



Department of Elder Affairs Prioritization Form

PRIORITY SCORE:

Rule 58A-1.010, F.A.C.

OWNER ID _____ OWNER ASSESSOR ID _____
 PROVIDER ID _____ PROVIDER ASSESSOR ID _____
 ASSESSOR NAME _____ SIGNATURE _____
##: Items required in CIRTS **P:** Priority Score Items

A. Demographic Information

##1. Name:

 First Middle Initial Last

##2. Social Security Number: - -

3. Medicaid Number: _____

3a. Consumer Type:
 Caregiver (C) Elder Recipient (E)

3b. Are you the caregiver of a grandchild or child, under 19 or disabled?
 Yes (Y) No (N)

##4. Physical Address:

 Street

 City State ZIP County

4a. Mailing Address (if different)

 Street

 City State ZIP County

4b. Phone Number:
 ()

##4c. Is this Public Housing?
 Yes (Y) No (N)

##4d. Assessment Date _____
 M M D D Y Y Y Y

##4e. Assessment Site

 Home (CH) Other (O) Provider (P)

##4f. Assessment Type
 Telephone (T) EHEAP (O) Update (U)

 Demographic (D) Waiting List Screening (WLS) Other Type (OT) Gr. Parent/Guardian (G)

##5. Date of Birth _____
 M M D D Y Y Y Y

##6. Sex Female (F) Male (M)

##7. Race
 White (W) Black (B) Native Am. (N) Asian/Pacific (A) Other (O)

##8. Ethnicity Hispanic (H) Other (O)

##9. Primary language _____

##10. Marital Status

 Married (M) Single (S) Separated (P) Widowed (W) Divorced (D) Partner (O)

##11. Referral Source
 Hospital (H) Upstreaming/CARES (U) Other (O) Self (S)

 CARES (C) APS (A) Lead Agency (L)

 Aging Out - DCF CCDA Aging Out - DCF HCDA

If consumer at Imminent Risk of NH placement, check :
 Imminent Risk (IM)

If Transitioning out of a Nursing Home, check :
 Transition from NH (TRNH)

If APS, check level of risk:
 High (H) Medium (M) Low (L)

##11a. Referral Date _____
 M M D D Y Y Y Y

##12. Is there a Primary Caregiver? **P** Yes (Y) No (N)

##13. Living Situation **P**
 With Caregiver (WC) With Other (WO) Alone (AL)

##14. Need outside assistance to evacuate? Yes (Y) No (N)

##15. Registered with County Special Needs Registry?
 Yes (Y) No (N)

##16a. Individual Monthly Income _____ Refused

##16b. Couple Monthly Income _____ Refused

##16c. Receiving Food Stamps? Yes (Y) No (N)

##17a. Estimated Total Individual Assets Refused
 \$0 - \$2,000 (M) \$2,001 - \$5,000 (N) over \$5,000 (P)

##17b. Estimated Total Couple Assets Refused
 \$0 - \$3,000 (M) \$3,001 - \$6,000 (N) over \$6,000 (P)



B. CONSUMER CONDITIONS

##1. Physical Health

##a. How would you rate your overall health at the present time? P

 Excellent (1) Good (2) Fair (3) Poor (4)

##b. Compared to a year ago, how would you rate your health? P

 Much Better (1) Better (2) About same (3) Worse (4)

##c. How much do your physical problems stand in the way of your doing the things you want to do? P

 Not at all (1) Occasionally (2) Often (3) All the time (4)

C. CONSUMER RESOURCES

##1.

##a. Is medical care readily available? P

 Always (4) Sometimes (3) Rarely (2) Never (1)

##b. Is transportation to medical care readily available? P

 Always (4) Sometimes (3) Rarely (2) Never (1)

##c. Do your finances/insurance permit access to healthcare and medications? P

 Always (4) Sometimes (3) Rarely (2) Never (1)

##2. Functional

How much help do you need with the following Activities of Daily Living (ADL's)? P

(Codes: 0=No Help, 1=No help but relies on Assistive Device, 2=Supervision, 3=Some Help, 4=Total Help, can't do at all)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	##a. Bathe
0	1	2	3	4	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	##b. Dress
0	1	2	3	4	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	##c. Eat
0	1	2	3	4	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	##d. Use Bathroom
0	1	2	3	4	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	##e. Transfer
0	1	2	3	4	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	##f. Walking/Mobility
0	1	2	3	4	

##2.

How often do you have adequate assistance with the following ADL's? P

(Codes: 3=Always, 2=Sometimes, 1=Rarely, 0=Never, 0=No help needed)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	##NEED FOR ASSISTIVE DEVICES? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
3	2	1	0	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3	2	1	0	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3	2	1	0	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3	2	1	0	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3	2	1	0	

##3. How much help do you need with the following Instrumental Activities of Daily Living (IADL's)? P

(Codes: 0=No Help, 1=No help but relies on Assistive Device, 2=Supervision, 3=Some Help, 4=Total Help, can't do at all)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	##a. Do heavy chores
0	1	2	3	4	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	##b. Do light housekeeping
0	1	2	3	4	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	##c. Use phone
0	1	2	3	4	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	##d. Manage money
0	1	2	3	4	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	##e. Prepare meals
0	1	2	3	4	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	##f. Do shopping
0	1	2	3	4	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	##g. Take medication
0	1	2	3	4	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	##h. Use transportation
0	1	2	3	4	

##3. How often do you have adequate assistance with the following IADL's? P

(Codes: 3=Always, 2=Sometimes, 1=Rarely, 0=Never, 0=No help needed)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	##NEED FOR ASSISTIVE DEVICES? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
3	2	1	0	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3	2	1	0	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3	2	1	0	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3	2	1	0	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3	2	1	0	



4. What physical problems does client have? _____

D. Nutrition Status (Section D - optional for entering into CIRTS)

NUTRITION SCORE:

Yes (Y) or No (N)

1. Have you lost or gained 10 pounds or more in the last 6 months without trying?
 Yes (2) No (0) If yes, Gain: _____ Loss: _____

2. Do you take 3 or more kinds of medicine a day? (Include over-the-counter AND prescription medicines)
 Yes (1) No (0)

3. Do you have 2 or more drinks of beer, wine, or liquor almost every day?
 Yes (2) No (0)

4. Do you have an illness or condition that made you change the food you eat?
 Yes (2) No (0) Are you on any special diets for medical reasons? If on special diet(s), check all that apply:

Low sodium/salt Low fat/cholesterol Low Sugar Calorie supplement
 Other (specify) _____

5. Do you eat at least two meals a day? How is your appetite? Would you say that your appetite is:
 Yes (0) No (3) Good Fair Poor

6. Do you eat some fruits and vegetables every day?
 Yes (0) No (1) Briefly describe what you usually eat and drink during a typical day (including food on weekends):

7. Do you have some milk products every day?
 Yes (0) No (1)

8. Do you have any problems with your teeth, mouth, or throat that make it hard for you to chew or swallow?
 Yes (2) No (0) Tooth or mouth problems Taste problems Can't eat certain foods Swallowing problems
 Food allergies Nausea Other (Describe) _____

9. Do you eat alone most of the time?
 Yes (1) No (0)

10a. Are you usually able to shop for yourself?
 Yes (0) No (0.5)

10b. Are you usually able to cook for yourself?
 Yes (0) No (0.5)

11. Are you usually able to eat without help?
 Yes (0) No (1)

12. Do you have enough money to buy the food you need?
 Yes (0) No (4)

TOBACCO USE

1. Do you smoke or use tobacco products? Yes (Y) No (N)

2. Have you ever smoked or used tobacco? Yes (Y) No (N)
 If yes, for how long? _____

3. Do you live with others who smoke? Yes (Y) No (N)

ASSESSOR, please answer:
DOES THERE APPEAR TO Yes (Y) No (N)
BE A NEED FOR FOOD STAMPS?

CURRENT HEIGHT: _____
CURRENT WEIGHT: _____

