

Florida Department of Elder Affairs  
701A Condensed Assessment  
Rule: 58-A-1.010, F.A.C.

Provider ID: \_\_\_\_\_ Provider Assessor/CM ID: \_\_\_\_\_  
Assessor/Case Manager (CM) Name: \_\_\_\_\_ Signature: \_\_\_\_\_

**A. DEMOGRAPHIC SECTION**

1. **ASSESSOR/CM: 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/CM: Current Physical Location Address** (If type is a facility, 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. Is client's home address public housing?  No  Yes

16. Mailing Address (If different from current physical location)

a. Street: \_\_\_\_\_ b. City: \_\_\_\_\_

c. State: \_\_\_\_\_ d. ZIP code: \_\_\_\_\_

Florida Department of Elder Affairs: 701A Condensed Assessment

17. **ASSESSOR/CM: Assessment date:** (mm/dd/yyyy) \_\_\_\_\_

18. **ASSESSOR/CM: Assessment site:**  
 Home     ALF     Nursing facility     Hospital     Adult day care     Other

19. **ASSESSOR/CM: Referral date:** (mm/dd/yyyy) \_\_\_\_\_

20. **ASSESSOR/CM: 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

21. **ASSESSOR/CM: Transitioning out of a nursing facility?**     No     Yes

22. **ASSESSOR/CM: Imminent risk of nursing home placement?**     No     Yes

23. Are you enrolled on a special needs registry?     No     Yes

24. Is there a primary caregiver?     No     Yes

25. Living situation:     With primary caregiver     With other caregiver     With other     Alone

26. Individual monthly income:    \$ \_\_\_\_\_     Refused

27. Couple monthly income:    \$ \_\_\_\_\_     Refused     N/A

28. Estimated total individual assets: \$ \_\_\_\_\_  
 \$0 to \$2,000     \$2,001 to \$5,000     \$5,001 or more     Refused

29. Estimated total couple assets: \$ \_\_\_\_\_  
 \$0 to \$3,000     \$3,001 to \$6,000     \$6,001 or more     Refused     N/A

30. Are you receiving S/NAP (food stamps)?     No     Yes

31. Do you need other assistance for food?     No     Yes

32. **ASSESSOR/CM: Is someone besides the client providing answers to questions?**     No (Skip to 33)     Yes  
a. Name: \_\_\_\_\_    b. Relationship: \_\_\_\_\_

33. Besides your own children, how many children under age 19 do you live with and provide care for? (if 0, skip to 34) # \_\_\_\_\_  
a. How many are grandchildren? # \_\_\_\_\_ Name(s): \_\_\_\_\_  
b. How many are other related children? # \_\_\_\_\_ Name(s): \_\_\_\_\_  
c. How many are other non-related children? # \_\_\_\_\_ Name(s): \_\_\_\_\_

34. How many disabled adults age 19 to 59 do you live with and provide care for? (if 0, skip to 35) # \_\_\_\_\_  
a. How many are grandchildren? # \_\_\_\_\_ Name(s): \_\_\_\_\_  
b. How many are other relatives? # \_\_\_\_\_ Name(s): \_\_\_\_\_  
c. How many are other non-relatives? # \_\_\_\_\_ Name(s): \_\_\_\_\_

**Notes & Summary**

**B. MEMORY SECTION**

35. 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

36. Have you become concerned about your memory or had problems remembering important things?

No  Yes

**C. GENERAL HEALTH, SENSORY & COMMUNICATION IMPAIRMENT SECTION**

37. How would you rate your overall health at this time?

Excellent  Very Good  Good  Fair  Poor

38. Compared to a year ago, how would you rate your health?

Much better  Better  About the same  Worse  Much worse

39. How many times have you fallen in the last six months? # \_\_\_\_\_

40. How often are there things you want to do but cannot because of physical problems?

Never  Occasionally  Often  All of the time

41. When you need medical care, how often do you get it?

Always  Most of the time  Rarely  Only in an emergency  Never

42. When you need transportation to medical care, how often do you get it?

Always  Most of the time  Rarely  Only in an emergency  Never

43. How often do finances/insurance allow you to obtain health care and medications when you need them?

Always  Most of the time  Rarely  Only in an emergency  Never

44. Have you visited the emergency room (ER) or been admitted to the hospital within the last year?

No  Yes: How many times? ER# \_\_\_\_\_ Hospital # \_\_\_\_\_

45. In the last year were you in a nursing or rehabilitation facility?

No  Yes

**Notes & Summary:**

**D. ACTIVITIES OF DAILY LIVING SECTION**

46. 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Using the bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Walking/Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

47. How much assistance do you have with the following tasks?

Task	No assistance needed	Always has assistance	Has assistance most of the time	Rarely has assistance	Never has assistance
a. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Using the bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Walking/Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Notes & Summary:**

**E. INSTRUMENTAL ACTIVITIES OF DAILY LIVING SECTION**

48. 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Light housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Using the telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Managing money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Managing medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Using transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

49. How much assistance do you have with the following tasks?

Task	No assistance needed	Always has assistance	Has assistance most of the time	Rarely has assistance	Never has assistance
a. Heavy chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Light housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Using the telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Managing money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Managing medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Using transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Notes & Summary:**

**F. HEALTH CONDITIONS & THERAPIES SECTION**

50. Have you been told by a physician that you have any of the following health conditions?  
**ASSESSOR/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. Mark all that apply.**

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



**G. MENTAL HEALTH SECTION**

52. How satisfied are you with your overall quality of life?  Very satisfied  Satisfied  
 Neither satisfied nor dissatisfied  Dissatisfied  Very dissatisfied
53. Thinking about how you were this time last year, how do you feel about the way things are now?  
 Much better  Better  About the same  Worse  Much worse
54. Have you been diagnosed with a mental condition or psychiatric disorder by a health professional?  
 No  Yes: *List conditions:* \_\_\_\_\_

**55. ASSESSOR/CM: 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. 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Gets lost or wanders off	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Easily agitated or disruptive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Sexually inappropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Threatens or is verbally hostile*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Physically aggressive or violent*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Intentionally injures or harms him/herself*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Expresses suicidal feelings or plans*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Hallucinates, hears/sees things that are not there*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*\*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.*

56. **ASSESSOR/CM: Does client need supervision?**  No  Yes

**Notes & Summary:**



**H. NUTRITION SECTION**

57. Do you usually eat at least two meals a day?  No  Yes

58. Do you eat alone most of the time?  No  Yes

59. How many cups of water, juice, or other liquid do you drink daily? (If more than eight, skip to 60) # \_\_\_\_\_

a. Do you ever limit the amount of fluids you drink?  No  Yes

60. On average, how many servings of fruits and vegetables do you eat every day? (One "serving" is one small piece of fruit or vegetable, about one-half cup of chopped fruit or vegetable, or one-half cup of fruit or vegetable juice.) # \_\_\_\_\_

61. On average, how many servings of dairy products do you have every day? (One "serving" of dairy is about a slice of cheese, a cup of yogurt, or a cup of milk or dairy substitute.) # \_\_\_\_\_

62. Estimate your current height and weight: Height: \_\_\_\_\_ ft. \_\_\_\_\_ inches Weight: \_\_\_\_\_ lbs.

63. Have you lost or gained weight in the last few months?  Unsure (Skip to 64)  No (Skip to 64)  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

64. Are you on a special diet(s) for medical reasons?  No (Skip to 65)  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? \_\_\_\_\_

65. Do you have any problems that make it hard for you to chew or swallow?  No  Yes; check any/all:

Mouth/tooth/dentures  Pain or difficulty swallowing  Taste  Nausea

Saliva production  Other, describe: \_\_\_\_\_

66. What working appliances do you have for storing/preparing food?

None  Refrigerator  Microwave  Toaster/Oven  Stove  Other: \_\_\_\_\_

67. Do you take three or more prescribed or over-the-counter medications a day?  No  Yes

68. How many days in a typical week do you drink alcohol?

Refused (Skip to 69)  None (Skip to 69)  One to two  Three to five  Six to seven

a. On the days when you have some alcohol, about how many drinks do you usually have?

One to two  Three to five  Six or more

b. About how many times in the last month have you had four or more drinks in a day?

None  One to two  Three to five  Six or more

**Notes & Summary:**

**I. SOCIAL RESOURCES SECTION**

69. If needed, is there someone (besides primary caregiver) who could help you?  No (Skip to 71)  Yes

70. Do I have your permission to contact this person, if you need help?  No (Skip to 71)  Yes

a. Name: \_\_\_\_\_ b. Relationship to client: \_\_\_\_\_

c. Phone: \_\_\_\_\_

**J. CAREGIVER SECTION**

**ASSESSOR/CM: If client has no primary caregiver, stop the assessment here. Otherwise, complete 71-86.**

71. **ASSESSOR/CM: HCE Caregiver? If yes, check**

72. Caregiver full name: a. First: \_\_\_\_\_ b. Middle Initial: \_\_\_\_\_  
c. Last: \_\_\_\_\_

73. Caregiver date of birth: (mm/dd/yyyy) \_\_\_\_\_

74. **ASSESSOR/CM: Caregiver identification number** \_\_\_\_\_

75. Caregiver sex:  Male  Female

76. Caregiver race (Mark all that apply.):  White  Black/African American  Asian  
 American Indian/ Alaska Native  Native Hawaiian/ Pacific Islander  Other

77. Caregiver ethnicity:  Hispanic/Latino  Other

78. Caregiver primary language:  English  Spanish  Other: \_\_\_\_\_

79. Caregiver relationship to client:  
 Wife  Husband  Partner  Parent  
 Son/In-law  Daughter/In-law  Other Relative  Other Non-relative

80. Caregiver address:  
a. Street: \_\_\_\_\_  
b. City: \_\_\_\_\_ c. State: \_\_\_\_\_ d. ZIP code: \_\_\_\_\_

81. Caregiver phone number: \_\_\_\_\_

82. How much of a mental or emotional strain is it on you to provide care for the client?  
 None  Some strain  A lot of strain

**J. CAREGIVER SECTION (CONTINUED)**

83. Considering other aspects of your life, rate the level of difficulty in your:	No difficulty	Little difficulty	Some difficulty	Moderate difficulty	A lot of difficulty
a. Relationship with client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Relationship with family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Relationships with friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Functional abilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Time for yourself to do the things you enjoy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

84. How confident are you that you will have the ability to continue to provide care?  
 Very confident (*Skip to 85*)       Somewhat confident (*Skip to 85*)       Not very confident

a. What is the main reason you may be unable to continue to provide care? \_\_\_\_\_

85. **ASSESSOR/CM: Is the caregiver in crisis?**       No       Yes; *check all that apply:*  
 Financial       Emotional       Physical

86. Ask the caregiver to answer the following about the client. (An answer of "Yes, a change" indicates that there has been a change in the last year caused by thinking and memory problems.)	Yes, a change	No change	Don't know or N/A
a. Problems with judgment (problems making decisions, bad financial decisions, problems with thinking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Repeats the same things over and over (questions, stories, or statements)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Daily problems with thinking or memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Adapted from the "Eight-item Informant Interview to Differentiate Aging and Dementia," a copyrighted instrument of Washington University, St. Louis, Missouri. Copyright 2005. All rights reserved.*

**Notes & Summary:**

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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.