



**Uniform Comprehensive Assessment, Part III**  
Medical (Level of Care) Assessment

**Assessment information.**

**(Assessor)** Attach completed Form 02HM001E, Uniform Comprehensive Assessment, Part I, Intake and Referral. Numbers in parenthesis refer to item numbers in the Oklahoma Long-Term Care Authority (OLTCA) Manual.

(1) Consumer name		Date
Social Security number (2)	Case number	Unique ID number

- (3) Location of:  assessment  reassessment  
 consumer's residence  relative's home  nursing home  
 hospital  other, specify \_\_\_\_\_

**Mental status questionnaire (MSQ)**

**(Assessor)** Write responses to questions. Do not score until section is completed. Count one error for each incorrect response up to the maximum errors for the item. No response is counted as an incorrect response.

(4) **(Say)** I'm going to read you a list of questions. These are questions often asked in interviews like this and we are asking them the same way to everyone. Some may be easy and some may be difficult. Let's start with the current year.

Question	Answer	Maximum errors	Score	Weight	Weighted score
What year is it now?	_____	1	_____	X 4 =	_____
What month is it now?	_____	1	_____	X 3 =	_____

**(Say)** I'm going to give you a man's name and address to memorize and you will be asked to repeat the phrase later.

Memory phrase: **John Brown, 42 Market Street, Chicago**

Elicit three correct repetitions from the consumer, phrase by phrase or word by word, if necessary, before continuing.

**(Ask)** Without looking at a clock, what time is it? (within one hour)

Time is: \_\_\_\_\_ Response: \_\_\_\_\_ 1 \_\_\_\_\_ X 3 = \_\_\_\_\_

**(Say)** Count backwards from 20 to 1.

Indicate missed or out of order numbers in boxes. Mark / for correct and x for incorrect.

2 \_\_\_\_\_ X 2 = \_\_\_\_\_

20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1
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**(Ask)** Say the months in reverse order.

For ease in scoring, start with the month of December. Indicate missed or out of order months in boxes. Mark / for correct and x for incorrect.

2 \_\_\_\_\_ X 2 = \_\_\_\_\_

Dec	Nov	Oct	Sep	Aug	Jul	Jun	May	Apr	Mar	Feb	Jan
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**(Ask)** Now, repeat the memory phrase.

Prompt the consumer if necessary: **It was John Brown...**

Write consumer's response on the line below to score.

<b>Error points</b>	<b>John</b>	<b>Brown</b>	<b>42</b>	<b>Market Street</b>	<b>Chicago</b>
	(1)	(1)	(1)	(1)	(1)

Response:

5 \_\_\_\_\_ X 2 = \_\_\_\_\_

Maximum weighted error score = 28	Total weighted error score
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**Health assessment.**

(1) Check source of information used for Health assessment:

- Consumer  Record review  Other, specify \_\_\_\_\_

**Health conditions.**

(2) **(Ask)** Do you have any health conditions, and how do they affect you?

Has a doctor told you that you have any of the following health problems or symptoms of health problems?

Read health conditions to consumer.

Reviewed	Health conditions	Present	Interferes with living	Condition is not under treatment	Number of years had condition
<input type="checkbox"/>	<b>Allergies</b> (drug/skin/etc.), type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Amputation, site: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Anemia</b> , type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Arthritis, type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Reviewed	Health conditions	Present	Interferes with living	Condition is not under treatment	Number of years had condition
<input type="checkbox"/>	<b>Asthma</b> , type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Bed sore(s)</b> , decubitus stage: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Bladder/kidney problems (UTI, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Blood disorder</b> , type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Brain injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Broken bones</b> , type, site: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Cancer, type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Cerebral palsy</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Cognitive learning disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Cystic Fibrosis</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Dehydration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Dementia</b> (ALZ, OBS, etc.), type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Dialysis, type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Diabetes</b> , type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Eating disorder</b> , type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Emphysema (COPD, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Falls</b> (past year): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Gall bladder problems (gallstones, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Hearing problems</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Heart problems (CHF, MI, etc.), type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>High blood pressure</b> (hypertension), type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Hormonal disorder</b> , type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Intestinal disorder, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Liver problems</b> (cirrhosis, hepatitis, etc.), type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Mental illness</b> , type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Migraine headaches</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Mood or behavior problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Multiple sclerosis</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Reviewed	Health conditions	Present	Interferes with living	Condition is not under treatment	Number of years had condition
<input type="checkbox"/>	Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Osteoporosis</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Paralysis, site: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Parkinson's disease</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Polio/post-polio syndrome</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Potassium/sodium imbalance (electrolytes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Seizure disorders</b> (epilepsy, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Shingles (herpes zoster)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Skin disease</b> , specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Spina bifida</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Spinal cord injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Stroke</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Thyroid problems</b> (Graves, myxedema, etc.), type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Ulcers</b> , type and site _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Vision problems (cataracts, glaucoma, etc.), Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>Other</b> , specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Substance abuse, type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Notes:****Drug, alcohol, and tobacco use.**

(3) **(Ask)** Do you use a recreational substance? For example, marijuana, LSD, crack cocaine, barbiturates, designer drugs, or inhalants.

- Uses. Specify frequency: \_\_\_\_\_
- Does not use.
- Used in the past. Specify when quit: \_\_\_\_\_

(4) **(Ask)** Do you drink any alcoholic beverages, including beer and wine?

- Drinks alcohol. **(Ask)** On average, how much beer, wine, and other alcoholic beverages do you drink?  
Specify frequency: \_\_\_\_\_
- Never drinks alcohol.
- Used alcohol in the past. Specify when quit: \_\_\_\_\_

(5) **(Ask)** Do you smoke, chew, or dip tobacco?

- Yes **(Ask)** How much do you use per day? \_\_\_\_\_
- No
- Used tobacco in the past. Specify when quit: \_\_\_\_\_

(6) **(Assessor)** Are you concerned about consumer's drug, alcohol, and tobacco use?

Yes  No

Describe why:

Comments and conditions unique to consumer pertaining to health conditions through drug, alcohol, and tobacco use sections:

(7) **Medication use.** Current medicines, refrigerated medicines, and non-prescription drugs, such as aspirin, vitamins, laxatives, home remedies, herbal products, and birth control.

Name	Dosage	Frequency	Physician	Date filled

(8) Pharmacy used by consumer. If more than one, note others in comments.

Name	Phone
Address	

(9) **(Ask)** How do you remember to take your medications? **Do not read list. Check answer and specify who gives or fills.**

- Caregiver gives \_\_\_\_\_
- Follow directions on label or doctor order \_\_\_\_\_
- Plastic pill minder \_\_\_\_\_
- Calendar or log \_\_\_\_\_

- Egg carton, envelopes \_\_\_\_\_
- Other, specify: \_\_\_\_\_

(10) **(Assessor)** Check if yes. I am concerned consumer is:

- not taking meds on time
- not taking proper number of meds
- taking meds prescribed for others
- not getting Rx properly filled
- not getting med needs re-evaluated
- not getting meds due to cost
- affected by drug side effects
- taking prescriptions from too many physicians
- using outdated meds
- refusing to take meds
- having other medication problems, specify: \_\_\_\_\_

Comments and service plan implications:

**Medical utilization.**

(11) **(Ask)** In the PAST SIX MONTHS have you seen a doctor (physician's assistant or nurse practitioner, eye doctor, foot doctor, dentist, or hearing exam), been admitted to a hospital, or gone to an emergency room?  Yes, complete below  No  Don't know

Name of physician/hospital/ER	Date	How long?	Reason for visit/admission

(12) Were you ever a resident of a nursing home, RCF, or similar place?  Yes, complete below  No  Don't know

Admit date	Discharge date	Name of facility (RCF, NF, SNF, ICF-MR)	Reason for admission

**Special equipment and assistive devices.**

(13) **(Ask)** Do you have or need any of the following special equipment or aids?

Equipment/ assistive device	Has and uses	Has, but doesn't use	Needs but doesn't have
<b>Prosthesis</b> , type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Walker</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair, type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Brace</b> , leg/back: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing aid(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Glasses</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Dentures</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency alert response (EAR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hospital bed</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bedside commode	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Bathing equipment</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfer equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Adaptive eating equipment</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disposable medical supplies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other</b> , specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments and service plan implications:

**Medical treatments and therapies**

(14) **(Ask)** Do you regularly receive any of the following medical treatments?

Medical treatment	Yes	No	Frequency
<b>Aseptic dressing</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Bedsore treatment	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Bowel/bladder rehab</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel impaction therapy	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Catheter care</b> , type: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Dialysis (type): _____	<input type="checkbox"/>	<input type="checkbox"/>	
<b>IV fluids</b>	<input type="checkbox"/>	<input type="checkbox"/>	
IV medicines	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Insulin therapy</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Lesion irrigation	<input type="checkbox"/>	<input type="checkbox"/>	
Ostomy care, type: _____	<input type="checkbox"/>	<input type="checkbox"/>	

Medical treatment	Yes	No	Frequency
Oxygen	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Resp. treatment</b> , type: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Suctioning	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Tube feeding</b> , type: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Occupational therapy</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Speech therapy	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Respiratory therapy</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	

Comments on medical treatment and therapies and service plan implications:

(15) **(Assessor)** Record consumer's diagnosis.

Diagnosis	DRG-code
Primary :	
Secondary:	

**Nutrition.**

(16) **(Ask)** Would you say that your appetite is good, fair, or poor?

Good (0) Fair (2) Poor (6) Score: \_\_\_\_\_

(17) Current weight and height? Weight \_\_\_\_\_ Height \_\_\_\_\_

(18) **(Ask)** Have you gained or lost a significant amount of weight in the last six months?

**10% unintentional change is significant.**

Yes (4)  Gain: \_\_\_\_\_ pounds  
 No (0)  Loss: \_\_\_\_\_ pounds

Score: \_\_\_\_\_

(19) Do you have any problems that make it difficult to eat?

List score. For example, do you have:	Yes	No
tooth or mouth problems	_____ (4)	_____ (0)
swallowing problems	_____ (4)	_____ (0)
nausea/vomiting	_____ (4)	_____ (0)
taste problems	_____ (0)	_____ (0)
problems eating certain foods	_____ (0)	_____ (0)
food allergies	_____ (0)	_____ (0)
any other problems eating	_____ (0)	_____ (0)
<b>Describe:</b>		
<b>Total:</b>	0	0

Comments and service plan implications:

(20) Are you on a special diet that the doctor told you to follow?

None (0) \_\_\_\_\_ 1 Diet (4) \_\_\_\_\_ 2 or more diets (6) \_\_\_\_\_

Are you following the diet?  Yes  No

Check if you are on one of the diets below:

- Low sodium (salt)
- Low fat/cholesterol
- Low sugar
- Calorie supplement
- Other prescribed special diet, specify: \_\_\_\_\_

Comments and service plan implications:

(21) **(Assessor)** Does consumer take three or more prescribed or over-the-counter drugs daily?

Yes (2) \_\_\_\_\_ No (0) \_\_\_\_\_

Briefly describe what the consumer usually eats and drinks during a typical day, including weekends. Enter one mark for each serving the consumer eats and drinks in a typical day. **Do NOT add these scores into nutrition total score.**

Type of food or drink	Breakfast	Lunch	Dinner	Snack	Total
Fluids					
Fats, oils, sweets					
Milk, yogurt, cheese					
Fruit					
Meat, poultry, fish, dry beans, eggs, nuts					

Type of food or drink	Breakfast	Lunch	Dinner	Snack	Total
Vegetables					
Bread, cereal, rice, pasta					

Specify any religious or self-imposed diets practiced:

Nutrition total score

**(22) Subjective evaluation of health.**

**(Ask)** Overall, do you consider your health excellent, good, fair, or poor?

**(Assessor)** Enter score: Excellent (0) \_\_\_\_\_ Good (5) \_\_\_\_\_  
Fair (15) \_\_\_\_\_ Poor (25) \_\_\_\_\_

**(Ask)** What makes you feel that way? **(Document answer)**

Subjective evaluation of health total score

**(23) (Assessor)** Rate consumer's speaking and communication ability based on performance in the interview:

**Speaking.**

- Speaks clearly with others of the same language
- Some defect in speech/usually gets message across
- Unable to speak clearly/does not speak

**Communication.**

- Transmits/receives information
- Limited ability
- Nearly or totally unable to speak

**(24) Health assessment.** Clinical judgment, pertaining to Health assessment.

Check risk level and document why.

- low risk  moderate risk  high risk

**Comments and service plan implications - Summary:**

**Functional assessment – ADLs.**

(1) Check sources of information used for Functional assessment section.

Consumer     Other, specify: \_\_\_\_\_

**For initial assessment:** List in the last column assistance needed in addition to what is already in place. Be specific about tasks needed and frequency.

**For reassessment:** Indicate in the last column if services need to be increased, decreased, or remain at the same level.

**Read all choices before taking answer.**

Assistant codes: 1 = Spouse 2 = Children 3 = Friend 4 = Other relative 5 = Agency 6 = Church 7 = Volunteer 8 = Private pay  
 Level of help needed codes: 0 = no assistance 2 = Some assistance/supervision 3 = Can't do at all

ACTIVITIES OF DAILY LIVING (ADLs) Would you say that you need help with:	No assistance	Some assistance/supervision	Can't do at all	Comments, required to justify score of 2 or more	Name and phone number of assistant	Assistant code	Frequency, hours, etc	Assistance needed
(2) <b>dress</b> ing. Includes getting out clothes, putting them on, fastening them, and putting on shoes.	—	—	—					
(3) <b>groom</b> ing. Includes combing hair, washing face, shaving, and brushing teeth.	—	—	—					
(4) <b>bath</b> ing. Includes running the water, taking the bath or shower, and washing all parts of the body, including hair.	—	—	—					
(5) <b>eat</b> ing. Includes eating, drinking from a cup, and cutting foods.	—	—	—					

<b>ACTIVITIES OF DAILY LIVING (ADLs)</b> <b>Would you say that you need help with:</b>	<b>No assistance</b>	<b>Some assistance/supervision</b>	<b>Can't do at all</b>	<b>Comments, required to justify score of 2 or more</b>	<b>Name and phone number of assistant</b>	<b>Assistant code</b>	<b>Frequency, hours, etc</b>	<b>Assistance needed</b>
ca(6) <b>transferring.</b> Includes getting in and out of a tub, bed, chair, sofa, vehicle, etc.	_____	_____	_____					
(7) <b>mobility.</b> Moving about, even with a cane or walker or using a wheelchair. Independence refers to the ability to walk or move yourself short distances. Does not include using stairs; may refer to history of falling.	_____	_____	_____					
(8) <b>stairs.</b> Ability to use any stairs that affect your daily activities three or more times per week, both in your home and community.	_____	_____	_____					
(9) <b>toileting.</b> How well can you manage using the toilet? Independence includes adjusting clothing, getting to and on/off the toilet, and keeping yourself clean and dry. If accidents occur and consumer manages it alone, count as <b>NO</b> assistance. If reminders are needed, count as <b>some</b> assistance/supervision.	_____	_____	_____					

<b>ACTIVITIES OF DAILY LIVING (ADLs)</b> <b>Would you say that you need help with:</b>	<b>No assistance</b>	<b>Some assistance/supervision</b>	<b>Can't do at all</b>	<b>Comments, required to justify score of 2 or more</b>	<b>Name and phone number of assistant</b>	<b>Assistant code</b>	<b>Frequency, hours, etc</b>	<b>Assistance needed</b>
(10) <b>bladder/bowel control.</b> How often do you have bladder or bowel accidents? _____ Never (0) _____ Occasionally (2) _____ Often (3) _____ Always (4)	enter one score: <u>0</u>							
(11) <b>incontinence.</b> Do you wear incontinence pads or use appliances or training programs? <input type="checkbox"/> Yes (Ask question below) <input type="checkbox"/> No (Skip next question) <input type="checkbox"/> pad/brief <input type="checkbox"/> urinal/bedpan <input type="checkbox"/> catheter <input type="checkbox"/> training programs <input type="checkbox"/> ostomy	Specify type appliance/training:							
(12) Do you need assistance to change pads or appliances or manage training programs?	_____	_____	_____					
<b>Totals</b>								

ADL total score

ADL impairment count

**Functional Assessment – IADLs.**

**For initial assessment:** List assistance needed in the last column in addition to what is already in place. Be specific about tasks needed and frequency.

**For reassessment:** Indicate in the last column if services need to be increased, decreased, or remain at the same level.

**Read all choices before taking answer.**

Assistant codes: 1 = Spouse 2 = Children 3 = Friend 4 = Other relative 5 = Agency 6 = Church 7 = Volunteer 8 = Private pay  
 Level of help needed codes: 0 = no assistance 2 = Some assistance/supervision 3 = Can't do at all

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs) Would you say that you need help to:	No assistance	Some assistance/supervision	Can't do at all	Comments, required to justify score of 2 or more	Name and phone number of assistant	Assistant code	Frequency, hours, etc	Assistance needed
(13) <b>answer the telephone.</b> Identify the signal and use the equipment to respond effectively to caller, etc. Includes the use of an amplifier or special equipment.	—	—	—					
(14) <b>make a telephone call.</b> Select and dial numbers to connect with desired parties. Use the equipment to effectively communicate purpose of call. Includes programmed calling systems.	—	—	—					
(15) <b>go shopping or run errands.</b> Shopping for food and other things you need. Does not include getting to and from store. Includes making lists, selecting needed items, reading labels, reaching shelves, completing the purchase, etc.	—	—	—					

<b>INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)</b> <b>Would you say that you need help to:</b>	<b>No assistance</b>	<b>Some assistance/supervision</b>	<b>Can't do at all</b>	<b>Comments, required to justify score of 2 or more</b>	<b>Name and phone number of assistant</b>	<b>Assistant code</b>	<b>Frequency, hours, etc</b>	<b>Assistance needed</b>
(16) <b>go places.</b> Arranging and using local transportation or driving to places beyond walking distance, to get to places you need to go.	____	____	____					
(17) <b>prepare meals.</b> Making sandwiches, cold or cooked meals, TV dinners, etc., so that you won't go hungry. Does not refer to quality of nutritional content.	____	____	____					
(18) <b>do laundry.</b> Using detergent, getting items in/out of washer or dryer, starting and stopping the machine, or otherwise washing and drying, sorting, folding, putting away, etc.	____	____	____					
(19) <b>do light housekeeping.</b> Includes dusting, vacuuming, sweeping, etc. Does not include laundry.	____	____	____					
(20) <b>do heavy chores.</b> Windows, moving furniture, general home maintenance, yardwork. Does not include laundry.	____	____	____					
(21) <b>take medication.</b> Ability to set up, remember, and take your own medication in correct doses and methods.	____	____	____					

<b>INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)</b> Would you say that you need help to:	No assistance	Some assistance/supervision	Can't do at all	Comments, required to justify score of 2 or more	Name and phone number of assistant	Assistant code	Frequency, hours, etc	Assistance needed
(22) <b>manage money.</b> Refers to only your own money. Paying bills, balancing checkbook, counting change, staying within available financial resources, etc.	—	—	—					
<b>Totals</b>								

IADL total score

IADL impairment count

**Consumer support and social resources.**

(1) Check source of information used for Consumer support and social resources.

Consumer  Other, specify \_\_\_\_\_

**For initial assessment:** List in the last column assistance needed in addition to what is already in place. Be specific about tasks needed and frequency.

**For reassessment:** Indicate in the last column if services need to be increased, decreased, or remain at the same level.

Assistant codes: 1 = Spouse 2 = Children 3 = Friend 4 = Other relative 5 = Agency 6 = Church 7 = Volunteer 8 = Private pay  
 Level of help needed codes: 0 = no assistance 2 = Some assistance/supervision 3 = Can't do at all

(2) CONSUMER SUPPORT Do you receive assistance from:	Yes	No	Name and phone number of assistant	Assistant code	Frequency, hours, etc.	Assistance needed
<b>a health professional</b> , such as RN, therapist, hospice, specify:	<input type="checkbox"/>	<input type="checkbox"/>				
<b>adult day care.</b>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>home-delivered meals.</b>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>any other kind of assistance</b> , such as respite, specify:	<input type="checkbox"/>	<input type="checkbox"/>				

**Social resources.**

(3) Does consumer live alone? \_\_\_ Yes (6) \_\_\_ No (0)

(4) **(Ask)** Is there someone who could stay with you if you needed it or if you were sick? \_\_\_ Yes (0), complete below \_\_\_ No (6)

Name	Relationship to consumer	Phone	

(5) If you could not continue to live in your present location, do you have any ideas about where you would live?

- |   |   |
|---|---|
| <input type="checkbox"/> Home<br><input type="checkbox"/> Smaller home (apartment, mobile home)<br><input type="checkbox"/> Relative's home, specify: _____<br><input type="checkbox"/> Residential care facility or group home<br><input type="checkbox"/> Assisted living | <input type="checkbox"/> Adult foster home<br><input type="checkbox"/> Nursing home<br><input type="checkbox"/> Other, specify _____<br><input type="checkbox"/> Don't know |
|---|---|

(6) Is there a person you can talk to when you have a problem? \_\_\_ Yes (0), complete below \_\_\_ No (4)

Name	Relationship to consumer

(7) Do you have a pet?  Yes, specify: \_\_\_\_\_  No

(8) How often do you talk to friends, relatives, or others on the phone, they call you or you call them?  
 \_\_\_ Once a day or more (0) \_\_\_ 1 - 3 times a month (3)  
 \_\_\_ 2 - 6 times a week (1) \_\_\_ Less than once a month (4)  
 \_\_\_ Once a week (2) \_\_\_ No phone (4)

Name	Phone number

Comments: \_\_\_\_\_

(9) How often do you spend time with someone who does not live with you? You go to see them or they come to visit you, or you do things together, in the home or out of the home?

- \_\_\_ Once a day or more (0) \_\_\_ 1 - 3 times a month (3)  
 \_\_\_ 2 - 6 times a week (1) \_\_\_ Less than once a month (4)  
 \_\_\_ Once a week (2)

Name	Phone number

Comments: \_\_\_\_\_

(10) What activities or interests do you enjoy?

(11) Are you able to attend services or practice your religion as often as you like?

Yes  No  N/A

Name of church/synagogue: \_\_\_\_\_

Contact person: \_\_\_\_\_

Notes:

**Social resources total score**

Comments and service plan implications:

### Mental health.

(1) Check source of information used for Mental health.

Consumer  Other, specify: \_\_\_\_\_

(2) Is there any indication that the consumer has a current mental health problem?

Yes  No

If yes, describe:

(3) **(Ask)** Are you currently, or have you previously, received mental health services or counseling?  Yes, complete below  No

Provider name	Phone

Comments:

### Emotional well-being.

(4) **(Ask)** I have some questions about how you have been feeling during the **past month**.

- Are you satisfied with your life?  Yes  No
- Have you been feeling in good spirits?  Yes  No
- Have you been depressed or very unhappy?  Yes  No
- Have you been very anxious or nervous?  Yes  No
- Have you had difficulty sleeping?  Yes  No
- Have you seen or heard things that other people didn't see or hear?  Yes  No
- Have you had serious thoughts about harming anyone?  Yes  No
- Have you had serious thoughts about harming or killing yourself?  Yes  No
- Is anyone plotting against you?  Yes  No

Comments and service plan implications:

### Memory assessment.

(5) **(Ask)** I'd like to ask you some questions about your memory and ability to find things. In the **past month** have you:

- had any problems with your memory?  
Specify: \_\_\_\_\_  Yes  No
- frequently lost items, such as your purse, wallet, or glasses?  Yes  No
- failed to recognize family members/friends?  Yes  No
- lost your way around the house. For example, can't find the bedroom or bathroom?  Yes  No
- forgotten to turn the stove off?  Yes  No

Comments/service plan implications:

(6) **(Assessor)** In your judgment, does the consumer:

- appear to be depressed, lonely or dangerously isolated?  Yes  No
- wander away from home or other places for no apparent reason?  Yes  No
- need supervision? If yes, specify how much, such as constant, at night only. \_\_\_\_\_  Yes  No
- pose a danger to self or others?  Yes  No
- show suicidal ideation?  Yes  No
- demonstrate significant memory problems?  Yes  No
- exhibit other behavior problems, specify: \_\_\_\_\_  Yes  No

Comments and service plan implications:

(7) Does the consumer require:

- Immediate intervention
- Mental health referral
- Neither

Document why or who, if immediate intervention is needed:

**Environmental assessment.****Subjective evaluation of environment.**

(1) **(Ask consumer only)** Are you concerned about your safety in your home or neighborhood?  Yes  No If yes, comment required:

(2) **(Assessor)** Indicate specific area(s) in which there are potential safety or accessibility problems for the consumer.

- Structural damage/dangerous floors
- Barriers to access, including steps and stairs
- Electrical hazards
- Fire hazards/safety equipment
- Unsanitary conditions/odors
- Insects or other pests
- Poor lighting
- Insufficient water/hot water
- Insufficient heat/air conditioning
- Shopping
- Transportation
- Telephone
- Neighborhood unsafe
- Unable to evacuate in emergency

Problem area:

**Environmental - clinical judgment.**

No risk (0) \_\_\_\_\_ Low risk (5) \_\_\_\_\_ Moderate risk (15) \_\_\_\_\_ High risk (25)

**Environmental total score**

Document why:

Comments:

Landlord name	Phone
Yardwork/home repairs name	Phone

**Caregiver assessment**

(1) Does an informal caregiver help the consumer on a regular basis?

**Yes**, complete this section.  **No**, go to Recommendations.

Name	Relationship
Address	Phone

**Address to caregiver alone:**

(2) **(Ask)** How long have you assisted **(name of consumer)**? \_\_\_\_\_ years \_\_\_\_\_ months

(3) How often do you assist **(name of consumer)**? Would you say you assist:

- |   |  |
|---|--|
| <input type="checkbox"/> every day            | <input type="checkbox"/> less than once a week |
| <input type="checkbox"/> several times a week | <input type="checkbox"/> never                 |
| <input type="checkbox"/> at least once a week | <input type="checkbox"/> don't know            |

(4) What kind of assistance do you give **(name of consumer)**?

**If caregiver gave information in Sections ADLs/IADLs and Consumer Support and Social Resources, verify and note here and go to the next question.**

You help the consumer with:	Yes	No	Comments
Personal care - assistance with bathing, dressing, using the toilet, getting in and out of the bath, and feeding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Housekeeping - assistance with meal preparation, cleaning, and laundry	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shopping and errands	<input type="checkbox"/>	<input type="checkbox"/>	_____
Supervision for safety	<input type="checkbox"/>	<input type="checkbox"/>	_____
Money management	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

(5) Are you employed?  Full-time  Part-time  Not working at all

(6) If you were suddenly unable to provide care, who would take your place?

No one  Other, specify: \_\_\_\_\_

(7) Would you say your own health is:  excellent  good,  fair  poor

(8) Considering the assistance you provide for **(name of consumer)**, I would like to ask you if various aspects of your life have become better, stayed the same, or become worse since you began providing care. Let's start with....

	Better	Same	Worse	Don't know
Relationship with (name of consumer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships with other family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships with friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your work, if applicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your emotional well-being	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(9) Is there anything that makes it difficult for you to manage care?  Yes  No  
If yes, describe:

(10) Do you **(caregiver)** need training or services?  Yes  No  
If yes, describe:

Comments:

(11) **(Assessor)** Has providing care to the consumer become a problem for the caregiver?  
 Very much a problem    Somewhat a problem    Not at all a problem

(12) How likely is it that **(caregiver)** will continue to provide the care to the consumer?  
 Very likely    Somewhat likely    Unlikely

Comments on caregiver and service plan implications:

(13) **Consumer support - clinical judgment.**

Check the consumer's level of need for additional services.

Very low    Low    Moderate    High

Justify informal supports:

Justify formal supports:

## Recommendations.

### Scoring matrix

Domain	Range	Score	Range	Score	Range	Score
Cognitive functioning (MSQ)	(0 - 6)		(7 - 11)		(12 - 28)	
Health assessment - clinical judgment	(5)		(15)		(25)	
Nutrition	(0 - 8)		(9 - 11)		(12 - 30)	
Subjective evaluation of health	(0, 5)		(15)		(25)	
Functional - ADL (count:     )	(0 - 2)		(3 - 9)		(10 - 31)	
Functional - IADL (count:    )	(0 - 2)		(3 - 11)		(12 - 30)	
Consumer support - clinical judgment	(0, 5)		(15)		(25)	
Social resources	(0 - 6)		(7 - 14)		(15 - 24)	
Environmental - clinical judgment	(0, 5)		(15)		(25)	
<b>Subtotals</b>						

Total score

**Overall risk score ranges, check one:**

Low (0 - 44)  Moderate (45 - 116)  High (117 - 243)

Meets expanded criteria for ADvantage

Is consumer homebound? Refer to Form 02HM001E,  
Uniform Comprehensive Assessment, Part 1.

Yes  No

Should consumer be referred for:

- physical health assessment/services?
- mental health assessment/services?

Yes  No

Yes  No

Was assessor override used for any of the domains?

Yes  No

**If yes, provide written justification.****(1) Alternatives.**

Check all alternatives that were discussed with the consumer and caregiver.

- a.  Home with services
- b.  Home without services
- c.  Assisted living, RCF, or adult foster home with services
- d.  Assisted living, RCF, or adult foster home without additional services
- e.  Mental health residential facility
- f.  Nursing home
- g.  Short-term respite care
- h.  Short-term nursing home stay with intent to return home with services
- i.  Developmental services facility (ICF/MR)/waiver
- j.  Consumer refuses service - place in NF, SNF, ICF/MR
- k.  Consumer refuses service - remains in community
- l.  Adult day care
- m.  ADvantage
- n.  Other: \_\_\_\_\_
- o.  Undecided

**(2) Recommendations.**

In your judgment, the consumer:

has community potential:

- low
- moderate
- high

requires care in a nursing home on a temporary basis but community potential exists.

requires care in a nursing home.

**Recommend, choose code from the Alternatives list above:**

Consumer's choice: \_\_\_\_\_ Family/caregiver's choice: \_\_\_\_\_

Assessor's recommendation: \_\_\_\_\_

Assessor name	Agency/program	Date

**Area nurse recommendations.**

Document why approved service/service setting is not what the OKDHS nurse assessor recommended:

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Area nurse signature Date