# Florida Department of Elder Affairs
# 701T Non-Community Placement Assessment
Rule: 58-A-1.010, F.A.C.

**Assessor Name:** ______________________________ **Signature:** ______________________________

**A. DEMOGRAPHIC SECTION**

1. **ASSESSOR: What is the purpose of this assessment?**
   ☐ Initial ☐ Annual ☐ Health ☐ Living situation ☐ Caregiver ☐ Environment ☐ Income
2. Social Security number: ______________________________
3. Name: a. First: ______________________________
   b. Middle initial: __________ c. Last: ______________________________
4. Medicaid number: ______________________________
5. Phone number: ______________________________
6. Date of birth *(mm/dd/yyyy)*: ______________________________
7. Sex: ☐ Male ☐ Female
8. Race *(Mark all that apply)*: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other
9. Ethnicity: ☐ Hispanic/Latino ☐ Other
10. Primary language: ☐ English ☐ Spanish ☐ Other: ______________
11. Does client have limited ability reading, writing, speaking, or understanding English? ☐ No ☐ Yes
12. Marital status: ☐ Married ☐ Partnered ☐ Single ☐ Separated ☐ Divorced ☐ Widowed
13. **ASSESSOR: Current Physical Location Address** *(If type is a facility, please enter facility name.)*
    a. Street: ______________________________
    b. City: ______________________________ c. ZIP code: ______________
    d. Type: ☐ Private residence ☐ Assisted living facility (ALF) ☐ Nursing facility ☐ Hospital ☐ Adult day care ☐ Other
    e. Name: ______________________________
14. Home Address *(If different from current physical location)*
    a. Street: ______________________________
    b. City: ______________________________ c. ZIP code: ______________
15. Mailing Address *(If different from current physical location)*
    a. Street: ______________________________ b. City: ______________________________
    c. State: ______________________________ d. ZIP code: ______________

16. **ASSESSOR: Assessment date:** *(mm/dd/yyyy)* ______________________

17. **ASSESSOR: Assessment site:**
☐ Home ☐ ALF ☐ Nursing facility ☐ Hospital ☐ Adult day care ☐ Other

18. **ASSESSOR: Referral date:** *(mm/dd/yyyy)* ______________________

19. **ASSESSOR: Referral source:** ☐ Self/Family ☐ Nursing facility ☐ Case management agency
☐ CARES ☐ Aging out ☐ Hospital ☐ Department of Children and Families ☐ Other
☐ APS; *Select level of APS risk:* ☐ High ☐ Intermediate ☐ Low

20. **ASSESSOR: Imminent risk of nursing home placement?** ☐ No ☐ Yes

21. Is there a primary caregiver? ☐ No ☐ Yes

22. Living situation: ☐ With primary caregiver ☐ With other caregiver ☐ With other ☐ Alone

23. **ASSESSOR: Is someone besides the client providing answers to questions?** ☐ No *(Skip to 24)* ☐ Yes

a. Relationship: ______________________

**B. MEMORY SECTION**

24. Has a doctor or other health care professional told you that you suffer from memory loss, cognitive impairment, any type of dementia, or Alzheimer's disease? ☐ No ☐ Yes

25. **ASSESSOR: If the client is not answering questions, skip to Question 32 and check:** ☐

26. "I am going to say three words for you to remember. Please repeat the words after I have said them. The words are: sock (something to wear), blue (a color), and bed (a piece of furniture). Now you tell me the three words." **ASSESSOR: Select the number of words correctly repeated after the first attempt:**
☐ Sock ☐ Blue ☐ Bed *Total number of correct words:* ☐ None ☐ One ☐ Two ☐ Three
"Thank you. I will ask you to repeat these to me again later."

27. Please tell me what year it is: ☐ Correct ☐ Missed by one year ☐ Missed by two to five years ☐ Missed by five or more years ☐ No answer

28. Please tell me what month it is: ☐ Correct ☐ Missed by one month ☐ Missed by two to five months ☐ Missed by five or more months ☐ No answer

29. Please tell me what day (of the week) it is: ☐ Correct ☐ Incorrect ☐ No answer

30. "Let's go back to an earlier question. What were those words I asked you to repeat back to me?"
☐ Sock ☐ Blue ☐ Bed

31. **ASSESSOR: Number of words correctly recalled without prompting:** ☐ None ☐ One ☐ Two ☐ Three

32. **ASSESSOR: In your opinion, are cognitive problems present?** ☐ No ☐ Yes ☐ Don't know

***Notes & Summary***

## C. GENERAL HEALTH SECTION

33. How many times have you fallen in the last six months? #__________

34. Have you visited the emergency room (ER) or been admitted to the hospital within the last year?
☐ No ☐ Yes: How many times? ER #__________ Hospital #__________

## D. ACTIVITIES OF DAILY LIVING SECTION

35. How much assistance do you need with the following tasks?

| Task | No assistance needed | Uses assistive device | Needs supervision or prompt | Needs assistance (but not total help) | Needs total assistance (cannot do at all) |
|---|---|---|---|---|---|
| a. Bathing | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. Dressing | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. Eating | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. Using the bathroom | ☐ | ☐ | ☐ | ☐ | ☐ |
| e. Transferring | ☐ | ☐ | ☐ | ☐ | ☐ |
| f. Walking/Mobility | ☐ | ☐ | ☐ | ☐ | ☐ |

## E. INSTRUMENTAL ACTIVITIES OF DAILY LIVING SECTION

36. How much assistance do you need with the following tasks?

| Task | No assistance needed | Uses assistive device | Needs supervision or prompt | Needs assistance (but not total help) | Needs total assistance (cannot do at all) |
|---|---|---|---|---|---|
| a. Heavy chores | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. Light housekeeping | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. Using the telephone | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. Managing money | ☐ | ☐ | ☐ | ☐ | ☐ |
| e. Preparing meals | ☐ | ☐ | ☐ | ☐ | ☐ |
| f. Shopping | ☐ | ☐ | ☐ | ☐ | ☐ |
| g. Managing medication | ☐ | ☐ | ☐ | ☐ | ☐ |
| h. Using transportation | ☐ | ☐ | ☐ | ☐ | ☐ |

***Notes & Summary***

**F. HEALTH CONDITIONS & THERAPIES SECTION**

37. Have you been told by a physician that you have any of the following health conditions?
**ASESSOR/CM: Indicate whether a problem occurred in the past by marking the first box and when a problem is current by marking the second box. Please mark all that apply.**

| Past | Current | Health Conditions | | | | |
|---|---|---|---|---|---|---|
| ☐ | ☐ | Acid reflux/GERD | | | | |
| ☐ | ☐ | Allergies, list: ______ | | | | |
| ☐ | ☐ | Amputation, site: ______ | | | | |
| ☐ | ☐ | Anemia | ☐ Severe | ☐ Moderate | ☐ Mild | |
| ☐ | ☐ | Arthritis, type: ______ | | | | |
| ☐ | ☐ | Bed sore(s) (Decubitus), location: ______ | | | | |
| ☐ | ☐ | Blood pressure | ☐ High | ☐ Low | | |
| ☐ | ☐ | Broken bones/fractures, location: ______ | | | | |
| ☐ | ☐ | Cancer, site: ______ | | | | |
| ☐ | ☐ | Cholesterol | ☐ High | ☐ Low | | |
| ☐ | ☐ | Chlamydia | | | | |
| ☐ | ☐ | Dehydration | | | | |
| ☐ | ☐ | Diabetes | ☐ IDDM | ☐ NIDDM | | |
| ☐ | ☐ | Dizziness | ☐ Constant | ☐ Frequent | ☐ Occasional | ☐ Rare |
| ☐ | ☐ | Fibromyalgia | | | | |
| ☐ | ☐ | Gallbladder | ☐ Removal | ☐ Problems | | |
| ☐ | ☐ | Gonorrhea | | | | |
| ☐ | ☐ | Heart problems | ☐ Pacemaker | ☐ CHF | ☐ MI | ☐ Other |
| ☐ | ☐ | Head, brain, or spinal cord trauma | | | | |
| ☐ | ☐ | Herpes | | | | |
| ☐ | ☐ | Human Immunodeficiency Virus (HIV) | | | | |
| ☐ | ☐ | Human Papillomavirus (HPV)/Genital warts | | | | |
| ☐ | ☐ | Incontinence, Bladder | ☐ Constant | ☐ Frequent | ☐ Occasional | ☐ Rare |
| ☐ | ☐ | Incontinence, Bowel | ☐ Constant | ☐ Frequent | ☐ Occasional | ☐ Rare |
| ☐ | ☐ | Kidney problems or Renal disease | | End stage? | ☐ No | ☐ Yes |
| ☐ | ☐ | Liver problems | ☐ Cirrhosis | ☐ Hepatitis | | |
| ☐ | ☐ | Lung problems | ☐ Emphysema | ☐ Asthma | ☐ Pneumonia | ☐ COPD |
| ☐ | ☐ | Lupus | | | | |
| ☐ | ☐ | Multiple Sclerosis | | | | |
| ☐ | ☐ | Muscular Dystrophy | | | | |
| ☐ | ☐ | Osteoporosis | | | | |
| ☐ | ☐ | Parkinson's disease | | | | |
| ☐ | ☐ | Paralysis | ☐ Full | ☐ Partial | ☐ Local, site: ______ | |
| ☐ | ☐ | Seizure disorder, type & frequency: ______ | | | | |
| ☐ | ☐ | Shingles | | | | |

**F. HEALTH CONDITIONS & THERAPIES SECTION, CONTINUED**

| Past | Current | Health Condition | | |
|---|---|---|---|---|
| ☐ | ☐ | Stroke/CVA | | |
| ☐ | ☐ | Syphilis | | |
| ☐ | ☐ | Thyroid problems/Graves/Myxedema | ☐ Hyper | ☐ Hypo |
| ☐ | ☐ | Tumor(s), site: ______ | | |
| ☐ | ☐ | Ulcer(s), site: ______ | | |
| ☐ | ☐ | Urinary Tract Infection (UTI) | | |
| ☐ | ☐ | Other(s): ______ | | |

38. Provide information on the frequency of current therapies or specialty care:

| Treatment type: | N/A or None | Monthly | Weekly | Several times a week | Daily | Several times a day |
|---|---|---|---|---|---|---|
| a. Bladder/bowel treatment | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. Catheter, type: ______ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. Dialysis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. Insulin assistance | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| e. IV Fluids/IV Medications | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| f. Occupational therapy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| g. Ostomy, site: ______ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| h. Oxygen | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| i. Physical therapy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| j. Radiation/Chemotherapy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| k. Respiratory therapy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| l. Skilled nursing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| m. Speech therapy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| n. Suctioning | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| o. Tube feeding | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| p. Wound care/Lesion irrigation | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| q. Other therapy, type: ______ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

***Notes & Summary***

## G. MENTAL HEALTH SECTION

| 39. Over the past two weeks, how often have you been bothered by any of the following problems? *(Adapted from the Patient Health Questionnaire PHQ-9, ©Pfizer)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| a. Little interest or pleasure in doing things | ☐ | ☐ | ☐ | ☐ |
| b. Feeling down, depressed, or hopeless | ☐ | ☐ | ☐ | ☐ |
| c. Trouble falling or staying asleep, or sleeping too much | ☐ | ☐ | ☐ | ☐ |
| d. Feeling tired or having little energy | ☐ | ☐ | ☐ | ☐ |
| e. Poor appetite or overeating | ☐ | ☐ | ☐ | ☐ |
| f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down | ☐ | ☐ | ☐ | ☐ |
| g. Trouble concentrating on things, such as reading the newspaper or watching television | ☐ | ☐ | ☐ | ☐ |
| h. Moving or speaking so slowly that other people noticed – Or, the opposite, being so fidgety or restless that you have been moving around a lot more than usual | ☐ | ☐ | ☐ | ☐ |
| i. Thoughts that you would be better off dead or of hurting yourself in some way* | ☐ | ☐ | ☐ | ☐ |

**Thoughts of suicide or self-injury, hallucinations, or aggressive behaviors are potentially serious problems that should be reported immediately to a supervisor, primary care physician, emergency care, law enforcement, and/or Adult Protective Services, as appropriate.*

**ASSESSOR: If the client answered "Not at all" to a-i above, skip to Question 42.**

41. How difficult have these problems made it for you in your daily life activities and interactions with others?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

42. Have you been diagnosed with a mental condition or psychiatric disorder by a health professional?

☐No ☐Yes; *List conditions:* ______________________________

43. **ASSESSOR: Indicate whether you noticed problem behaviors or any recurring problems have been reported to you by the client, caregiver, in-home worker, family, or staff, and note the frequency of occurrence in the last month. Please provide details in the Notes & Summary section, below.**

| Problem behaviors | Not at all | Once | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|---|
| a. Forgetful or easily confused | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. Gets lost or wanders off | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. Easily agitated or disruptive | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. Sexually inappropriate | ☐ | ☐ | ☐ | ☐ | ☐ |
| e. Threatens or is verbally hostile* | ☐ | ☐ | ☐ | ☐ | ☐ |
| f. Physically aggressive or violent* | ☐ | ☐ | ☐ | ☐ | ☐ |
| g. Intentionally injures or harms him/herself* | ☐ | ☐ | ☐ | ☐ | ☐ |
| h. Expresses suicidal feelings or plans* | ☐ | ☐ | ☐ | ☐ | ☐ |
| i. Hallucinates, hears/sees things that are not there* | ☐ | ☐ | ☐ | ☐ | ☐ |
| j. Other: | ☐ | ☐ | ☐ | ☐ | ☐ |

**Thoughts of suicide or self-injury, hallucinations, or aggressive behaviors are potentially serious problems that should be reported immediately to a supervisor, primary care physician, emergency care, law enforcement, and/or Adult Protective Services, as appropriate.*

44. **ASSESSOR: Does client need supervision?** ☐ No ☐ Yes

## H. NUTRITION SECTION

45. Have you lost or gained weight in the last few months? ☐ Unsure *(Skip to 46)* ☐ No *(Skip to 46)* ☐ Yes
   a. How much? ☐ Less than five pounds ☐ Five to ten pounds ☐ Ten pounds or more
   b. Was the weight loss/gain on purpose *(i.e., dieting or trying to lose/gain weight)*? ☐ No ☐ Yes
46. Are you on a special diet(s) for medical reasons? ☐ No *(Skip to 47)* ☐ Yes; *check any/all*:
   ☐ Calorie supplement ☐ Low fat/cholesterol ☐ Low salt/sodium ☐ Low sugar/carb ☐ Other
   a. How long have you been on this diet? ____________________
   b. Why are you on this diet? ____________________

## I. MEDICATIONS SECTION

47. Do you take three or more prescribed or over-the-counter medications a day? ☐ No ☐ Yes
48. May I see all the medications you take, both regularly and those taken only as needed? Also, please show me all types of over the counter medications and any supplements that you regularly take.

**ASSESSOR: Check the original bottles in the medicine cabinet, nightstand, and refrigerator, as well as non-prescription drugs, over the counter drugs, sleep aids, herbal remedies, vitamins, and supplements.**

| Medication name | Prescribed dose | Prescribed Frequency | Taken as prescribed? Yes/No | Administration method | Prescriber name |
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If you have a printed list of meds managed by a facility, attach sheet. If there are more medications to record, use the Notes & Summary section or a blank sheet of paper to write the information.

49. Please list the doctors you usually go to for treatment and medications:

| Physician name | Phone number | Approx. date of last visit | Reason for last visit: |
|---|---|---|---|
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If you have more than ten physicians to record, use the Notes & Summary section or a blank sheet of paper to write the information.

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# WHY ARE WE COLLECTING YOUR SOCIAL SECURITY NUMBER?

We are required to explain that your Social Security number is being collected pursuant to Title 42 Code of Federal Regulations, Section 435.910, to be used for screening and referral to programs or services that may be appropriate for you.

The provision of your Social Security number is voluntary, and your information will remain confidential and protected under penalty of law. We will not use or give out your Social Security number for any other reason unless you have signed a separate consent form that releases us to do so.