency or organization?

Have you received any **other** services in the past 6 months? What were they?

Are there any services that are scheduled to begin sometime soon? What are they?

(If in the hospital or nursing facility)

Are you receiving physical therapy . . . occupational therapy . . . speech therapy?

Are there any services that are scheduled to begin when you go home . . . (or when you get to the nursing facility?)

SECTION 10: FORMAL SERVICES

1. Has consumer received formal services during the past 6 months or does consumer have formal services ordered?
 No. Skip to page 17, Question 1 Yes. Uncertain. Continue . . .

Instructions: List services consumer is currently scheduled to receive, is receiving, or has received during the past 6 months (even if discontinued). Include equivalent services being provided by an institution, PCH, Dom Care.

CODES for status of service
C = Current P = Past 6 months O = Ordered previous to this assessment

2. Services	Code for Services	Notes
a. Adult Day Care		
b. Attendant Care		
c. Case Management		
d. Center Services		
e. Congregate Meals		
f. Counseling		
g. Financial Management		
h. Home Delivered Meals		
i. Home Health Aide		
j. Home Support		
k. Job Counseling/Vocational Rehabilitation		
l. Legal Services		
m. Nursing		
n. Occupational Therapy		
o. Ombudsman		
p. Personal Care		
q. Personal Assistance Services		
r. Physical Therapy		
s. Respite Care		
t. Speech Therapy		
u. Transportation		
v. Partial Hospitalization		
w. Other		

PHYSICAL ENVIRONMENT

1. **Dwelling Unit** - Where do you currently live? Is that a house, an apartment, or what? Do you own it or rent it?
 - a. Service supported housing means elderly apartment with available services such as meals and housekeeping.

2. **Remain** - Will you be able to stay in that living situation or might you have to move? Why is that?

4. **Condition of Living Environment** - What is the condition of your home? I'm going to ask you about a list of things . . . would you tell me whether each thing is okay or whether there is some problem with that thing? Check if okay. If not give problem location and describe the problem.

Note: Describe the place the consumer expects to live during the next 6 months. There is no need to completely describe nursing facilities, group homes, DC or PCH or other settings which are regulated or supervised **unless** you wish to document problems.

If living environment is not seen, write "not seen" across the first line and complete the checklist based on consumer report, if possible.

Important When Considering FCSP:

A walk-through inspection is required of rooms/areas where consumer spends most of time and receives care and where the caregiver provides care and performs caregiving activities (e.g. kitchen - food preparation).

SECTION 11: PHYSICAL ENVIRONMENT

1. Current Dwelling Unit

- a. Type House Service Supported Housing ICF/MR
 Apartment PCH CLAI/CRR
 Mobile Home Dom Care Other _____
 Subsidized Housing Nursing Facility

- b. Consumer Owns Rents

2. Can consumer remain in current living arrangement?

- No. Explain, then skip to Question 4. : _____

 Yes Uncertain - Continue . . .

3. Condition of living environment checklist skip. Check if:

- Consumer's anticipated home is a NF, program home, group home or DC/PCH. Complete C, J, K for the anticipated home, if known. Then skip to Question 6.
 --- other, continue (by completing checklists for anticipated home, if known)

4. Condition of Living Environment <input type="checkbox"/> Check if unable to determine	Check if OK	If not, give Problem Location	Describe problem
a. Sound Building			
b. Sound Furnishings			
c. Stairs or Other Barriers			
d. Free of Health Hazards			
e. Security/Safety			
f. Electricity			
g. Running Hot Water			

(OPTIONAL) 5. **Accessible** - Are there places nearby to shop? Are you able to get there without too much difficulty?

What about a place to do your banking? . . . your laundry?

What about your doctor's office or clinic? Are you able to get there without too much difficulty?

What about a drug store for your medications?

What about places to go out and do things or be with other people?

6. If there is potential for home modification(s) which would benefit the consumer, it should be documented under the comment section as well as any comments regarding neighborhood and additional problems.

Condition of Current Dwelling	Check if OK	If not, give Problem Location	Describe Problem
h. Heating System			type:
i. Cooling System			
j. Toilet Facilities			
k. Bathing Facilities			
l. Refrigerator/Freezer			
m. Stove/Food Prep Area & Storage			
n. Telephone			
o. TV/Radio			
p. Washer/Dryer			

OPTIONAL

5. Accessible To:	Yes	No	Comments
a. Shopping			
b. Banking			
c. Laundry			
d. Doctor/Clinics			
e. Pharmacy			
f. Recreational/Social Activities			

6. Comments: neighborhood; additional problems:

FOR FCSP ASSESSMENT

2. and 3. must be completed for consumer and caregiver and other family members as appropriate.

5.b. "With": e.g.name of funeral home, bank

6. Check if local form for expenses, assets.

Yes. Skip to page 21

No. Continue . . .

7. Assets	Amount
a. Savings Account	
b. Checking Account	
c. Certificates	
d. Real Estate	
e. Insurance	
f. stocks/bonds	
g. Other (Specify)	
TOTAL	

8. Describe unusual or excessive expenses.

9. Comments

COAF ASSESSMENT DECISION NARRATIVE

Consumer's Name: _____

Social Security #: _____

PS indicated No Yes, complete REPORT OF NEED

Home and Community Based Services (HCBS) Recommended - See Care Plan

Full Lottery Funded
Limited Lottery Funded
FCSP
Bridge
PDA Waiver
LTCCAP

NF Clinically eligible (NFCE) Yes No

Placement Recommended

DC PCH

NF

Long Term
Short Term

End Date _____

Waiting List

FNM Score _____

No Services Recommended

Document in detail providing justification for NF placement, PDA Waiver, PCH, DC recommendations and if NFCE (use back of form or attach additional pages if needed). List diagnosis(es)/condition and symptoms and medical need(s) created by diagnosis(es); complications, severity, effect on function, treatment and who provides. Consideration must be given to consumer's condition and to availability and feasibility of using more economical alternative facilities and services when considering NF recommendation. When a consumer has applied for and requests NF or PDA Waiver services, and the OPTIONS decision/recommendation is for something other than what the consumer applied for and requested, clearly explain and document why the consumer does not meet the criteria for Nursing Facility Clinically Eligible (NFCE) and therefore does not qualify for the NF benefit or the waiver. If a consumer has applied for HCBS and chooses not to apply for PDA Waiver services or has been assessed and found eligible for PDA Waiver services, but chooses not to be enrolled in the waiver program, this must be clearly documented.

(Continue on back of this page if necessary)

SIGNATURES: Assessor _____

Date _____

Supervisor _____

Date _____

Registered Nurse _____

Date _____

PLACEMENT OPTIONS INFORMATION (Additional Assessment Information)

1. Consumer Preferences/Special Needs	Yes	No	Describe Problems
a. Would you share a room?			
b. Would you live in a home with pets?			
c. Would you live in a home with children?			
d. Do you drink alcohol?			
e. Would you live with someone who drinks alcohol?			
f. Do you smoke? (cigarettes, pipes, cigars)			
g. Would you live with someone who smokes?			
h. Do you have a girlfriend (boyfriend)?			
i. Do you want to live in a particular area? (Specify)			
j. Do you need a first floor bedroom?			
k. Do you care about the religion of the provider or others you live with?			
l. Would you like to work for pay?			

Other preferences/special needs:

2. Further comments regarding behavior that would affect consumer placement decision.

SCORING INSTRUCTIONS

The Stress Interview is scored by summing the responses of the individual items. Higher scores indicate greater caregiver distress (Never = 0, Rarely = 1, Sometimes = 2, Quite Frequently = 3, Nearly Always = 4). The Stress Interview, however, should not be taken as the only indicator of the caregiver's emotional state. Clinical observations and other instruments such as measures of depression should be used to supplement this measure. Norms for the Stress Interview have not been computed, but estimates of the degree of stress can be made from preliminary findings.

These are:

0 - 20 = Little/No Stress

21 - 40 = Mild/Moderate Stress

41 - 60 = Moderate/Severe Stress

61 - 88 = Severe Stress

If utilized, results from this instrument can be transferred as indicated to the caregiver stress section of the Functional Needs Measurement.

Caregiver Stress Interview (Steven H. Zarit, Ph.D. - modified version)

This interview should be completed for all FCSP consumers; OPTIONAL for others.

Read to Caregiver: The following is a list of statements which reflect how people sometimes feel when taking care of another person. After each statement, indicate how often you feel that way: never, rarely, sometimes, quite frequently, or nearly always. There are no right or wrong answers.

QUESTION	Never	Rarely	Sometimes	Quite Frequently	Nearly Always
1. Do you feel that your relative asks for more help than he/she needs?					
2. Do you feel that because of the time you spend with your relative that you don't have enough time for yourself?					
3. Do you feel stressed between caring for your relative and trying to meet other responsibilities for your family or work?					
4. Do you feel embarrassed over your relative's behavior?					
5. Do you feel angry when you are around your relative?					
6. Do you feel that your relative currently affects your relationship with other family members or friends in a negative way?					
7. Are you afraid of what the future holds for your relative?					
8. Do you feel your relative is dependent upon you?					
9. Do you feel strained when you are around your relative?					
10. Do you feel your health has suffered because of your involvement with your relative?					
11. Do you feel that you don't have as much privacy as you would like because of your relative?					
12. Do you feel that your social life has suffered because you are caring for your relative?					
13. Do you feel uncomfortable about having friends over because you are caring for your relative?					
14. Do you feel that your relative seems to expect you to take care of him/her as if you were the only one he/she could depend on?					
15. Do you feel that you don't have enough money to care for your relative in addition to the rest of your expenses?					
16. Do you feel that you will be unable to take care of your relative much longer?					
17. Do you feel you have lost control of your life since your relative's illness?					
18. Do you wish you could just leave the care of your relative to someone else?					
19. Do you feel uncertain about what to do about your relative?					
20. Do you feel you should be doing more for your relative?					
21. Do you feel you could do a better job in caring for your relative?					
22. Overall, do you feel burdened caring for your relative?					

To be completed by Case Manager:

TOTAL ZARIT SCORE _____