



PRIORITY SCORE:

Department of Elder Affairs Assessment Instrument

RISK 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 **(O)**: Items required for OAA **(C)**: Items required for CARES

(O) (C) 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) Hospital (H)

Nurs. Home (NH) Day Care (DC) ALF (ALF) Other (O)

##4f. Assessment Type
 OAA (O) OA3E (O3E) Update (U)
 signif. change
Initial (I) Waiting List CARES (C) Annual (A)
Asmt. Full Asmt. (WL) non-community

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

Hospital (H) Upstreaming/CARES (U) Other (O) Self (S)

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
 (OAA only)

##16b. Couple Monthly Income _____ Refused
 (OAA only)

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

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

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



B. CONSUMER CONDITIONS

C. CONSUMER RESOURCES

(O)##2. 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)

(O)##2.

##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)

(O) (C)##3. 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	

(O)##3.
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?
3	2	1	0	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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	

(O) (C)##4. 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	

(O)4##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?
3	2	1	0	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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	



(O) ##D. Nutrition Status

NUTRITION SCORE:

YES (Y) or NO (N)

(C) ##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: _____

(C) ##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:

DOES THERE APPEAR TO Yes (Y) No (N)

BE A NEED FOR FOOD STAMPS?

CURRENT HEIGHT: _____

CURRENT WEIGHT: _____

SUMMARY



(O) (C) E1. Health Conditions YES (Y) or NO (N)

##1. Arthritis (type) _____

##2. Bed sore(s) (Decubitus)
Location _____

##3. Cancer
 Lung Skin Oral Other

##4. Dementia(Alz, OBS, etc.)

##5. Diabetes (IDDM/NIDDM)

##6. Emphysema/COPD

##7. Heart Problems (CHF, MI, etc.)

##8. Incontinence (Bladder/Bowel)

##9. Liver Problems (Cirrhosis, Hepatitis)

##10. Pneumonia

##11. Stroke (CVA, etc.)

##12. Osteoporosis

##13. Parkinson's Disease

##14. Other (from list below)

Others: Yes(Y) or No (N) Enter most problematic in #14 above

Allergies (type) _____

Amputation (site) _____

Asthma (type) _____

Bladder/Kidney Problems (UTI, etc.)

Blood Pressure - High Low

Broken Bones/Fractures
Location _____

Dehydration

Dizziness

Falls in past year

Gallbladder Problems

Hearing Problems

Ostomy care (type) _____

Pacemaker

Paralysis (site) _____

Seizure disorder

Sleep Problems

Thyroid Problems (Graves, Myxedema, etc.)

Ulcers (type/site) _____

Vision Problems (Cataracts, Glaucoma)

Other _____

(O) (C) E2. Special Services

Yes or No, if yes, indicate frequency

##Physical Therapy _____

##Occupational Therapy _____

##Respiratory Therapy _____

##Other, from list on right _____

Others: YES (Y) or NO (N)

Bowel/bladder rehab

Bowel impaction therapy

Catheter care (type) _____

Dialysis

Insulin therapy

Lesion irrigation

Oxygen therapy

Oxygen treatment

Skilled Nursing

Speech therapy

Suctioning

Tube Feeding

Wound care

Other _____

F. Medications

(including refrigerated meds, non-prescription drugs, over the counter, herbal remedies, etc.)

Medication	Dosage	Administration Method	Frequency	Physician

1. **ASSESSOR:** Does consumer seem to be compliant with medications?
 Yes No Unsure

2. **ASSESSOR:** What interferes with medication compliance?
 Alcohol Interaction Drug Interaction Can't Afford Confused N/A

Other: _____

3. Has consumer been hospitalized in the last 6 months?
 No Yes
 If yes, why? _____

3a. Has consumer visited the Emergency Room in the past 6 months?
 No Yes
 If yes, why? _____

4. Indicate consumer's status:

a. Vision (w/glasses if used) Good Fair Poor Blind

b. Hearing (w/ aid if used) Good Fair Poor Deaf

c. Speech Good Fair Poor Gestures Signs Unable

d. Walking (w/ device if used) Good Fair Poor Chairbound Bedbound



G. Caregiver Assessment

##1. HCE Caregiver? Yes (Y) No (N)

##2. Is caregiver new to the consumer? Yes (Y) No (N)

(O) ##3. Social Security Number: _____ - _____ - _____

(O) ##4. Name _____
 First Middle Initial Last

(O) ##5. Relationship
 Spouse (SP) Parent (P) Child (CH) Grandchild (GC)
 Friend (FR) Other relative (OR) Other (OT)

##6. Physical Address

 Street

 City State ZIP County

(O) 7. Telephone () _____

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

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

##9a. Primary Language _____

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

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

##12. Is caregiver employed outside the home? Full-time Part-time N/A

(O) ##13. How is your own health? P
 Excellent (1) Good (2) Fair (3) Poor (4)

##13a. How long have you been providing care?
 Less than 6 mon. 6 mon. - 1 year 1 - 2 years Over 2 years

##14. How likely is it that you will continue to provide care?
 CAREGIVER: Very likely Somewhat likely Unlikely

(O) ##14a. How likely is it that you will have the ability to continue to provide care?
 CAREGIVER: Very likely (1) Somewhat likely (2) Unlikely (3)
P ASSESSOR: Very likely (1) Somewhat likely (2) Unlikely (3)

##15. If you were unable to provide care, who would?
 No One Friend/Neighbor Close Relative Other

##16. INITIAL :
 Since you began providing care, have various aspects of your life become better, stayed the same, or worsened?
 OR
 REASSESSMENT:
 Since you began receiving services, have aspects of your life become better, stayed the same, or worsened?

How is /are:	Better (1)	Same (2)	Worse (3)
Your relationship w/ consumer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your relationships w/ other family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your relationships w/ friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your work (If applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
##Your emotional well-being.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ASSESSOR:
 (O) ##17. Is the caregiver in crisis? Yes (Y) No (N) P
 If yes, check all that apply:
 ##17a. Financial Emotional Physical



H. Social Resources

1. Does consumer live alone? Yes (6) No (0) If no, with whom? _____

##1a. Does consumer care for grandchildren on a permanent basis? Yes No

##2. If needed, could you stay with someone, or they stay with you? Yes (Complete below) (0) No (6)

Name: _____ Relationship to consumer: _____

Address: _____ Phone: _____

##3. Do you have someone you can talk to when you have a problem (other than caregiver)? Yes (0) No (4)

Name: _____ Relationship to consumer: _____

##4. About how many times do you talk to friends, relatives, telephone reassurance volunteers or others on the telephone in a week, either they call you or you call them?

Once a day or more (0) 2-6 times a week (2) Once a week (2) Not at all (4) No phone (4)

##5. How many times during a week do you spend time with someone who does not live with you - you go see them, they come to visit, or you do things together? Once a day or more (0) 2-6 times a week (2) Once a week (2) Not at all (4)

6. Are you able to participate in activities such as day care, senior center, church or other interests that you enjoy? Yes No
If no, why not? _____

7. Do you own a pet? Yes No If yes, specify _____

Can you feed your pet? Yes No Clean up after your pet? Yes No Exercise your pet? Yes No

8. If consumer is the caregiver/guardian of a grandchild or child, under 19 years old or disabled, (section A. #3a. & 3b.) complete information on the child:

Child's name: _____ Child's date of birth: ____ - ____ - ____

Child's relationship to the consumer: _____ Is child disabled? _____ (Yes or No)

SUMMARY

##I. Environmental Assessment (Enter Risk below in CIRTs)

Case Manager: Please indicate the specific area(s) where there are potential safety or accessibility problems for the client.

- | | | |
|---|---|---|
| <input type="checkbox"/> Building in need of repairs | <input type="checkbox"/> Refrigerator not working | <input type="checkbox"/> Grab bars/handrails needed |
| <input type="checkbox"/> Furniture in need of repairs | <input type="checkbox"/> Telephone not working | <input type="checkbox"/> Bathtub/shower unsafe |
| <input type="checkbox"/> Inadequate/insufficient plumbing | <input type="checkbox"/> No telephone | <input type="checkbox"/> Commode unsafe |
| <input type="checkbox"/> No/insufficient heat | <input type="checkbox"/> Flooring/rugs loose | <input type="checkbox"/> Electrical hazards |
| <input type="checkbox"/> No/insufficient hot water | <input type="checkbox"/> Lighting inadequate | <input type="checkbox"/> Insect or other pests present |
| <input type="checkbox"/> No air conditioning | <input type="checkbox"/> Stairs/railings unsafe | <input type="checkbox"/> Unsanitary conditions or odors |
| <input type="checkbox"/> Stove not working | <input type="checkbox"/> Ramp needed/unavailable | <input type="checkbox"/> Other - specify in comments |

COMMENTS:

No Risk: The physical environment is generally well equipped and supportive. _____

This includes building, neighborhood and necessary furnishings.

Low Risk: The physical environment has few negative aspects. _____ The few negative aspects are minor or within acceptable living standards and are not hazardous to the consumer's well-being.

Moderate Risk: The physical environment is negative. _____

Many aspects are substandard or hazardous. The consumer may not be able to remain in the current dwelling.

High Risk: The physical environment is strongly negative or hazardous. _____ The consumer should change dwellings or is very likely to need to change dwellings unless immediate corrective action is taken to address the negative or hazardous aspects.



ASSESSMENT SUMMARY

PROBLEMS	LIABILITIES/ CHALLENGES/BARRIERS	RESOURCES/ASSETS	GAPS WHICH NEED TO BE MET IN CARE PLAN
B. CONSUMER CONDITIONS			
D. NUTRITION			
E. HEALTH			
F. MEDICATIONS			
G. CAREGIVER			
H. SOCIAL RESOURCES			
I. ENVIRONMENTAL			