

Florida Department of Elder Affairs  
701S Screening Form  
Rule: 58-A-1.010, F.A.C.

Provider ID: \_\_\_\_\_

Provider Screener ID: \_\_\_\_\_

Screener Name: \_\_\_\_\_

Signature: \_\_\_\_\_

1. **SCREENER: What is the purpose of this assessment?**

Initial    Annual    Health    Living situation    Caregiver    Environment    Income

2. 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.**

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. **SCREENER: 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. Mailing Address (If different from current physical location)

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

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

16. **SCREENER: Assessment date:** (mm/dd/yyyy) \_\_\_\_\_

17. **SCREENER: Referral date:** (mm/dd/yyyy) \_\_\_\_\_

Florida Department of Elder Affairs: 701S Screening Form

18. **SCREENER: 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

19. **SCREENER: Transitioning out of a nursing facility?**  No  Yes

20. **SCREENER: 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. Individual monthly income: \$ \_\_\_\_\_  Refused

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

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

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

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

28. Do you need other assistance for food?  No  Yes (*complete Nutritional Risk Score Section*)

29. **SCREENER: Is someone besides the client providing answers to questions?**  No (*Skip to 30*)  Yes:  
a. Name: \_\_\_\_\_ b. Relationship: \_\_\_\_\_

30. How would you rate your overall health at this time?  Excellent  Very Good  Good  Fair  Poor

31. Compared to a year ago, how would you rate your health?  
 Much better  Better  About the same  Worse  Much worse

32. How often are there things you want to do but cannot because of physical problems?  
 Never  Occasionally  Often  All of the time

33. When you need medical care, how often do you get it?  
 Always  Most of the time  Rarely  Only in an emergency  Never

34. When you need transportation to medical care, how often do you get it?  
 Always  Most of the time  Rarely  Only in an emergency  Never

35. How often do finances/insurance allow you to obtain healthcare and medications when you need them?  
 Always  Most of the time  Rarely  Only in an emergency  Never

36. 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

37. In the last year were you in a nursing or rehabilitation facility?  No  Yes

**Notes & Summary:**

Florida Department of Elder Affairs: 701S Screening Form

38. 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"/>

39. 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"/>

40. 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"/>

**Notes & Summary:**

Florida Department of Elder Affairs: 701S Screening Form

41. 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"/>

42. Have you been told by a physician that you have any of the following health conditions?  
**SCREENER: 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

Florida Department of Elder Affairs: 701S Screening Form

Past	Current	Health Conditions, continued				
<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:	_____			
<input type="checkbox"/>	<input type="checkbox"/>	Shingles				
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/CVA				
<input type="checkbox"/>	<input type="checkbox"/>	Syphilis				
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems/Graves/Myxedema		<input type="checkbox"/> Hyper	<input type="checkbox"/> Hypo	
<input type="checkbox"/>	<input type="checkbox"/>	Tumor(s), site:	_____			
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer(s), site:	_____			
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infection (UTI)				
<input type="checkbox"/>	<input type="checkbox"/>	Other:	_____			

43. 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Catheter, type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Insulin assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. IV Fluids/IV Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Occupational therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Ostomy, site: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Oxygen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Radiation/Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Respiratory therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Skilled nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Speech therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Suctioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Tube feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Wound care/Lesion irrigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Other therapy, type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Florida Department of Elder Affairs: 701S Screening Form

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

45. Caregiver phone number: \_\_\_\_\_

46. 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

47. Considering other aspects of your life, rate the level of difficulty in your physical health:  
 No difficulty     Little difficulty     Some difficulty     Moderate difficulty     A lot of difficulty

48. How confident are you that you will have the ability to continue to provide care?  
 Very confident (*Skip to 49*)       Somewhat confident (*Skip to 49*)       Not very confident

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

49. **SCREENER: Is the caregiver in crisis?**     No       Yes; check all that apply:  
 Financial     Emotional       Physical

**Nutritional Risk Score Section**

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

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

52. 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.*) # \_\_\_\_\_

53. 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.*) # \_\_\_\_\_

54. Have you lost or gained weight in the last few months?     Unsure (*Skip to 55*)     No (*Skip to 55*)     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

55. Are you on a special diet(s) for medical reasons?     No (*Skip to 56*)     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? \_\_\_\_\_

56. 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: \_\_\_\_\_

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

58. How many days in a typical week do you drink alcohol?  
 Refused (*Skip a-b*)       None (*Skip a-b*)       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 (*Skip b*)       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