Chapter 11:
National Family Caregiver Support Program

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Chapter 11

National Family Caregiver Support Program

11-1: Description of the National Family Caregiver Support Program

The National Family Caregiver Support Program (NFCSP) establishes an infrastructure of program resources and assistance for family caregivers and grandparents or other relative caregivers. The NFCSP in Tennessee shall be provided in accordance with Title III, Part E, of the Older Americans Act (OAA), as amended in 2006, and TCAD Program and Policy Manual. Grants to States, with State Plans approved under Section 307, shall pay for the Federal share of the cost of carrying out State programs to enable area agencies on aging or entities that such area agencies on aging contract with, to provide a multifaceted system of support services. The NFCSP shall be accessible and provided throughout each of the planning and service areas of Tennessee.

11-1-.01: Caregiver Definitions

The focus of NFCSP is the caregiver and provides a service delivery system that respond to the needs of the caregiver. **The caregiver is the client in the NFCSP program.** Caregivers include:

(1) Family Caregivers

- (a) Adult family members (age 18 years or older) or other adult informal caregivers providing care to adults age 60 and over.
- (b) Adult family members or other adult informal caregivers providing care to individuals of any age with Alzheimer's disease and related disorders.

(2) Grandparents and Relative Caregivers

- (a) Grandparents, step-grandparents, or other relatives (including parents) age 55 and older providing care to adults, age 18 to 59, with disabilities. Disability refers to conditions attributable to mental or physical impairment or to a combination of mental and physical impairment that results in substantial functional limitations in one or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficient, cognition functioning, and emotional adjustment [see 42 USC 3002 (8)]

(b) Grandparents, step-grandparents, or other relatives (not parents) age 55 or older providing care to children under the age of 18 years.

(c) Grandparent and relative caregivers referred to in 11-1-.01 (2)(a) and (b) must also:

(i) live with a child that is not more than 18 years of age or is an individual with a disability (18-59 years of age with a disability).

(ii) be the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child.

(iii) has a legal relationship to the child, such as legal custody or guardianship, or is raising the child informally.

11-1-.02: Service Components

The Tennessee Commission on Aging and Disability (TCAD), working in partnership with the nine (9) Area Agencies on Aging and Disability (AAAD) and local community service providers, shall provide five (5) categories of services for caregivers. The number of activities/ contacts/hours/sessions required for each of the 5 categories is indicated in parentheses. The categories are as follows:

(1) Information Services (1 activity)

This service for caregivers provides the public and individuals with information, resources, and services available to the individuals within their community. Information services are activities, such as but not limited to, disseminating publications and conducting media campaigns, directed to a large audience of current and potential caregivers.

(2) Access Assistance

(a) Information and Assistance (1 contact)

This service assists caregivers in obtaining access to the services and resources that are available within the community. To the maximum extent practicable, this service ensures that the individual receives the services needed by establishing adequate follow-up procedures.

(b) Care Management (1 hour)

This service provides assistance either in the form of access or care coordination in circumstances where the care recipient is experiencing diminished functioning capacities, personal conditions, or other characteristics which require the provision of services by formal service providers or family caregivers. Activities of case management include such practices as assessing needs, developing care plans, authorizing and coordinating services among providers, and providing follow-up and reassessment, as required.

(c) Outreach (1 contact)

This service provides intervention with individuals initiated by an agency or organization for the purpose of identifying potential caregivers and encouraging their use of existing services and benefits.

(3) Individual Counseling, Organization of Support Groups, and Caregiver Training (1 session)

This service is provided to assist the caregivers in the areas of health, nutrition, and financial literacy in order to make decisions and solve problems related to their care giving roles. The services include:

(a) Individual Counseling

Caregiving can be very stressful, both physically and emotionally. Individual counseling allows the caregiver the opportunity to discuss issues related to caregiving such as, but not limited to, identifying signs of caregiver burnout or stress; coping with the emotions such as frustration, feelings of inadequacy, and depression; and, above all, taking care of one's self. A licensed professional counselor should provide individual counseling; however, if a licensed professional counselor is not available, a staff person qualified by training or experience can deliver the service if he/she is supervised by a counselor licensed by the State of Tennessee. The AAADs must have a Licensed Counselor or a counseling agency to which to make a referral if a caregiver is in need of an individual counseling. Licensure can be verified at http://health.state.tn.us/Licensure/index.htm through the Tennessee Department of Health. Licensure includes: Licensed Professional Counselor, Licensed Clinical Social Worker, Licensed Clinical Psychologist, or PhD.

(b) Support Groups

This service offers sessions that allow caregivers the opportunity to discuss their attitudes, feelings, and problem with input from other members of the group; attempt to achieve greater understanding and adjustment; and explore solutions to their problems.

(c) Caregiver Training

This service offers training/education that is designed to assist caregivers with acquiring knowledge and skills that will help them in providing care.

(4) Respite Care

This service offers temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers. Respite care may include:

(a) in-home respite such as personal care, homemaker services, and sitter service;

(b) respite in a non-residential program such as adult day care;

(c) institutional respite provided by placing the care recipient in an institutional setting such as a nursing home for a short period of time as a respite service to the caregiver; and

(d) summer camps for children.

Transportation of the care recipient to an adult day care center or similar program, such as transporting children to summer camp, may be part of the respite expense.

(5) Supplemental Services

This service is provided on a limited basis to complement the care provided by caregivers. Examples of supplemental services include, but not limited to, home modification, home-delivered meals, medical equipment and supplies, personal emergency response system (PERS), incontinence supplies, and assistive technology. Supplemental services also include:

(a) Legal assistance that includes counseling as well as training sessions on legal issues should be reported as a supplemental service.

(b) Transportation to medical appointments would be a supplemental service.

11-1-.03: Priority

In providing services, priority shall be given to:

(1) caregivers who are adults age 60 and over with the following conditions:

(a) greatest social need caused by non-economic factors which include physical and mental disabilities; language barriers; and cultural, social and geographic isolation (including racial or ethnic status) that restricts an individual's ability to perform normal daily tasks or threatens his/her capacity to live independently; and

(b) greatest economic need resulting from an income level at or below the poverty line (100%) as defined by the Office of Management and Budget and adjusted by the Secretary of Health and Human Services with particular attention to low-income adults age 60 and over who are providing care to adults age 60 and over.

(2) adults age 60 and over providing care to individuals with severe disabilities, including children with severe disabilities;

(3) family caregivers who provide care for adults age 60 and over with Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(4) grandparents or relative caregivers who provide care for children with severe disabilities.

11-1-.04: Eligibility

Information, assistance, and counseling can be provided to any caregiver, but Respite and Supplemental Services funded under the NFCSP can be provided only if the **care recipient** meets the definition of frail. Frail means an individual that is determined to be functionally impaired according to the following guidelines;

(1) The care recipient is unable to perform at least two (2) Activities of Daily Living (ADL) without substantial human assistance, including verbal reminding, physical cueing, or supervision; and/or

(2) The care recipient has a cognitive or other mental impairment that requires substantial supervision to prevent the individual from harming him/herself or others.

Any of the five (5) NFCSP service categories may be provided to grandparents, step-grandparents, and other older relative caregivers caring for a child. The child is not required to meet frail guidelines to receive services.

Non-citizens are eligible to receive services through the NFCSP. In accordance with AoA guidelines, non-citizens, regardless of the alien status, should not be banned from services authorized by the OAA and administered by the AoA based solely on their alien status.

11-1-.05: Funding Limitations

(1) Caregiver services under the NFCSP shall not exceed a maximum of $7,000 annually per caregiver. AAADs who provide adult day care services only to caregivers that exceed $7,000 must have prior approval from TCAD.

(2) The total maximum annual amount of funding per caregiver must not exceed $7,000 regardless of the funding source including when individuals receive services from multiple funding sources. In rare cases where the caregiver has multiple care recipients and the cost to provide services to support the needs of the care recipient exceeds $7,000 the AAAD can request that the care plans be reviewed by TCAD for approval to provide services above the $7,000.

(3) Reimbursement for in-home services such as personal care, homemaker, home delivered meals and respite shall not exceed the OAA rate of reimbursement (See HCBS chapter for reimbursement rates.

(4) AAADs shall not use more than twenty percent (20%) of its award to provide supplemental services. Supplemental services are flexible enhancements to caregiver support programs designed for the benefit of caregivers. Each AAAD can elect supplemental services based on local needs.

11-1-.06: Administrative Standards

Funds made available under the NFCSP shall supplement, not supplant, any Federal, State, or local funds expended by a State or unit of general purpose local government (including the AAAD) to provide services described in Title III, Part E, Section 373 of the Older Americans Act.

(1) TCAD shall:

- (a) designate a coordinator to implement and oversee program development of the NFCSP statewide.
- (b) develop and maintain consistent standards and mechanisms for the NFCSP to be implemented statewide. These standards and mechanisms shall be used to assure the quality of services provided in accordance with the Older Americans Act, Administration of Aging regulations and policies, and TCAD policies and rules.
- (c) develop standard individual assessment tools to be used by all AAADs.
- (d) collect, maintain, and report information in State Reporting Tool (SRT).

(e) provide training to the family caregiver program staff, as needed.

(f) provide technical assistance, as needed.

(g) assume quality assurance responsibilities for all caregiver programs to ensure compliance with standards, policies, and procedures of TCAD and the Older Americans Act.

(2) At a minimum each AAAD shall:

(a) publicize NFCSP services to ensure that individuals throughout the area know about the availability of the services.

(b) provide caregiver information and referral and screen individuals for caregiver support services.

(c) complete an in-home assessment on individuals whose screening indicates need for respite or supplemental services.

(d) arrange for the provision of individually needed family caregiver services directly and/or through local service providers.

(e) organize new and/or coordinate with existing caregiver support groups and caregiver training events.

(f) have a licensed professional counselor referral source to which caregivers can be referred for individual counseling, if needed.

(g) coordinate NFCSP with other programs and service systems serving individuals with disabilities.

(h) use trained volunteers to expand the provision of the five (5) service components.

(i) attend training planned or approved by TCAD.

(j) ensure appropriate program/financial reporting, billing, and budget reconciliation.

(k) negotiate contracts and provide quality assurance program implementation.

(l) compile, maintain, and report waiting lists of persons requesting caregiver services for which service is not available.

(3) Service providers must:

(a) be licensed in accordance with the regulations of the State. Service provider agencies providing in-home services (homemaker and personal care) must have a PSSA license or be licensed as a home health care agency by the Tennessee Department of Health

(b) ensure services and units of service to be provided to individuals consistent with the Provider Authorization (Appendix E), where applicable

(c) begin services within five (5) working days of the receipt of the Provider Authorization (Appendix E), where applicable

(d) keep documentation of all contact with or on the behalf of the caregiver and/or care recipient and ensure that the assigned task identified in the Provider Checklist is carried out

(e) keep documentation of each service provided with each visit, which includes a service rendered checklist that is signed by the individual and the worker

(f) have methods and procedures in place for the collection and reporting of individual specific data, including but not limited to rosters, invoices, and daily logs and provide to the AAAD by the 10th day of the month following the month being reported.

11-1-.07: Consumer's Right to Self-Determination

(a) All adult individuals have a right to choose how they will live, as well as where they will live, as long as they are competent to make that decision and able to understand the consequences of their actions.

(b) All adult individuals are presumed legally competent unless they have been deemed incompetent by a court.

(c) It is essential to encourage the individual to live in an environment or situation that is safe. The NFCSP is not expected to assist an individual that chooses to continue to live in a situation that is unsafe or to make plans that are unrealistic and unsafe.

(d) Reports to Adult Protective Services (APS) are mandated by state law when "any person" has reasonable cause to suspect abuse, neglect (including self-neglect), or financial exploitation. This includes neighbors, friends, relatives, doctors, dentists, caregiver, agency personnel, etc.
(Adult Protect Act T.C.A. 71-6-103(b) (1)

11-1-.08: Service Coordination

The Family Caregiver Coordinator/Options Counselor will provide service coordination whether it is in the form of access to services or care coordination to the caregiver to relieve caregiver burden they may experience in providing care to their loved ones.

Service coordination supports information sharing among agencies/organizations, service providers, types and levels of service, service sites, and timeframes to ensure that the individual's needs and preferences are achieved and that services are efficient and of high quality. Activities of service coordination include assessing needs, developing care plans, authorizing services, arranging services, coordinating the provision of services, follow-up and reassessment. Service coordination ensures non-duplication of services by identifying the services and/or service providers, the informal supports, and resources that are currently being utilized and/or provided to the individual.

11-1-.09: Assessment and Reassessment

If the screening indicates a caregiver's need for respite or supplemental services, the Caregiver Form 2010a (Appendix A) shall be completed. The most updated Social Assistance Management System Independent Living Assessment (SAMS ILA) (Appendix H) shall be completed on the care recipient that should include the following minimum sections:

- Section A – Intake/Assessment
- Section B – Individual Identification
- Section C – Demographics
- Section D – Caregiver Identification
- Section I – ADL/IADL and Other Limitations
- Section J – Nutrition Screening (If receiving a meal)

All assessments and reassessments shall be completed in a face-to-face interview in the home with the caregiver. Both the caregiver and the care recipient must sign the Signature Page (Appendix D). The care recipient must at a minimum sign the following:

- Privacy Practices and Individual Rights and Responsibilities
- Release of Information for Statistical Reporting
- Title VI
- Authorization for Referral for Services
- Client Agreement

If the care recipient is unable to sign or if the care recipient is a minor child, then the Signature Page can be signed by their Authorized Representative.

A reassessment is required at least annually; however, staff should be alerted for changes in a caregiver's condition or circumstances that may warrant a reassessment at an earlier date. Follow-up calls to the caregiver are recommended to be made semi-annually to ensure that the needs of the caregiver are being met. If follow-up calls are completed, they should be documented in a case note in the record of the caregiver.

Respite and Supplemental services provided through Title III-E must comply with policies and procedures of the service being provided. For example, a caregiver and/or care recipient that receives home-delivered meals through the NFCSP must comply with Nutrition guidelines.

If the caregiver is a Grandparent/Relative Caregiver of a minor child, then the caregiver would need to be assessed using the Caregiver Form 2010a (Appendix A) and the minor child would be assessing using the SAMS ILA (Appendix H) completing the following sections:

- Section A – Intake/Assessment
- Section B – Individual Identification
- Section C – Demographics
- Section D – Caregiver Identification

11-1-.10: Care Plan

The Options Counselor shall work with the caregiver to develop the care plan. The care plan specifies the types, frequency, and amount of in-home services provided to an individual based on a comprehensive assessment of the caregiver's needs. Service decisions must always be made in the best interest of the caregiver. The care plan must be discussed and developed with the participation of the caregiver ensuring the plan meets their needs. The care plan must be documented in the SAMS database.

(1) Care Plan Components

The care plan in the SAMS database must document at a minimum the following:

(a) The specific support services needed including the frequency and duration of each service;

(b) Start and end date of services;

(c) Primary care manager (Options Counselor);

(d) Allocated units of service;

(e) The name of the provider that will be providing the service; and,

(f) Cost of services

(2) Changes to Care Plan

Care Plans must be updated when a service is decreased, increased, discontinued, or a new service is added. Any changes to the Care Plan must be approved by the caregiver during an in-home visit or by phone. Changes to the Care Plan must be documented in a case note that the change was discussed and approved by the caregiver.

A caregiver is considered in Interrupted Status if the care recipient does not receive services for thirty (30) days due to hospitalization or other causes. The Options Counselor should maintain regular contact with the caregiver during this time. The AAAD may terminate a caregiver from the program after the care recipient has been in Interrupted Status for thirty (30) days.

(3) Care Plan Not Developed

If any of the following conditions apply, a Care Plan shall not be developed:

(a) if the caregiver notifies/tells the Options Counselor that he/she does not want to proceed with the development of the care plan;

(b) if the caregiver/care recipient refuses to release or provide information that is necessary to complete the assessment or develop the care plan; or

(c) if the services needed to support the caregiver are not available or the cost is above the $7,000 limit to develop and carry out the care plan.

11-1-.11: Reporting Requirements

TCAD is required to submit the State Reporting Tool (SRT) on an annual basis that includes data on the NFCSP. The NFCSP is on the federal fiscal year, October 1 through September 30. The AAAD shall document all data in the SAMS database monthly by the 20th day of the following month for the previous month. Required reports must be submitted to TCAD according to the instructions, schedule, and form(s) provided. The year-end report should include data for the entire fiscal year.

Each AAAD shall maintain program data and individual information for each service provided through the NFCSP.

(1) The following demographic data for each caregiver must be entered into the SAMS database in order to qualify as a client of the program. An aggregate number may not be entered. The caregiver and the care recipient must be linked in SAMS. Demographic data should include the following:

(i) Name

(ii) Address

(iii) Telephone number

(iv) Age

(v) Gender

(vi) Race/ethnicity

(viii) Rural status (usually determined by the AAAD based on address information)

(ix) Name and relationship to the care recipient

(x) Optional: Cell phone number or Email address, if available

(2) The only service that is excluded from entering demographic data is Group Information. For this service, an aggregate number can be entered.

(3) For Individual Counseling, Support Groups, and Caregiver Training, a unit of service is equal to a session. Each caregiver will receive a unit of service for each session he/she attend.

(4) Home-delivered meals served with Title III-E funds may be counted as a Nutrition Services Incentive Program (NSIP) eligible mean **if** the meal:

(a) meets the requirements of the OAA (Title III-C);

(b) is served by an agency that has a grant or contract with TCAD or AAAD; and

(c) is served to an individual qualified for service under Title III of the OAA:

(i) care recipients, who are age 60 and over;

(ii) caregivers, who are age 60 or older; or

(iii) caregivers, regardless of age, that are the spouse of a care recipient who is age 60 or older.

11-1-.12: Long Distance Caregivers

There are two (2) types of long-distance caregivers:

(1) The caregiver lives within the State of Tennessee and the care recipient lives in another State.

(2) The caregiver lives in another State and the care recipient lives within the State of Tennessee.

Caregiver services may be provided to long distance caregivers whose care recipient resides within the State of Tennessee, if funds are available. However, the decision to provide Respite and Supplemental services to long distance caregivers will be done on a case-by-case basis and must be pre-approved by TCAD. Title III-B or Title III-C in-home services or state funding home and community-based services should be considered first if the care recipient is eligible to receive services under those programs. If the caregiver resides in Tennessee and the care recipient resides within another state, the Tennessee AAAD should make a referral to the AAA in the State where the care recipient lives.

11-1-.13: Volunteers

Each AAAD shall make use of trained volunteers to expand the provision of the five (5) service components. The AAAD should work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service) in community service settings. Such programs include Senior Corps and AmeriCorps (VISTA).

11-1-.14: Background Checks

This program must be in compliance with the Background Check Chapter of the TCAD *Program and Policy Manual.*

11-1-.15: Cost Sharing and Voluntary Contribution Requirements

Cost sharing shall be at the discretion of the AAAD. However, if the AAAD chooses to implement cost share, then cost share should be calculated on the care recipient's income with the payment being the responsibility of the caregiver. (See the HCBS chapter for cost share standards.)

Voluntary contributions shall be allowed and may be solicited for all services for which funds are received under the Older Americans Act if the method of solicitation is noncoercive. Contributions shall be encouraged for individuals whose self-declared income is at or above 185 percent of the poverty line, at contribution levels based on the actual cost of services.

Appendix A

Caregiver Assessment

Caregiver Form 2010a

I. Profile

I.A. Caregiver Identification

1. **What is the date of the assessment?**

   ______/______/____________

2. **Specify the type of assessment, or the reason for the assessment.**
   - ☐ Initial assessment
   - ☐ Reassessment

3. **What is the name of the person conducting this assessment?**

   ____

4. **What is the name of the agency the assessor works for?**

   ____

5. **What is the client's first name?**

   ____

6. **What is the client's last name?**

   ____

7. **What is the client's middle initial?**

   ____

8. **Enter the client's residential street address or Post Office box.**

   ____

9. **Enter the client's residential city or town.**

   ____

10. **Enter the client's state of residence.**

    ____

11. **Enter the client's residential zip code.**

    ____

12. **Enter the client's mailing street address or Post Office box.**

    ____

13. **Enter the client's mailing city or town.**

    ____

14. **Enter the client's mailing state.**

    ____

15. **Enter the client's mailing ZIP code.**

    ____

16. **What is the client's social security number (SSN)?**

    _________-_________-____________

17. **Enter the primary local client identifier for the client .**

    ____

18. **Enter the client's telephone number.**

    ____

19. **Alternate telephone number for client**

    ____

20. **What is the client's gender?**
    - ☐ Female
    - ☐ Male

21. **What is the client's date of birth?**

    ______/______/____________

22. **Enter the age of the client in years.**

    ☐

23. **Select the client's current marital status.**
    - ☐ Divorced
    - ☐ Legally Separated
    - ☐ Married
    - ☐ Single
    - ☐ Widowed

24. **What is the client's primary caregiver's ethnicity?**
    - ☐ Hispanic or Latino
    - ☐ Not Hispanic or Latino
    - ☐ Unknown

25. **What is the client's race?**

- [ ] American Indian/Native Alaskan
- [ ] Asian
- [ ] Black/African American
- [ ] Missing
- [ ] Native Hawaiian/Other Pacific Islander
- [ ] Non-Minority (White, non-Hispanic)
- [ ] Other
- [ ] White-Hispanic

26. **Is the client currently employed?**

- [ ] Full time
- [ ] Part time
- [ ] No

I.B. Caregiver Profile

1. **What is the care recipient's last name?**

____

2. **What is the care recipient's first name?**

____

3. **Does the client live with the care recipient?**

- [ ] No
- [ ] Sometimes
- [ ] Yes

4. **What is the relationship of the client to the care recipient?**

- [ ] Daughter/Daughter-in-law
- [ ] Grandparent (60+)
- [ ] Husband
- [ ] Non-relative
- [ ] Other elderly non-relative (55+)
- [ ] Other elderly relative
- [ ] Other relative
- [ ] Relationship Missing
- [ ] Son/Son-in law
- [ ] Wife

5. **What is the care recipient's status.**

- [ ] Alzheimer's disease or related disorder
- [ ] Client elderly (60+)
- [ ] Disabled (18 to 59)
- [ ] Minor (18 and under)

6. **How long has client provided most of the care?**

- [ ] Less than 6 months
- [ ] 6 to 12 months
- [ ] 1 to 2 years
- [ ] 2 to 5 years
- [ ] 5+ years

7. **Does the client have any other caregiving responsibilities? (Children, other adults, etc.)**

____

____

____

____

8. **Describe any significant changes or events that have taken place in the client's life during the last six months.**

____

____

____

____

9. **Are there other persons who can assist the client with the care recipient if the client is not available?**

- [ ] No
- [ ] Yes

10. **What contacts/services/supportive interventions have been provided for the client?**

____

____

____

____

11. **Do others assist the client with the care recipient?**

- [ ] No
- [ ] Yes

II. Caregiving Tasks

II.A. Type of Service

1. **Does the primary client provide the care recipient with personal care?**

- [ ] Yes
- [ ] No

2. **Does the client help the care recipient with housekeeping?**

- [ ] Yes
- [ ] No

3. **Does the client help the care recipient manage his/he r money?**

- [ ] Yes
- [ ] No

4. Does the client help the care recipient with shopping and/or errands?

- ☐ Yes
- ☐ No

5. Does the client help the care recipient with taking medication?

- ☐ Yes
- ☐ No

6. Does the client provide the care recipient with transportation?

- ☐ Yes
- ☐ No

7. Does the client provide the care recipient with other assistance?

- ☐ Yes
- ☐ No

8. If services were not in place, would there be anything that would make it difficult for the client to provide care?

- ☐ Yes
- ☐ No

9. How often does the care recipient receive assistance from the client?

- ☐ Monthly
- ☐ Weekly
- ☐ One to two times per week
- ☐ Three or more times per week
- ☐ Once daily
- ☐ Several times during day
- ☐ Several times during day and night

III. Impact of Caregiving

III.A. Caregiver Challenges

1. How does the client rate his/her health?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

2. Does the client feel that s/he has lost control of his/h er life since the care recipient became ill?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

3. Does the client feel that his/her health has suffered because of involvement with the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

4. Does the client feel that the care recipient affects his /her relationship with family members/friends in a negative way?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

5. Does the client feel that his/her social life has suffered because s/he is caring for the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

6. Does the client feel that s/he doesn't have enough privacy because of caring for the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

7. Does the client feel that s/he does not have enough time for him/herself because of the time spent caring for the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

8. Does the client feel stressed between caring for the care recipient and trying to meet other responsibilities?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

9. Does the client feel angry when s/he is around the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

10. Does the client feel that s/he does not have enough money to take care of the care recipient and pay for the rest of his/her expenses?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

11. Overall, does the client feel burdened caring for the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

12. Indicate the behaviors the care recipient has demonstrated at least one a week.

- ☐ Delusional
- ☐ Disruptive behavior
- ☐ Getting lost/wandering
- ☐ Impaired decision-making
- ☐ Memory deficit
- ☐ Physical aggression
- ☐ Verbal disruption
- ☐ Not applicable

Title : ____________________ Date

Title : ____________________ Date

Appendix B

Cost Share Forms

COST SHARE WORKSHEET

OPTIONS, OAA

Name ______________________ Date: ____________

DOB ______________________ Id#: ____________

1

Household Size	**1**	**2**
Declared Monthly Income	$0.00	$0.00
200% of FBR (*Update yearly*)	$1,542.00	$ 2,314.00
Income Subject to Cost Share	**-$1,542.00**	**-$2,314.00**

2 Action Plan Estimation (HDM is subject to donation only)

	Units/Month or Year	**Unit Cost**	**Total**
Homemaker	0	$ -	$ -
Personal Care	0	$ -	$ -

Monthly or Yearly Cost Estimate for Service $ -

3 **Cost Share Rate** (Income subject to Cost Share divided by the amount given for the appropriate number in the household)

Cost Share Rate:	-50.00%	1	$ 3,084.00	(Update yearly with FBR x 4)
	-50.00%	2	$ 4,628.00	(Update yearly with FBR x 4)

4 **Cost Share**

$0.00	Household 1
$0.00	Household 2

Options Counselor ______________________ Date ____________

Note: The amount of cost share cannot exceed 45% of their declared income

Note: If cost share is less then $25/month, the Individual will not be required to pay

If assessed a cost share, 1 copy for Fiscal and original for file

FINANCIAL RESOURCES-INCOME

Name: | **Id:**

Income

INCOME	Individual	Spouse (if applicable)
Social Security		
SSI		
Retirement/Pension		
Interest from Savings, CDs, etc		
VA Benefits		
Wages/Salaries/Earnings		
Other (specify)		
TOTAL	0	

Savings/Assets

Type of Asset	Amount	Comments
Checking		
Savings		
CDs		
Other		

Monthly Living Cost

SOURCE	AMOUNT PER MONTH	COMMENTS
Rent/Mortgage		
Heat		
Electric		
Water/Garbage		
Telephone		
Cable		
Property Tax		
Home Insurance/Rental Insurance		
Medical Insurance		
Medications		
Transportation		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
TOTAL	0	

Available Income	0

Fee Waived: ______ **Yes** _____ **No**

Options Counselor		Date:	

Appendix C

Missed Visit Report

MISSED VISIT REPORT

Individual's Name: ______________________________________**Id#:** ____________________

If NFCSP, Care Recipient Name: __________________________ **Id#:** ____________________

Provider Agency: ______________________________________ **County:** _________________

Program *(check one)*: ☐ **OPTIONS** ☐ **NFCSP (Caregiver, Title III-E)** ☐ **OAA (Title III)**

Dates of Missed Visit: ____

____

Type of Visit:

☐ Personal Care ☐ Home Delivered Meals ☐ In-Home Respite

☐ Homemaker ☐ Other: __________________________________

Reason for Missed Visit:

☐ Individual/Care Recipient had unscheduled appointment

☐ Individual/Care Recipient hospitalized
☐ Individual/Care Recipient refused services
☐ Individual/Care Recipient refused alternate staff member services

☐ Individual/Care Recipient unavailable: ☐ Hospital ☐ Nursing Home ☐ Other:

____

☐ Knocked – No Response: Contact Person Notified/Response: ________________________

☐ Called – No Answer: Contact Person Notified/Response: ___________________________
☐ Scheduling error
☐ Hazardous weather

☐ Holiday scheduling – ☐ Provider canceled ☐ Individual/Care Recipient canceled

☐ Provider unable to provide service because: ______________________________________

____

Additional Provider Comments: ____

____

Signature of Agency Representative: _______________________________**Date:** ________

AAAD Use Only: ☐ Provider Liable	☐ Consumer Liable	☐ No Fault

FAX/SCAN WITHIN 5 BUSINESS DAYS OF MISSED VISIT TO AAAD

Appendix D

Signature Page

SIGNATURE PAGE

Individual's Name: ______________________________ **Individual's ID:** _______________

☐ **AGE DECLARATION** – I am unable to provide proof of age and I declare that I am 60 years of age or older and that my date of birth, _________________ (Month/Day/Year), is correct to the best of my knowledge.

☐ **ASSESSMENT** – I certify that the information provided to the Options Counselor regarding my functional assessment, social and financial circumstances is accurate and complete. I understand that if it is determined at a later date that the information collected is incorrect, my eligibility for services may be affected.

☐ **CHOICE OF PROVIDERS** – I have been offered a choice of service providers from a list of available service providers in my county for each service I am authorized to receive. I understand that it is my choice as to whom I want to provide the in-home services.

☐ **PRIVACY PRACTICES AND INDIVIDUAL RIGHTS AND RESPONSIBILITIES** – By signing this form I acknowledge that I have received a copy of the Notice of Privacy Practices and a copy of the Individual Rights and Responsibilities. I also acknowledge that I understand the information provided in the Notice of Privacy Practices and the Rights and Responsibilities.

☐ **RELEASE OF INFORMATION FOR STATISTICAL REPORTING** – I understand that the information released will not be identified with me personally. It will be used in statistical reports. I give my permission to use the information for statistical reporting.

☐ **REQUEST FOR INTERAGENCY INFORMATION SHARING** – I receive services for more than one program funded through the Tennessee Commission on Aging and Disability and the Area Agency on Aging and Disability. I request the information from my assessment be shared with agencies that would otherwise have to interview me again to collect the same data.

☐ **SERVICES POLICY** – I understand that initiating/continuing services is based upon the availability of funding from State/Federal sources. Additionally, change(s) in Individual circumstances may determine eligibility for an increase or decrease in services.

☐ **TITLE VI** – I understand that I have the right not to be discriminated against on the ground of race, color, or national origin. I understand the procedures for filing a complaint if I feel that I have been discriminated against.

☐ **VOLUNTARY CONTRIBUTIONS** – I understand how to make a voluntary contribution to help pay for the cost of my services paid for by the AAAD. I understand that my contribution can be made anonymously and/or confidentially if that is my preference. I also understand that my contribution will have no effect on the care I receive.

☐ **COST SHARING** – I understand there is a possibility that I will have cost share and that I will be receiving a letter informing me about my cost sharing responsibilities if my income exceeds 200% of the Federal Benefit Rate. I understand that prior to my services starting; I will be informed of my costs, if any.

_______________________________________ ______ _______________________________ ______

Initials of Individual/Authorized Representative Date Initials of Care Recipient (If NFCSP) Date

Individual's Name: ______________________________ **Individual's ID:** _______________

☐ **RECEIPT OF ADVANCED DIRECTIVE INFORMATION** – I have received written information on my right to create an advanced directive.

☐ **PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)** – I understand that if I have PERS equipment and stop receiving PERS services that the equipment will be removed from the home when the service ends.

☐ **NUTRITION COUNSELING** – I understand that due to identified nutritional risk factors, I have been referred for Nutrition Counseling. ☐ Accept or ☐ Deny

☐ **CARE PLAN –** I was permitted to be involved in the development of my care plan and the services that will be provided will help me to remain independent within my home or will assist in my ability to provide care to my family. I understand that if changes are needed to be made in the care plan, I can contact my Options Counselor.

☐ **AUTHORIZATION FOR REFERRAL FOR SERVICES** – I give permission for the Area Agency on Aging and Disability to contact, on my behalf, the agencies or persons listed below and/or on my care plan and to release only such information to them as may be needed to determine the level and types of services that I may need. I also grant permission to the receiving agencies to report back regarding services that I may or may not receive and/or any additional information that may significantly reflect on my need for services. This authorization may be revoked at any time by my written statement and is automatically revoked at my transfer from the agency or at notification of death to include a period of six (6) months.

AGENCY	PURPOSE
1. ________________________________	________________________________
2. ________________________________	________________________________
3. ________________________________	________________________________
4. ________________________________	________________________________

☐ **CLIENT AGREEMENT** – By my signature, I affirm that I have read, or have had explained to me, the above statements. The telephone number I need for questions or complaints has been left with me, and I do give the authorization for release of information as listed above. Unless otherwise stated, this expires in one year.

____ ___________________

Signature of Individual or Authorized Representative Date

____ ___________________

Signature of Care Recipient (When enrolled in NFCSP) Date

____ ___________________

Signature of Options Counselor Date

Appendix E

Provider Authorization/Notification of Change

PROVIDER AUTHORIZATION/NOTIFICATION OF CHANGE

☐ Service Start ☐ Service Change ☐ Change of Information ☐ Service End

☐ Hold as of: ___________ ☐ Resume Services as of: ___________

I. Individual's Information

Name:		DOB:	Id#:	County:
Street Address:			City/Zip Code:	
Phone #:	Emergency Contact:		EC Phone #:	
If Title III-E (NFCSP), Name of Care Recipient:			Care Recipient Id#:	

II. Service Authorization

Service	Date Service Authorized	Provider Name	Funding Source	Units/ Frequency	Unit Cost	End Date
Homemaker						
Personal Care						
Home Delivered Meal						
Chore						
In-Home Respite						
Adult Day Care						
Other:						

Special Frequency Instructions:

Comments/Considerations:

Options Counselor: ____ Phone: ______________________

Date Faxed: ______________________ If Change of Services, Date Individual Notified: ________

III. Service Provider

☐ Accepted ☐ Declined Service Start Date: _____________ Date Ended: _____________

Authorized Provider Signature: ____________________________________ Date:________________

FAX/SCAN REPLY WITH START DATE WITHIN 5 WORKING DAYS TO AAAD

Provider Checklist

PROVIDER CHECKLIST

Date: _________ County: __________

Individual's Name: __________________________________ Id#: _____________________

If NFCSP, Care Recipient: ___________________________ Id#: ______________________

☐ PERSONAL CARE

Type of Bath:
- ☐ Tub Bath
- ☐ Shower
- ☐ Complete bed bath
- ☐ Complete sponge bath
- ☐ Partial sponge bath

Foot Care:
- ☐ Foot soak
- ☐ Lotion Feet
- ☐ Other _______________

Hair Care:
- ☐ Shampoo in shower
- ☐ Shampoo in sink
- ☐ Shampoo in bed
- ☐ Brush hair
- ☐ Shave
- ☐ Other________________

Mouth Care:
- ☐ Brush teeth
- ☐ Clean dentures
- ☐ Swab mouth

Dressing:
- ☐ Dressing Assistance

Skin Care:
- ☐ Lotion massage
- ☐ Other_______________

Nail Care:
- ☐ Clean nails
- ☐ Other_______________

Ambulation:
- ☐ Assist to ambulate
- ☐ With assistive device
- ☐ Do not ambulate

Other Duties:
- ☐ Assist with eating
- ☐ Assist with toileting

☐ HOMEMAKER

- ☐ Straighten/Pick up
- ☐ Vacuuming
- ☐ Mop
- ☐ Laundry/Laundromat
- ☐ Dusting
- ☐ Empty trash
- ☐ Prescription pickup

- ☐ Shopping
- ☐ Grocery shopping

Bedroom:
- ☐ Change bed linen
- ☐ Straighten bed linen
- ☐ Other__________________

Bathroom:
- ☐ Clean tub/shower
- ☐ Clean bath basin
- ☐ Clean commode
- ☐ Other__________________

Kitchen:
- ☐ Clean stove
- ☐ Clean countertop
- ☐ Clean refrigerator
- ☐ Clean dishes
- ☐ Meal preparation
- ☐ Other______________

☐ Special Instructions:

☐ Safety needs identified:

____ __________

Signature of Individual or Authorized Representative Date

Appendix G

Reimbursement Rate of Services

Reimbursement Rate

OPTIONS for Community Living (State-Funded)
Older Americans Act – Title III (Federally Funded)

Service	Reimbursement Rate
Personal Care – OAA Title III	*The lesser of* $20.52 per hr. or usual and customary charges*
Personal Care – State Funds	*The lesser of* $20.52 per hr. or usual and customary charges*
Homemaker Services – OAA Title III	*The lesser of* $20.52 per hr. or usual and customary charges*
Homemaker Services – State Funds	*The lesser of* $20.52 per hr. or usual and customary charges*
In-home Respite – OAA Title III	*The lesser of* $16.28 per hr. or usual and customary charges*
Hot Home-Delivered Meals – OAA Title III	*The lesser of* $7.00 per meal or usual and customary charges*
Hot Home-Delivered Meals – State Funds	*The lesser of* $7.00 per meal or usual and customary charges*
Frozen Home-Delivered Meals – OAA Title III	*The lesser of* $6.00 per meal or usual and customary charges*
Frozen Home-Delivered Meals – State Funds	*The lesser of* $6.00 per meal or usual and customary charges*

**For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost for providing the service. The same requirements are to be applied in the above noted programs. Thus, only the lesser of the maximum rate as specified above or the usual and customary charges for each service should be billed.*

These are the maximum rates which may **not** be exceeded; a lesser amount should be billed and reimbursed, if the provider's usual and customary charge to persons not participating in these programs is lower. Reimbursement rates for OAA and State-Funded services shall not exceed the TennCare reimbursement rates.

Appendix H

Social Assistance Management System Independent Living Assessment (SAMS ILA) and Guide

SAMS ILA 2018

A	Intake/Assessment				Req?
	Intake/Assessment	1144	1	What is the date of the assessment? ☐☐ – ☐☐ – ☐☐☐☐ Month Day Year	Yes
		1145	2	Specify the type of assessment, or the reason for the assessment. ☐ **1** Initial assessment ☐ **2** Reassessment	Yes
		1001	3	What is the name of the person conducting this assessment? ____________________ ____________________	Yes
		2999	4	Describe formal/informal supports already in place. ____________________ ____________________	No
		5695	5	Comment on type of assistance requested. ____________________ ____________________ ____________________	Yes

B	Individual Identification				Req?
	Individual Identification	1128	1	What is the client's first name? ____________________	Yes
		1493	2	Enter the client's 'also known as' first name. ____________________	No
		1129	3	What is the client's middle initial? ____________________	No
		1127	4	What is the client's last name? ____________________	Yes
		1134	5	What is the client's date of birth? ☐☐ – ☐☐ – ☐☐☐☐ Month Day Year	Yes
		4297	6	What document was used to verify the client's age? ☐ **1** Birth certificate	Yes

B	Individual Identification			Req?
			☐ **2** State issued identification ☐ **3** Military/veteran's identification card ☐ **4** Self declaration ☐ **5** Other (Answer next question if this is chosen)	
	4298	7	What other document was used to verify the client's age? ____________________	No
	1131	8	What is the client's Pension/Social Security Number? (Optional or collect if making CHOICES referral) ______-______-________	No
	1495	9	Enter the client's telephone number. ____________________	Yes
	6627	10	Alternate telephone number for client ____________________	No
	5362	11	What is the client's e-mail address? ____________________ ____________________	No
	1501	12	Enter the client's residential address. ____________________	Yes
	1502	13	Enter the client's residential city or town. ____________________	Yes
	1408	14	Enter the client's state of residence. ____________________	Yes
	1409	15	Enter the client's residential zip code. ____________________	Yes
	1724	16	What county does the client reside in? ____________________	Yes
	1505	17	Describe how to get to the client's home. ____________________ ____________________ ____________________	No
	1497	18	Enter the client's mailing street address or Post Office box. ____________________	Yes
	1498	19	Enter the client's mailing city or town. ____________________	Yes

B	Individual Identification				Req?
		1499	20	Enter the client's mailing state. ____________________	Yes
		1500	21	Enter the client's mailing ZIP code. ____________________	Yes
		1012 Score: 3	22	Select the client's current living arrangement. ☐ **1** Lives Alone (3) ☐ **2** Lives with spouse only ☐ **3** Lives with spouse and others ☐ **4** Lives with others.	Yes

C	Demographics				Req?
	Demographics	4005	1	What is the client's ethnicity? ☐ **1** Hispanic or Latino ☐ **2** Not Hispanic or Latino ☐ **3** Unknown	Yes
		4006	2	What is the client's race? ☐ **1** American Indian/Native Alaskan ☐ **2** Asian ☐ **3** Black/African American ☐ **4** Native Hawaiian/Other Pacific Islander ☐ **5** Non-Minority (White, Non-Hispanic) ☐ **6** White-Hispanic ☐ **7** Other	Yes
		1133	3	What is the client's gender? ☐ **1** Male ☐ **2** Female ☐ **3** Other	Yes
		1010	4	Select the client's current marital status. ☐ **1** Single ☐ **2** Married ☐ **3** Divorced ☐ **4** Widowed ☐ **5** Separated ☐ **6** Other	Yes

D	Caregiver Identification				Req?
	Caregiver Identification	1066 Score: 2	1	Does the client have an identified primary (informal) helper/caregiver who provides care on a regular basis? ☐ **1** Yes ☐ **2** No, If no, skip to next section. (2)	Yes

D	Caregiver Identification				Req?
		4732	2	What is the caregiver's first name?	No
		4731	3	What is the caregiver's last name?	No
		2531	4	Caregiver's birth date? (Month – Day – Year)	No
		4734	5	What is the caregiver's telephone number?	No
		5363	6	What is the caregiver's e-mail address?	No
		2545	7	What is the address of the client's caregiver?	No
		2548	8	What is the client's caregiver's Zip Code?	No
		5360	9	What is the caregiver's relationship to the elderly care recipient? ☐ **1** Child ☐ **2** Spouse/Partner/Significant other ☐ **3** Other relative ☐ **4** Other non-relative	No
		1429	10	How often does the client receive assistance from the primary caregiver? ☐ **1** Daily ☐ **2** Several times a week ☐ **3** Weekly ☐ **4** Less than weekly	No

E	Emergency Contacts				Req?
	Emergency Contacts	2400	1	Name of Friend or Relative (outside client's home) to contact in case of an Emergency.	Yes
		2401	2	Relationship of Friend or Relative (outside client's home) to contact in case of an Emergency.	Yes

E	Emergency Contacts				Req?
		2402	3	Primary Telephone Number of Friend or Relative (outside client's home) to contact in case of an Emergency. ________	Yes
		2403	4	Alternate Telephone Number of Friend or Relative (outside client's home) to contact in case of an Emergency. ________	No
		1040	5	What is the name of a second relative or friend of the client? ________	No
		1503	6	What is the home phone number of the second relative or friend of the client? ________	No
		1504	7	What is the alternate phone number of the second relative or friend of the client? ________	No
		1514	8	Does the client have a power of attorney? ☐ **1** Yes, Health ☐ **2** Yes, Finances ☐ **3** Yes, Both ☐ **4** No (If no, skip to question #11) ☐ **5** Don't Know (If don't know, skip to question # 11)	No
		1515	9	What is the name of the client's power of attorney? ________	No
		1517	10	Enter the phone number of the client's power of attorney. ________	No
		2228	11	Does the client have a living will? ☐ **1** Yes ☐ **2** No	No

F	Social Screening				Req?
	Social Screening	1559 Score: 3	1	Is there a friend or relative that could take care of the client for a few days? ☐ **1** Yes ☐ **2** No (3)	Yes

G	Health Screening				Req?
	Health Screening	1561 Score: 1 Score: 2	1	How does the client rate his/her health? ☐ **1** Excellent ☐ **2** Good ☐ **3** Fair (1) ☐ **4** Poor (2)	Yes

G	Health Screening			Req?
		4292 2	In the past year, how many times has the client stayed overnight in a hospital?	Yes
			☐ **1** Not at all	
		Score: 1	☐ **2** Once (1)	
		Score: 2	☐ **3** 2 or 3 times (2)	
		Score: 3	☐ **4** More than 3 times (3)	
		1566 3	Has the client fallen in the past three months?	Yes
		Score: 3	☐ **1** Yes (3)	
			☐ **2** No	
		2714 4	Is the client homebound?	Yes
		Score: 3	☐ **1** Yes (3)	
			☐ **2** No	
		1124 5	Indicate which of the following conditions/diagnoses the client currently has.	Yes
			☐ Alzheimers disease/other Dementia	
			☐ Ankle/leg swelling	
			☐ Any urinary or bowel problems	
			☐ Arthritis/rheumatic disease/gout	
			☐ Cancer	
			☐ Chronic pain	
			☐ Contagious/Communicable Disease	
			☐ Do you take any medication for depression or anxiety	
			☐ Diabetes	
			☐ Have you ever had a stroke	
			☐ Hearing impairment	
			☐ Heart problems	
			☐ Hypertension	
			☐ Intellectual/Developmental disability	
			☐ Memory Loss	
			☐ Missing limb (e.g., amputation)	
			☐ Problems with breathing	
			☐ Tremors	
			☐ Vision problems	
			☐ Other significant illness	
			☐ None of the Above	
		1126 6	Enter any comments regarding the client's medical conditions/diagnoses. __________ __________ __________	No

H	Mental Health Observations			Req?
	Mental Health Observations	7406 1	Can the client express basic needs and wants?	No
			☐ 1 Yes	
			☐ 2 No	
		1936 2	How many days per week does the client have problems making him/herself understood?	Yes
			☐ 1 Never	
		Score: 1	☐ 2 Sometimes (1)	
		Score: 2	☐ 3 Always (2)**	
		7391 3	Can the client understand and follow simple instructions?	No
			☐ 1 Yes	
			☐ 2 No	
		1938 4	How many days per week does the client have problems understanding others?	Yes
			☐ 1 Never	
		Score: 1	☐ 2 Sometimes (1)	
		Score: 2	☐ 3 Always (2)**	
		1978 5	How is the client's orientation to people?	Yes
			☐ 1 No apparent problem	
		Score: 1	☐ 2 Sometimes a problem - 1 to 3 days (1)	
		Score: 2	☐ 3 Often a problem - 4 to 7 days (2) **	
		1969 6	How is the client's orientation to place?	Yes
			☐ 1 No apparent problem	
		Score: 1	☐ 2 Sometimes a problem - 1 to 3 days (1)	
		Score: 2	☐ 3 Often a problem - 4 to 7 days (2) **	
		4888 7	Has the individual exhibited behavior problems?	Yes
			☐ 1 No apparent problem	
		Score: 1	☐ 2 Sometimes a problem - 1 to 3 days (1)	
		Score: 2	☐ 3 Often a problem - 4 to 7 days (2) **	
		1460 8	Indicate the behaviors the client has demonstrated.	No
			☐ Verbal disruption	
			☐ Physical aggression	
			☐ Disruptive behavior	
			☐ Delusional	
			☐ Getting lost/wandering	
			☐ Presents other problems	

I	ADL/IADL and Other Limitations			Req?
	ADL	1081 1	During the past 7 days, and considering all episodes, was the client able to BATHE without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No, required assistive technology - 1	

I	ADL/IADL and Other Limitations				Req?
	Score: 2	☐	3	No, required supervision (SBA - Verbal someone there to watch or prompt) - 2	
	Score: 3	☐	4	No, required limited assistance (1 to 3 days physical hands on help) - 3	
	Score: 4	☐	5	No, required extensive/total assistance (4 to 7 days a week hands on help) - 4	
	1077 2	During the past 7 days, and considering all episodes, was the client able to Dressing without help?			Yes
		☐	1	Yes	
	Score: 1	☐	2	No, required assistive technology - 1	
	Score: 2	☐	3	No, required supervision (SBA -Verbal someone there to watch or prompt) - 2	
	Score: 3	☐	4	No, required limited assistance (1 to 3 days physical hands on help) - 3	
	Score: 4	☐	5	No, required extensive/total assistance (4 to 7 days a week hands on help) - 4	
	1074 3	During the past 7 days, and considering all episodes, was the client able to TRANSFER without help?			Yes
		☐	1	Yes	
	Score: 1	☐	2	No, required assistive technology - 1	
	Score: 2	☐	3	No, required supervision (SBA - Verbal someone there to watch or prompt) - 2	
	Score: 3	☐	4	No, required limited assistance (1 to 3 days physical hands on help) - 3	
	Score: 4	☐	5	No, required extensive/total assistance (4 to 7 days a week hands on help)** - 4	
	1076 4	During the past 7 days, and considering all episodes, was the client able to GET AROUND THE HOME without help?			Yes
		☐	1	Yes	
	Score: 1	☐	2	No, required assistive technology - 1	
	Score: 2	☐	3	No, required supervision (SBA - Verbal someone there to watch or prompt) - 2	
	Score: 3	☐	4	No, required limited assistance (1 to 3 days physical hands on help)- 3	
	Score: 4	☐	5	No, required extensive/total assistance (4 to 7 days a week hands on help)** - 4	
	1078 5	During the past 7 days, and considering all episodes, was the client able to EAT without help?			Yes
		☐	1	Yes	
	Score: 1	☐	2	No, required assistive technology - 1	
	Score: 2	☐	3	No, required supervision (SBA - Verbal someone there to watch or prompt) - 2	
	Score: 3	☐	4	No, required limited assistance (1 to 3 days physical hands on help) - 3	
	Score: 4	☐	5	No, required extensive/total assistance (4 to 7 days a week hands on help)** - 4	
	1079 6	During the past 7 days, and considering all episodes, was the client able to USE THE TOILET without help?			Yes
		☐	1	Yes	
	Score: 1	☐	2	No, required assistive technology - 1	
	Score: 2	☐	3	No, required supervision (SBA - Verbal someone there to watch or prompt) - 2	
	Score: 3	☐	4	No, required limited assistance (1 to 3 days physical hands on help)- 3	
	Score: 4	☐	5	No, required extensive/total assistance (4 to 7 days a week hands on help)** - 4	
	2118 7	Enter the total ADL impariments as calculated above. (This is the SAMS ADL score and cannot be greater than 6. They get 1 point for each ADL question they answered No to.) ☐			Yes

I	ADL/IADL and Other Limitations			Req?
	IADL	1084 1	During the past 7 days, and considering all episodes, was the client able to MANAGE MEDICATIONS without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No, required assistive technology - 1	
		Score: 2	☐ 3 No, required supervision (SBA -Verbal somone there to watch or prompt) - 2	
		Score: 3	☐ 4 No, required limited assistance (1 to 3 days physical hands on help) - 3	
		Score: 4	☐ 5 No, required extensive/total assistance (4 to 7 days a week hands on help)** - 4	
		1901 2	Is the client able to MANAGE MONEY without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		1086 3	Is the client able to SHOP without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		1082 4	Is the client able to PREPARE MEALS without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		1902 5	Is the client able to do HEAVY HOUSEWORK without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		1903 6	Is the client able to do LIGHT HOUSEKEEPING without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		1087 7	Is the client able to USE TRANSPORTATION without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		3820 8	Is the client able to USE THE TELEPHONE without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		2119 9	Enter the Total IADL impariements as calculated above. (This is the SAMS IADL Score. It cannot be greater than 8. They receive 1 point for each question they answered No to.) ☐	Yes
		4384 10	Comment on the client's functional ability. ______ ______ ______	No
	Adaptive Equipment	5380 1	Does the client have any of the following devices or equipment?	No
			☐ 1 Artificial limb	
			☐ 2 Bath stool	

I	ADL/IADL and Other Limitations			Req?
			☐ **3** Bedside commode ☐ **4** Cane ☐ **5** Dentures ☐ **6** Extended shower head ☐ **7** Eyeglasses ☐ **8** Grab bars ☐ **9** Hand Held Shower ☐ **10** Hearing aid ☐ **11** Hospital bed ☐ **12** Lift chair ☐ **13** Nebulizer ☐ **14** Oxygen ☐ **15** Raised toilet seat ☐ **16** Ramp ☐ **17** Walker ☐ **18** Wheelchair ☐ **19** Other	
		6772 2	Please specify the other assistive devices the client uses. ____________________ ____________________ ____________________	No
		5785 3	If the client did not receive agency funded services, would the client have enough help to remain independent? ☐ **1** Yes, without difficulty ☐ **2** Yes, with difficulty ☐ **3** No/not sure	No

J	Nutrition Screening			Req?
	Nutrition Screening	2383 1 Score: 2	Has the client made any changes in lifelong eating habits because of health problems? ☐ **1** Yes - 2 ☐ **2** No	Yes
		1108 2 Score: 3	Does the client eat fewer than 2 meals per day? ☐ **1** Yes - 3 ☐ **2** No	Yes
		1110 3 Score: 2	Does the client have 3 or more drinks of beer, liquor or wine almost every day? ☐ **1** Yes - 2 ☐ **2** No	Yes
		2384 4	Does the client eat fewer than five (5) servings (1/2 cup each) of fruits or vegetables every day?	Yes

J	Nutrition Screening			Req?
		Score: 1	☐ **1** Yes - 1 ☐ **2** No	
		2385 5 Score: 1	Does the client eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day? ☐ **1** Yes - 1 ☐ **2** No	Yes
		1818 6 Score: 2	Does the client have trouble eating well due to problems with chewing/swallowing? ☐ **1** Yes - 2 ☐ **2** No	Yes
		1112 7 Score: 4	Does the client sometimes not have enough money to buy food? ☐ **1** Yes - 4 ☐ **2** No	Yes
		1113 8 Score: 1	Does the client eat alone most of the time? ☐ **1** Yes - 1 ☐ **2** No	Yes
		1114 9 Score: 1	Does the client take 3 or more different prescribed or over-the-counter drugs per day? ☐ **1** Yes - 1 ☐ **2** No	Yes
		1115 10 Score: 2	Without wanting to, has the client lost or gained 10 pounds in the past 6 months? ☐ **1** Yes - 2 ☐ **2** No	Yes
		1116 11 Score: 2	Is the client not always physically able to shop, cook and/or feed themselves (or to get someone to do it for them)? ☐ **1** Yes - 2 ☐ **2** No	Yes
		2563	Total score of Nutritional Risk Questions. ☐	Yes
		2116 12	Is the client at a high nutritional risk level? (Scored 6 or more) ☐ **1** Yes ☐ **2** No	Yes

K	Current Health Status			Req?
	Current Health Status	1804 1	Describe the client's allergies, if any. __________ __________ __________	No
		1817 2	Describe the client's special diet(s).	No

K	**Current Health Status**			**Req?**
			__________ __________ __________	
L	**Home Hazards**			**Req?**
	Home Hazards	4052 1	Is there evidence of pets/animals that are a danger to those who come to the client's home? ☐ **1** Yes ☐ **2** No	No
M	**Home Environment**			**Req?**
	Environmental Checklist	1941 1	Does the client have problems with dangerous stairs or floors in his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1942 2	Is it difficult for the client to get to the entrance of his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1943 3	Is it difficult for the client to get to the bathroom or bedroom in his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1944 4	Does the client have problems with the major appliances or toilet in his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1945 5	Does the client have problems with the heating or cooling in his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1946 6	Does the client have problems getting water or hot water in his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1947 7	Does the client have difficulties keeping his/her home free from odor or pests? ☐ **1** Yes ☐ **2** No	Yes
		1948 8	Does the client need a smoke alarm in his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1949 9	Does the client have problems with electrical hazards in his/her home? ☐ **1** Yes	Yes

M	Home Environment					Req?
				☐ 2 No		
		1950	10	Does the client have problems with poor lighting in his/her home? ☐ 1 Yes ☐ 2 No		Yes
		1951	11	Does the client have problems with an unsafe stove in his/her home? ☐ 1 Yes ☐ 2 No		Yes
		1952	12	Does the client have problems with loose slippery rugs in his/her home? ☐ 1 Yes ☐ 2 No		Yes
		1953	13	Does the client have problems with inadequate locks on the doors and/or windows in his/her home? ☐ 1 Yes ☐ 2 No		Yes
		1954	14	Does the client have problems keeping his/her home clean and free of clutter? ☐ 1 Yes ☐ 2 No		Yes
		1955	15	Does the client have any other environmental problems in his/her home? ☐ 1 Yes ☐ 2 No		Yes
		1956	16	Describe any other environmental problems. __________ __________ __________		Yes
		1957	17	In the case of an emergency, would the client be able to get out of his/her home safely? ☐ 1 Yes ☐ 2 No		Yes
		1958	18	In the case of an emergency, would the client be able to summon help to his/her home? ☐ 1 Yes ☐ 2 No		Yes
		4227	19	Comment on the client's home environment in general. __________ __________ __________		Yes

N	Financial Resources				Req?
	Total Resources	2068	1	What is the total income of the client's household per month?	Yes

N	Financial Resources			Req?
		2529 2	How many people does the houshold income support? ☐	Yes
		2115 3 Score: 2	Is the client's income level below the national poverty level? ☐ **2** Yes (2) ☐ **2** No	Yes
		1555 4	Specify the client's monthly income (or client and spouse if married).	No
		3910 5 Score: 3	What is the client's Monthly Income Range? ☐ **1** Below 150% federal poverty level (3) ☐ **2** Over 150% of poverty level up to 200% of poverty level ☐ **3** More than 200% of poverty level but less than 300% of FBR ☐ **4** Over 300% federal benefit rate	Yes
		5802 6 Score: 1	Does the client have excessive expenses, such as medical bills, that prevent them from meeting their needs? ☐ **1** Yes (1) ☐ **2** No	Yes
	Other Assistance	1552 1	Does the client want to apply for any of the following services or programs? ☐ **1** Energy assistance (LIHEAP) ☐ **2** Food stamps (SNAP) ☐ **3** Home Repair/Weatherization ☐ **4** QMB/SLMB/LIS/Q1 ☐ **5** SSI ☐ **6** Medicare Counseling ☐ **7** None	Yes
		2123 2	Is the client a veteran or the spouse/widow of a veteran? ☐ **1** Yes ☐ **2** No	Yes
	Health Insurance	1780 1	Does the client have Medicare A health insurance? ☐ **1** Yes ☐ **2** No (Skip next two questions) ☐ **3** Don't know	Yes
		1002 2	Enter the client's Medicare number. ____________________	No
		1781 3	What is the effective date of the client's Medicare A policy? ☐☐ – ☐☐ – ☐☐☐☐ Month Day Year	No
		1782 4	Does the client have Medicare B health insurance? ☐ **1** Yes ☐ **2** No (Skip next question)	No

N	Financial Resources				Req?
				☐ 3 Don't know	
		1783	5	What is the effective date of the client's Medicare B policy? ☐☐ – ☐☐ – ☐☐☐☐ Month Day Year	No
		1785	6	Does the client have Medigap health insurance? ☐ 1 Yes ☐ 2 No	No
		5979	7	Does the client have Medicare D health insurance? ☐ 1 Yes ☐ 2 No	No
		1788	8	Does the client have LTC health insurance? ☐ 1 Yes ☐ 2 No	No
		13430	9	Does the client have Medicaid or TennCare? ☐ 1 Yes ☐ 2 No	No
		1791	10	Does the client have other health insurance? ☐ 1 Yes ☐ 2 No	No
		2440	11	Please indicate if the individual has QMB/SLMB ____________________ ____________________	No

O	CHOICES Screening				Req?
	CHOICES	5991	1	Does the client own his/her home or any other property? ☐ 1 Yes ☐ 2 No	No
		7140	2	What are the client's resources/assets? ☐ 1 Certificate of Deposits ☐ 2 Checking Account ☐ 3 Savings certificate ☐ 4 IRA or Annuity ☐ 5 Savings Account ☐ 6 Stocks, Bonds ☐ 7 Burial contract ☐ 8 Life insurance policy with cash value ☐ 9 Property other than home	No
		8131	3	Are the Consumer's assets valued at less than $2000? ☐ 1 Yes	No

O CHOICES Screening — Req?

- ☐ 2 No
- ☐ 3 Don't Know

6332 4 Has the client transferred any property or money in the last five years? — Req? No

- ☐ 1 Yes
- ☐ 2 No

11925 5 While you are more likely to get more services sooner by getting CHOICES, getting CHOICES also means that any property and assets you have are subject to Estate Recovery. Knowing this, would you still like to be screened for CHOICES? — Req? No

- ☐ 1 Yes
- ☐ 2 No

3989 6 What is the date of the consumer's last medical evaluation by a physician? — Req? No

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

1025 7 What is the name of the client's primary care physician? — Req? No

____

1028 8 What is the work phone number for the client's primary care physician? — Req? No

____

P Other Observations — Req?

Other Observations

4044 1 Client is assigned for in-depth assessment for the following programs? — Req? Yes

- ☐ 1 CHOICES
- ☐ 2 OPTIONS
- ☐ 3 Title IIIE, NFCSP services
- ☐ 4 Title IIIB
- ☐ 5 Title IIIC, Home Delivered Meals
- ☐ 6 None

4688 2 Enter assessment comments. — Req? No

____

____

____

Q Prioritization — Req?

Prioritization

2486 1 Is this an APS Referral? — Req? No

- ☐ 1 Yes
- ☐ 2 No

5353 2 Other Factors — Req? No

____

____

Q	Prioritization			Req?
		1778 3	Enter the Total Priority Score as calculated above	No
		15055 4	Total Risk Level ☐ **1** Low Risk (1 to 15) ☐ **2** Moderate Risk (16 to 30) ☐ **3** High Risk (31-70)	No

Tennessee Commission on Aging and Disability Uniform Assessment Form Guidance Manual

April 2018

Introduction

With over 100 Tennesseans turning sixty every day and soaring demand for a limited pool of state-funded home and community based services (HCBS), in the summer of 2015, the Tennessee Commission on Aging and Disability (TCAD) in partnership with the aging network sought to revise and update its screening and assessment policies and processes. The end goal was to develop a system in place that was focused on the individual and could efficiently identify and prioritize their needs. To achieve this goal TCAD enlisted the help of the Department of Finance and Administration's Office of Consulting Services (now under the Governor's Office of Customer Focused Government) to use the Lean process to revamp the current system. The Lean process brought together stakeholders from TCAD, four Area Agencies on Aging and Disability (AAAD), and a service provider to reimagine and reengineer a new way of screening and assessing individuals seeking state-funded HCBS services.

This manual is one of the many products of the Lean process that designed to create a more efficient and consistent screening and assessment process. This manual will help ensure that anyone using the Intake and Assessment Form will have clear instructions on how to use it and that collected information is consistent from initial contact to reassessment and across all districts.

Special thanks to the following individuals for making this possible:

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Overview

Items presented in the Intake and Assessment Form should not be read word for word. Instead they should be presented in a natural and conversational manner. For example, instead of asking, "What is the client's date of birth?" Ask, "When is your birthday? What year were you born?"

Each item contained in the Intake and Assessment Form is included in this manual. There are instructions for how each item should be completed. For more complicated items, there is also a description that provides background on the importance of the item and help in understanding and collecting the right information.

An asterisk (*) at the end of an item denotes that the item should generally be completed during an I&A screening. All items should be completed for an in-home assessment with the exception of the Medicare subsection in Section I: Financial Resources.

The following symbols at the end of an item denote that an item is especially important to complete:

[E] = item used for eligibility

[P] = item used to evaluate priority

[R] = item required to report to funders

Intake/Assessment (Section A)

1 What is the date of the assessment? *

Instructions: Enter the date the assessment is conducted.

2 Specify the type of assessment, or reason for the assessment? *

Instructions: Select whether this is an initial assessment or a reassessment.

3 What is the name of the person conducting this assessment? *

Instructions: Enter the name of the person conducting the assessment.

4 Describe formal/informal supports already in place. [P]

Instructions: Enter the current formal and informal services and supports the individual is currently receiving.

5 Comment on the type of assistance requested.*

Instructions: Note the type of assistance the individual is seeking.

Individual Identification (Section B)

1 What is the client's first name? *

Instructions: Enter the first name of the person being assessed.

2 What is the client's 'also known as' first name?

Instructions: Enter the preferred name of address of the person being assessed.

3 What is client's middle initial?

Instructions: Enter the middle initial of the person being assessed.

4 What is the client's last name? *

Instructions: Enter the last name of the person being assessed.

5 What is the client's date of birth? *[ER]

Description: With a few exceptions, services under the Older Americans Act may only be provided to individuals age 60 or over therefore this item is the key eligibility determinant and must be collected.

Instructions: Enter the date of birth of the person being assessed.

6/7 What document was used to verify the client’s age?* What other document was used to verify the client’s age?

Description: Because age is the key eligibility determinant, verification is strongly encouraged. However, in some situations an individual may be unable to provide documentation. They may choose to self-declare by completing the appropriate portion of the signature page.

Instructions: Select the documentation used to very age. If a document other than those outlined in Question 6 was used, note what that documentation was in Question 7.

8 What is the client’s Pension/ Social Security Number? (Optional or collect if making CHOICES referral)

Description: Social Security Number may be needed to refer an individual to other services such as TennCare CHOICES or the State Health Insurance Assistance Program (SHIP). They are not required to provide this to receive any services offered under the Older Americans Act.

Instructions: Enter the Social Security Number of the person being assessed if they would like to be screened for additional services and supports such as CHOICES or SHIP.

9 Enter the client's telephone number. *

Instructions: Enter the best phone number for reaching the person being assessed.

10 Enter the client’s alternate phone number.

Instructions: Enter the client’s alternate phone number if available.

11 What is the client’s e-mail address?

Instructions: Enter the client’s e-mail address if available.

12/13/14 Enter the client's residential street address .* Enter the client's residential city or town.* Enter the client's residential zip code. *[ER]

Description: Services may only be provided to individuals residing in Tennessee with limited exceptions for the Family Caregiver Support Program. Aside from the obvious need to know where services are to be delivered, the zip code where the individual resides is used to determine if they live in a rural area for federal reporting purposes.

Instructions: Enter the address including zip code where the person being assessed lives.

15 What county does the client reside in? *[R]

Instructions: Enter the county where the person being assessed lives.

16 Describe how to get to the client’s home. (Optional)

Description: Generally, this will not need to be included unless the individual lives somewhere that is difficult to navigate to.

Instructions: Enter a directions to the home of the person being assessed in enough detail that someone who has never been there before could use them.

17/18/19/20 Enter the client's mailing street address or Post Office box. * Enter the client's mailing city or town. * Enter the client's mailing state. * Enter the client's mailing ZIP code. *

Description: There are occasions where important program information may need to be mailed to the individual.

Instructions: If the person being assessed receives mail at another address, enter the mailing address.

21 Select the client's current living arrangement. *[R]

Description: It is well documented that individuals living along are at higher risk for a number of adverse health and mental health outcomes. Collecting this information can help assess if there are other services to explore in support the individual.

Instructions: Select the current living arrangement of the person being assessed.

Demographics (Section C)

1 What is the client's ethnicity? *[R]

Instructions: Select the ethnicity that the person being assessed identifies as.

2 What is the client's race? *[R]

Instructions: Select the race that the person being assessed identifies as.

3 What is the client's gender? *[R]

Instructions: Select the gender that the person being assessed identifies as.

4 Select the client's current marital status. *

Instructions: Select the current marital status of the person being assessed.

Caregiver Identification (Section D)

1 Does the client have an identified primary (informal/unpaid) helper/caregiver who provides care? *[P]

Instructions: Select whether the client has someone who acts as an informal/unpaid caregiver. If yes, complete the rest of the Caregiver Identification Subsection. If no, continue to the Emergency Contact Subsection.

2 What is the caregiver's first name?

Instructions: Enter the caregiver's first name.

3 What is the caregiver's last name?

Instructions: Enter the caregiver's last name.

4 Caregiver's birth date?

Instructions: Enter the caregiver's date of birth.

5 What is the caregiver's telephone number?

Instructions: Enter the best phone number to reach the caregiver.

6 What is the caregiver's e-mail address?

Instructions: Enter the caregiver's e-mail address if available.

7 What is the address of the client's primary caregiver?

Instructions: Enter the primary caregiver's address including street, city, state, and apartment number.

8 What is the client's primary caregiver's Zip Code?

Instructions: Enter the primary caregiver's Zip Code.

9 What is the caregiver's relationship to the care recipient?

Instructions: Select the relationship type between caregiver and care recipient.

10 How often does the client receive assistance from the primary caregiver? [P]

Description: This item will better help us to understand the level of involvement the caregiver has in helping the care recipient meet their basic activities of daily living and other needs required to live independently.

Instructions: Select how often the caregiver provides assistance to the care recipient.

Emergency Contacts (Section E)

1/2/3/4 Name of friend or relative (outside client's home) to contact in case of an emergency. * Relationship of friend or relative (outside client's home) to contact in case of an emergency. * Primary telephone number of friend or relative (outside client's home) to contact in case of an emergency. * Alternate telephone number of friend or relative (outside client's home) to contact in case of an emergency.

Description: There are occasions where the AAAD or service provider will need to notify someone of an emergency involving the person receiving services. The purpose of these questions are to provide a contact outside the home that may be reach in the case of an emergency.

Instructions: Enter the name and contact information for friend or relative who may serve as an emergency contact.

5/6/7 What is the name of a second relative or friend of the client's? What is the primary phone number of the second relative or friend of the client's? What is the alternate phone number of the second relative or friend of the client's?

Description: An alternate contact may be needed in some situations.

Instructions: Enter the name and contact information for a second friend or relative of the person being assessed.

8 Does the client have a power of attorney?

Description: In some cases, if an individual has a power of attorney, that individual will need to be notified before further action can be taken to assist the person seeking services. This is also an opportunity to help the individual plan ahead for their eventual needs.

Instructions: Select the type of power of attorney the person has if any.

9/10 What is the name of the client's power of attorney? Enter the phone number of the client's power of attorney.

Description: If the person being assessed has a power of attorney, we need to know how to reach that person if anything they need to be aware of occurs.

Instructions: If the person being assessed has a power of attorney, enter their name and phone number.

11 Does the client have a living will?

Description: A living will is an important document that lays out in advance an individual's end of life wishes in the event that they are not able to voice those wishes. We can help the individual navigate this process if they haven't already done so before.

Instructions: Select whether the person being assessed has a living will.

Social Screening (Section F)

1 Is there a friend or relative that could take care of the client for a few days? *

Description: Older individuals often face situations such as recovery from illness or injury that requires significant but short-term care. If an individual does not have someone who can provide this care, additional services may be needed to support them through these episodes.

Instructions: Select whether the individual has a friend or relative who could take care of them for a few days.

Health Screening (Section G)

1 How does the client rate his/her health? *P

Description: Self-rated health is an important indicator of an individual's general health and well-being. That means that if an individual rates their health poorly, even if they may not have significant health problems currently, they are likely to get worse soon.

Instructions: Select the individual's self-rate level of health.

2 In the past year, how many times has the client stayed overnight in a hospital? *P

Description: Overnight hospital stays are a strong indicator of significant health problems that may signal further decline.

Instructions: Select whether or not the individual has had an overnight hospital stay in the last year for any reason.

3 Has the client fallen in the past three months? *P

Description: Falls are an indication that the individual's mobility is beginning to decline and are an early sign of the onset of frailty. This question is also important because it is used to determine CHOICES eligibility.

Instructions: Select whether or not the individual has had a fall in the last three months for any reason.

4 Is the client homebound? *EP

Description: Federal Regulations require that priority for services be given to individuals who are homebound or otherwise isolated. An individual is considered homebound if they meet one or more of the following criteria:

- Leaving home is not recommended due to the condition of the individual; or
- Leaving home takes a considerable and taxing effort; or
- The individual's condition keeps him/her from leaving home without help (such as using a wheelchair or walker, needing special transportation, or getting help from another person); or
- The individual is unable to access a congregate meal site.

An individual may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as attending religious services and still be considered homebound.

Instructions: Using the guidelines in the description above, select whether or not the individual is homebound.

5 Indicate which of the following conditions/ diagnoses the client currently has. *

Description: Knowing what health and mental conditions the individual has can help better tailor services to meet the individual's needs. Also, knowing the number of individuals with a certain diagnoses receiving or waiting to receive service can help in pursuing additional funding opportunities.

Instructions: Ask the individual what conditions a doctor or other professional has told them that they have. Select any of the health conditions and diagnoses that the individual reports.

6 Enter any comments regarding the client's medical conditions/ diagnoses.

Description: This item is a space for additional notes on the individual's medical conditions and diagnoses. This includes conditions not covered in the previous item as well as any important details about conditions already noted.

Instructions: Enter any additional notes about the individual's health conditions and diagnoses.

Mental Health Observations (Section H)

1 Can the individual express basic needs and wants?

Description: The individual is incapable of reliably communicating basic needs and wants (e.g. need for assistance with toileting, presence of pain) in a manner that can be understood by others, including through the use of assistive devices.

Instructions: Select whether or not the individual can express basic needs and wants. If there is a limitation, document medical conditions that led to this limitation.

2 How many days per week does the individual have problems making him/herself understood? *

Description: This information is needed because CHOICES eligibility is determined by the level of unmet need the individual has.

Instructions: Select how often the individual has difficulty making him/herself understood.

3 Can the individual understand and follow simple instructions?

Description: The individual is incapable of understanding and following very simple instructions and commands (e.g. raise the client's right and point to the client's nose) without continual intervention.

Instructions: Select whether or not the individual can express basic needs and wants. If there is a limitation, document medical conditions that led to this limitation.

4 How many days per week does the individual have problems understanding others?

Description: This information is needed because CHOICES eligibility is determined by the level of unmet need the individual has.

Instructions: Select how often the individual has difficulty understanding others.

5/6 How is the client's orientation to people? *[P] How is the client's orientation to place? *[P]

Description: The individual is disoriented to person (e.g. fails to remember own name or recognize immediate family members) or place (e.g. does not know residence).

Instructions: Select whether or not the individual is oriented to person or place. If there is a limitation, document medical conditions that led to this limitation.

7/8 Has the individual exhibited behavior problems? * Indicate the behaviors the client has demonstrated at least once a week?

Description: These can be used as qualifiers for programs, including the CHOICES program.

Instructions: Select whether or not the individual displays any behavior problems. Check what behaviors apply to the individual.

ADL/IADL and Other Limitations (Section I)

Description: Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) refer to the physical and cognitive limitations that prevent an individual from doing the activities they need to maintain independence. ADLs and IADLs include the following activities of daily livings which will be addressed in more detail below:

ADLs
- Transferring
- Getting around (Mobility)
- Eating
- Toileting
- Bathing
- Dressing

IADLs
- Managing money
- Shopping
- Managing medications
- Preparing meals
- Doing heavy housework
- Doing light housekeeping
- Transportation

Each ADL and IADL is assessed by the following question:

1. During the past 7 days, and considering all episodes, was the client able to [ADL or IADL] without help?

Following is a general description and instructions for each of these questions. More detailed information for each ADL and IADL is provided further down.

During the past 7 days, and considering all episodes, was the client able to (ADL or IADL) without help? *EPR

Description: This question is used to screen for and determine eligibility for TCAD-funded services in two ways. First, most in-home services require that a person be frail which is defined as two ADL limitations. Second, to be eligible for home-delivered meals, an individual must have a limitation in preparing meals. Additionally, ADLs and the medication management IADL are used to screen for CHOICES eligibility.

If an individual can and does use adaptive equipment, such as a shower chair for bathing or a cane for walking, safely and without significant burden to the individual then a no response should be selected to this question.

Instructions: Using the description above and the guidance for each ADL and IADL below, select whether or not the individual was able to perform ADL or IADL without help or if they did require help whether it is human help or adaptive equipment. If the answer is yes skip to the next ADL or IADL. If no, continue to ask the next question in the series.

For ADLs and Medication Management:

- If the individual can complete the activity without any assistance, select 'Yes'.

- If the individual can complete the activity by using an assistive device that they already possess (e.g. using a shower chair to bathe, a cane to walk, etc.), select 'No, required assistive technology'.
- If the individual can complete the activity but requires oversight, encouragement, or cueing to complete the task, select 'No, required supervision (SBA-Verbal someone there to watch or prompt)'.
- If the individual can complete the activity but requires limited physical assistance such as maneuvering of limbs or other non-weight bearing assistance, select 'No, required limited assistance (1 to 3 days physical hands on help)'.
- If the individual is completely unable to complete the activity without physical assistance, select 'No, required extensive/total assistance (4 to 7 days a week hands on help)'.

For other IADLs:

In addition to an individual requiring help to complete the task, other reasons to select a yes response to this question include if the individual takes a significantly longer period of time than normal to complete the task (e.g. preparing a simple meal takes over an hour) or if completing the task leads to over-exertion and inability to resume normal activity (e.g. light housework causes sever exhaustion requiring several hours to recuperate).

Detailed Descriptions and Instructions for Each ADL and IADL

Activities of Daily Living

Bathing

Is the client able to BATHE (include shower, full tub or sponge bath, exclude washing back or hair) without help?

Considerations: Not being able to get in and out of the tub/shower without assistance from a human being or an assistive device (this includes standby assistance). Not being able to prepare and dispose of things needed for a sponge bath? Not being able to bathe when no one else is home in case of a fall. Bathing less frequently because of limitation. Takes an extended period of time (45 minutes). Counselor's observation of hygiene is also a consideration.

Dressing

Is the client able to DRESS without help?

Considerations: Not wearing certain clothing to accommodate limitations. Not being able to pick out clothing or get clothing out of the closet or dresser. Not having dexterity to button clothing. Takes an extended period of time (30 minutes).

Transferring

Is the client able to TRANSFER without help?

Considerations: Needing standby assistance to supervise for safety. Staying in the bed or in the same spot for most of the day because of this limitation. Needing someone to put the client's legs/feet in and out of the bed. Taking an extensive amount of time and effort to transfer. Individual reports falling while transferring at least twice within the past 3 months.

Mobility

Is the client able to get around the home without help?

Considerations: Standby assistance or fall risk (reports at least 2 falls in the past 3 months). Becomes noticeably winded or short of breath quickly and must rest. Individual stays in one spot most of the day because of limitation. Counselor's observation of unsteady gait and/or safety risk is a consideration.

Eating

Is the client able to EAT without help?

Considerations: Prompting or reminding to eat. Thickened foods and liquids or supervision while eating because of choking hazard. Holding food in the mouth and being prompted to swallow.

Toileting

Is the client able to USE TOILET without help?

Considerations: Constant prompting or reminding to toilet. Not being able to adjust clothing, wipe properly or clean self properly after toileting or an incontinent episode. Frequent UTIs in females and improper wiping habits. Not being able to change/empty bedside commode independently.

Instrumental Activities of Daily Living

Medication Management

Is the client able to MANAGE MEDICATIONS without help? *

Considerations: If the pharmacy or anyone other than the individual fixes a medication box. If the individual forgets to have prescriptions refilled. Needs prompting or reminders to take medications. If medications have to be crushed or put in apple sauce because of swallowing problems. Counselor observation of med box or pills on the floor is considered.

Money Management

Is the client able to MANAGE MONEY without help? *

Considerations: The individual needs someone to write checks, balance checkbook or go get money orders to pay bills. All bills are paid through auto draft because the individual is unable to understand how to budget money or pay bills on time. A POA over finances does not always mean a deficiency unless the individual specifies that the POA manages their finances.

Shopping

Is the client able to SHOP without help?

Considerations: Inability to physically or safely shop independently in a store and might require assistance from employees. Can only shop if is a scooter is available. Can only go and pick up a few items from local corner store. Inability to transfer groceries from the store to the car or carry groceries into the home.

Meal Preparation

Is the client able to perform MEAL PREPARATION without help? *

Considerations: Forgets to turn off the stove or burns food frequently. Doesn't prepare food or eat balanced meals often because of this limitation. Unable to physically stand long enough to prepare a meal or needs to sit while preparing a meal (and this method does not adequately meet the need).

Heavy Housework

Is the client able to perform HEAVY HOUSEWORK without help? *

Considerations: Heavy housework is considered household chores that require moving furniture, getting down on the ground or floor, dusting baseboards, washing windows, heavy lifting, packing boxes, mowing the lawn.

Light Housekeeping

Is the client able to perform LIGHT HOUSEKEEPING without help? *

Considerations: Light housekeeping is considered light household chores like sweeping, mopping, dusting, vacuuming, wiping counters, washing dishes, changing bed linens, and doing the laundry. Consider a deficit if the individual is not physically or safely able to do light housework. It takes the individual all week to complete household chores or if after doing chores, they are hurting or unable to do anything the next day. Individual must to sit on chair or use a device to assist with this need.

Transportation

Is the client able to perform TRANSPORTATION without help? *

Considerations: The individual needs help walking to the car, getting in and out of the car, putting legs in the car, closing the door, buckling the seat belt, or needs help getting wheelchair or walker into the car. Consider a deficit if the individual does not have access to transportation. Consider all types of vehicles (for example if they need help getting into their son's truck or medical transportation van but not into their friend's sedan).

Telephone

Is the client able to use the Telephone without help? *

Considerations: The individual can answer the phone but cannot see to dial out or does not understand how to dial out. A deficit may be considered if the individual is deaf, visually impaired or unable to speak and/or does not have assistive devices to address this need (activity does not occur).

Adaptive Equipment Subsection

1/2 Does the client have any of the following devices or equipment? Please specify the other assistive devices the client uses.

Description: Assistive technology can help individuals adapt to many limitations they may have. Knowing what devices they currently can help identify other devices that might be helpful.

Instructions: Note any devices that are observed in use. If the individual stated that they use a device to assist with a certain ADL, follow up by asking what devices specifically are used and also check to see if there are any other devices that individual uses. Select all of the devices the individual currently uses. If the device is not listed, enter it into the space provided in the following item.

3 If the client did not receive agency-funded services, would the client have enough help to remain independent?

Description: We need to be able to demonstrate to our funders whether our services are successful in helping individuals to remain independent.

Instructions: List the services that the agency currently funds for the individual and then ask if they believed they could remain independent without those services. Select the appropriate response.

Nutrition Screening (Section J)

Description: The Administration for Community Living requires that any individuals receiving nutrition services be screened annually using the eleven questions above. These questions are designed to assess whether the individual is at risk of nutritional deficiencies that can lead to larger health problems. Because these questions are so strongly linked to other health issues, they are also used in determining priority for all TCAD-funded services.

Instructions: If an individual will be receiving nutrition services, for each of the items (below) in the Nutrition Screening section, ask the individual the question and select the yes or no response that they give.

1 Has the client made any changes in lifelong eating habits because of health problems? *

2 Does the client eat fewer than 2 meals per day? *

3 Does the client have 3 or more drinks of beer, liquor or wine almost every

day? *

4 Does the client eat fewer than five (5) servings (1/2 cup each) of fruits or vegetables every day? *

5 Does the client eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day? *

6 Does the client have trouble eating well due to problems with chewing/swallowing? *

7 Does the client sometimes not have enough money to buy food? *

8 Does the client eat alone most of the time? *

9 Does the client take 3 or more different prescribed or over-the-counter drugs per day? *

10 Without wanting to, has the client lost or gained 10 pounds in the past 6 months? *

11 Is the client not always physically able to shop, cook and/or feed themselves (or to get someone to do it for them)? *

12 Is the client at a high nutritional risk level (score of 6 or higher)? *[R]

Description: Each of the nutrition screen questions is weighted. An individual who score six or higher is considered to be at high nutritional risk. Individuals identified as high risk must be referred to nutrition counseling.

Instructions: If completed electronically, this will automatically be determined. If not, the score for each response to the questions in the nutrition screening section must be added up. If the individual receives a score of six or higher, select that the individual is high nutritional risk.

Health Status (Section K)

1 Describe the client's allergies, if any.

Description: We want to be sure that any services that we provide do not trigger allergies for the individual.

Instructions: Note any allergies, particularly food allergies that the individual has.

2 Describe the client's special diet(s).

Description: While we cannot meet every need, we strive to provide each individual with the most appropriate diet available.

Instructions: Note any special diets the individual requires for cultural, religious, or health reasons such as diabetic, sodium-restricted, vegetarian, or kosher.

Home Hazards (Section L)

1 Is there evidence of pets/animals that are a danger to those who come to the client's home?

Description: Service coordinators should be aware of any potentially harmful conditions they may encounter prior to entering into a home.

Instructions: Note any issues the individual may have related to unsafe/unsanitary living conditions or any potential threats to visitors from hostile pets.

Home Environment Checklist (Section M)

Description: The purpose of this section is to determine whether the individual's home is safe and accessible and to identify additional services that may assist the individual in remaining at home safely.

Instructions: For each item, select whether or not applies based on the individual's responses and/or the client's own observations of the home environment. Discuss issues of concern with the individual and provide information about resources or offer to make referrals on their behalf.

General observations for completing this section should include:

- Access
    - Bedrooms and bath on second floor if the individual has limited mobility
    - Clutter or loose runners on stairs
    - Stairs with narrow steps/no rails
    - Need for visual marks or non-slip surfaces at stair edges
    - Pathways between bedroom/bed and bathroom unobstructed

- Lack of elevator to living quarters if multi-story apartment
  - Doorways too narrow for wheelchairs
- Structural/Electrical
  - Exposed or frayed wiring or electrical cords
  - Over-use of extension cords
  - Damaged/improperly used electrical heaters
  - Uneven floors or ceiling with watermarks
  - Bathroom/kitchen for potential problems such as slippery floors
  - Poor/glaring lighting
  - Need for adaptive equipment such as grab bars
  - Thresholds which present tripping hazards
  - Skid proof strips in tub or shower
  - Elevated toilet seat if needed
  - Sinking or leaning toilet
- Other Hazards
  - Unsafe use of oxygen (e.g. open flame or smokers in home)
  - Unvented or improperly used space heaters
  - Dangerous wood stove installation/chimney
  - No fire extinguisher
  - Rugs not secured with non-slip backing
  - Wall-to-wall clutter
  - Unsanitary conditions may be indicated by odors, pest or pet droppings, dirty clothing, etc.
  - Dirty dishes may indicate a lack of hot water.

1 Does the client have problems with dangerous stairs or floors in his/her home? *

2 Is it difficult for the client to get to the entrance of his/her home? *

3 Is it difficult for the client to get to the bathroom or bedroom in his/her home? *

4 Does the client have problems with the major appliances or toilet in his/her home? *

5 Does the client have problems with the heating or cooling in his/her home? *

6 Does the client have problems getting water or hot water in his/her home? *

7 Does the client have difficulties keeping his/her home free from odor or pests? *

8 Does the client need a smoke alarm in his/her home? *

9 Does the client have problems with electrical hazards in his/her home? *

10 Does the client have problems with poor lighting in his/her home? *

11 Does the client have problems with an unsafe stove in his/her home? *

12 Does the client have problems with loose slippery rugs in his/her home? *

13 Does the client have problems with inadequate locks on the doors and/or windows in his/her home? *

14 Does the client have problems keeping his/her home clean and free of clutter? *

15 Does the client have any other environmental problems in his/her home? *

16 Describe any other environmental problems. *

17 In the case of an emergency, would the client be able to get out of the client's home safely? *

Instructions: In addition to considering responses to the previous items, look for locks that make doors difficult to open; check for windows painted, nailed, or barred shut; and ask whether a caregiver is present to help in an evacuation. Based on these observations, select whether or not the individual would be able to get out of their home safely in an emergency.

18 In the case of an emergency, would the client be able to summon help to his/her home? *

Instructions: Based on the individual's response, observe whether there is a telephone that is accessible and in working order and if the individual has a Personal Emergency Response System (PERS). Based on these observations, select whether or not the individual could summon help to their home in an emergency.

19 Comment on the client's home environment in general. *

Instructions: Record specifics about problems in the comment box. Indicate clearly whether these are the client's concerns or those of the individual. Also, indicate if any of the problems are of immediate/serious danger to the individual or may interfere in the provision of services. Document any resources provided or referrals to be made on their behalf.

Financial Resources (Section N)

Total Resources Subsection

1/2 What is the total income of the client's household per month? * How many people does the household income support? *

Description: This question is important for accessing eligibility for programs such as SNAP or LIHEAP, which typically want information on the household as a whole.

Instructions: For this item, consider the income of the individual being assessed, their spouse, and all individuals living in the household if applicable. This should include all sources of income including Social Security, pensions, earned income, and any other revenue received. The response is based on the self-report of the individual although they should be made aware that the accuracy of their response is important for connecting them with the appropriate services and supports. Enter the dollar amount of the individual's household's total monthly income and the number of people this income supports.

3 Is the client's income level below the national poverty level? *[PR]

Description: This question is critical for several reasons. Although Older Americans Act services are not means-tested, we do use this information to prioritize individuals when there is a waiting list for services. Additionally, individuals with incomes below this mark are eligible for many assistance programs not available to individuals at higher incomes such as QMB and/or are more likely to receive more services quicker such as SNAP.

Instructions: Using the current year Income Thresholds Card, select whether the individual is below poverty.

4 Specify the client's monthly income (or client and spouse if married).

Description: This question is critical for several reasons. Although Older Americans Act services are not means-tested, we do use this information to prioritize individuals when there is a waiting list for services. Additionally, individuals with incomes below this mark are eligible for many assistance programs not available to individuals at higher incomes such as QMB and/or are more likely to receive more services quicker such as SNAP.

Instructions: For this item, consider the income of the individual being assessed and their spouse, if applicable. This should include all sources of income including Social Security, pensions, earned income, and any other revenue received. The response is based on the self-report of the individual although they should be made aware that the accuracy of their response is important for connecting them with the appropriate services and supports. Enter the dollar amount of the individual's household's total monthly income and the number of people this income supports.

5 What is the client's monthly income range? *[P]

Description: Select the most appropriate option for the individual's monthly income range. Following are descriptions of each the levels and why that information is important:

> Below 150% Federal Poverty Level
>
> Description: This question is critical for several reasons. Although Older Americans Act services are not means-tested, we do use this information to prioritize individuals when there is a waiting list for services. Additionally, individuals with incomes below this mark are eligible for many assistance programs such as LIS/Extra Help and LIHEAP.
>
> Below 200% Federal Poverty Level
>
> Description: An individual is exempt from Options cost share requirements, if their income is below this level.
>
> Below 300% of the current Federal benefit rate
>
> Description: This question is critical for screening for CHOICES. CHOICES is TennCare's long-term services and supports program that can help provide the assistance an individual needs to stay in their homes.

Instructions: Using the current year Income Thresholds Card, select the most appropriate response that reflects the individual's income range. For example in 2016:

- If their income is $841/month for one person, select "Below 100% Federal Poverty Level".
- If their income is $2,297/month for two people, select "Below 300% of the current Federal benefit rate".

6 Does the client have excessive expenses, such as medical bills, that prevent them from meeting their needs? * [P]

Description: There are many instances where an individual may not have the resources to meet their needs but are not low income. Consideration should be given to large expenses or debts that that leave very little income left over. For example, the individual may have high medical costs or property tax liens. Giving consideration to this can help prevent the individual from further declining or increasing their expenses to the point that they will need even more costly assistance.

Instructions: Select whether or not the individual is able to meet their needs with the financial resources they have available to them.

Other Assistance Subsection

1 Does the client want to apply for any of the following services or programs? *

Description: While this is intended primarily for use in more intensive client interactions, it is important to at least offer to provide an overview of these programs during screening and eligibility determination activities. This question is used to identify additional assistance that the individual may be eligible for and/or is interested in apply for. Below is a guide to each program identified as a potential response.

Instructions: Provide the individual with an explanation of each of the programs and mark those for which they are interested in receiving more information or applying for.

Energy Assistance (LIHEAP)

Overview
Low-Income Home Energy Assistance (LIHEAP) provides low-income households with financial assistance to cover high home heating and cooling costs. Assistance is subject to funding availability.

Eligibility
A household must bear responsibility for covering its heating and cooling costs and at minimum, meet the following limits:

Household Size	Monthly Income	Asset Limits
1 or 2	150% FPL	No Limit

How to Apply
Application should be submitted to the local LIHEAP agency. Applications and agency info are both available here: http://thda.org/business-partners/low-income-home-energy-assistance-program

SNAP (Food Stamps)

Overview
SNAP provides extra money for buying food. Specific assistance depends on net income but is a minimum of $16/month and for the average person over 60 is $106/month.

Eligibility

Older adults (60+) and persons with disabilities have less restrictive eligibility requirements than the general population. They must meet the following net income and asset requirements:

Household Size	Monthly Net Income (2015)^	Asset Limits ^^
1 or 2	100% FPL	3,250

^ Calculating net income involves removing certain expenses for housing, utilities, and medical costs among other expenses. Additionally, public benefits and some types of income such as OAA Title V (SCSEP) payments are not counted. Additional information available in "SNAP Outreach for Older Adults" handout.

^^ Many types of assets are excluded including home, vehicle, and personal effects among other resourced. Additional information available in "SNAP Outreach for Older Adults" handout.

How to Apply
Submit an application (available here: http://www.tennessee.gov/humanservices/article/supplemental-nutrition-assistance-program-snap) to County DHS office or call 1-866-311-4287 for assistance.

Home Repair/Weatherization

Overview
Multiple agencies and programs in the state provide assistance in home repair and weatherization:

THDA – Emergency Repair for the Elderly Program. This program assists older adults in making needed home repairs.

THDA – Weatherization Assistance Program. This program is available to low-income households for minor home modifications to improve energy efficiency.

USDA Rural Development – Rural Housing Repair Program. This program provides low-interest loans up $20,000 to low-income households (and grants up to $7,500 to very low-income persons 62+) for home repairs in rural communities.

Eligibility
THDA – Emergency Repair for the Elderly Program.

THDA – Weatherization Assistance Program.

USDA Rural Development – Rural Housing Repair Program. To qualify for a loan, must be a homeowner and below 50% of area median income (See: Very Low Income rows:

http://www.huduser.gov/datasets/il/il15/FY2015_IL_tn.pdf). To qualify for a grant, must meet income requirements, be 62+, and be unable to repay loan.

How to Apply
THDA – Emergency Repair for the Elderly Program. Contact THDA at 615-815-2030 to be directed to a local agency.

THDA – Weatherization Assistance Program. Contact THDA at 615-815-2030 to be directed to a local agency.

USDA Rural Development – Rural Housing Repair Program. Contact Don Harris with TN USDA Rural Development at 615-783-1388.

QMB/SLMB/QI/LIS

Overview
These programs help reduce costs associated with Medicare. Specifically:

QMB covers a Medicare enrollee's Parts A and B premiums, deductibles, and co-insurance. It also covers Part D premium and deductible and reduces copays.

SLMB covers a Medicare enrollee's Part B premium. It also covers Part D premium and deductible and reduces copays.

QI covers a Medicare enrollee's Part B premium. It also covers Part D premium and deductible and reduces copays.

Extra Help (or LIS) covers a Medicare enrollee's Part D premium and deductible and reduces copays.

Eligibility
You must be a Medicare enrollee and meet the following income and asset limit requirements:

Monthly Income Limits (Including Medicare premiums)				
Household Size	QMB	SLMB	QI	LIS/Extra Help
1 or 2	100% FPL	120% FPL	135% FPL	150% FPL

Asset Limits **(Excludes house, vehicle, personal effects, burial**

funds, public assistance)		
Household Size	QMB/SLMB/QI	LIS
1	7,280	12,140
2	10,930	24,250

How to Apply
Call the State Health Insurance Assistance Program (SHIP) hotline at 1-877-801-0044.

SSI

Overview
Supplemental Security Income (SSI) is a Federal income supplement program. It is designed to help aged, blind, and disabled people, who have little or no income. It provides cash to meet basic needs for food, clothing, and shelter.

Eligibility
An individual must be aged (65+), blind, or disabled and fall below the following income and asset limits:

Household Size	Monthly Income	Asset Limits (excluding home and vehicle)
1	100% FBR (~74% FPL)	2,000
2	(~82% FPL)	3,000

How to Apply
Call the Social Security Administration at 1-800-772-1213 or schedule an appointment with the client's local SSA office.

2 Is the client a veteran or the widow of a veteran? *

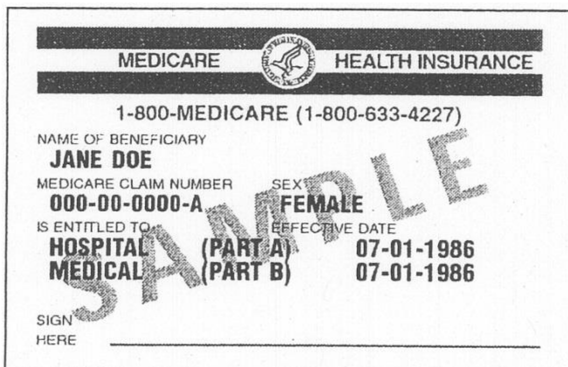
Description: Some veterans <u>may</u> qualify for additional assistance provided through the Veterans Administration (VA). Additionally, many other agencies and organizations offer additional programs and assistance to veterans. Some spouses and widows of veterans <u>may</u> also qualify

for additional assistance provided through the Veterans Administration (VA) and other programs.

Instructions: Select whether or not the individual is a veteran of US Armed Forces or the spouse or widow of a veteran.

Health Insurance Subsection

Collecting the information in this section is not required but is encouraged because SHIP (State Health Insurance Assistance Program) counselors can use it to assist program participants in identifying the best Medicare plan for them. SHIP counselors can also help connect low-income participants to QMB, SLMB, QI, and LIS services listed above. Much of the information needed in this section can be found on the participant's Medicare card.



1 Does the client have Medicare A health insurance? *

Description: Medicare Part A is an Original Medicare service and covers hospital and certain other healthcare facility services.

Instructions: Mark whether the participant has Medicare Part A. If yes, answer the next question regarding Medicare A effective date.

2 Enter the client's Medicare Number?

Instructions: If the participant has Original Medicare (i.e. the Red, White, and Blue Card), enter the participant's Medicare Number. If the participant has Medicare Advantage (e.g. Cigna Healthspring, Blue Cross Blue Shield, AARP, etc.), make a notation including the name of the plan, plan number, and note if it includes drug coverage.

3 What is the effective date of the client's Medicare Part A policy?

Instructions: Enter the effective date of Medicare A coverage.

4 Does the client have Medicare Part B Health Insurance?

Description: Medicare Part B is an Original Medicare service and covers most medical services, such as doctor's visits, and outpatient services.

Instructions: Mark whether the participant has Medicare Part B. If yes, answer the next question regarding Medicare B effective date.

5 What is the effective date of the client's Medicare Part B policy?

Instructions: Enter the effective date of Medicare B coverage.

6 Does the client have Medigap health insurance?

Description: Medigap supplement insurance is a private policy that helps cover medical expenses not covered by Original Medicare.

Instructions: Mark whether the participant has Medigap coverage.

7 Does the client have Medicare Part D Health Insurance?

Description: Medicare Part D is an additional Medicare program that covers the costs of prescription drugs.

Instructions: Mark whether the participant has Medicare Part D coverage.

8 Does the client have LTC health insurance?

Description: LTC (long-term care) health insurance covers certain costs related to nursing home care and alternative long-term care services and supports, such as homemaker and personal care.

Instructions: Mark whether the participant has long-term care health insurance.

9 Does the client have Medicaid or TennCare?

Description: Individual may be participating in the state's Medicaid or TennCare program, this can effect where referrals go for individual for programs such as the CHOICES program.

Instructions: Mark whether the participate has Medicaid or TennCare.

10 Does the client have other health insurance?

Description: Other health insurance may include services such as private coverage through a spouse's employer or veteran's health coverage.

Instructions: Mark whether the participant has any other health insurance.

11 Please indicate if the individual has QMB/SLMB

Instructions: Enter additional information regarding the individual's participation in these programs that may be helpful in connecting them to services such as the specific program they are in (e.g. QMB vs. SLMB).

Rev. 04/19/2018

CHOICES Screening (Section O)

1 Does the client own his/her home or any other property?

Description: State and federal law requires the state to recover funds spent by TennCare on behalf of individuals age 55 and older. Participating in CHOICES requires the individual to agree to estate recovery. This means that when they pass away, TennCare will have first claim to any assets left behind in order to make up for the cost of services provided.

Instructions: Select whether or not the individual owns their home or any other property.

2What are the client's resources/ assets?

Description: In order to qualify for CHOICES an individual must not have assets above a certain amount. Home, vehicle, and personal effects are generally excluded, but most other assets are counted.

Instructions: Select any of the resources and assets the individual has.

3 Are the Consumer's assets valued at less than $2,000?

Description: This response to this question should take into account all of the financial resources identified in the last two questions. The response should not include home, vehicles, or personal effects. If an individual is over the asset limit, they will need to "spend down" their assets for noncountable assets such as paying off a mortgage or prepaying for a burial plan. If the individual is married, special exceptions may allow the household to have additional resources.

Instructions: Ask the individual to consider all of the financial resources identified in the last two items. Select whether or not those resources are below the appropriate limit.

4 Has the client transferred any property or money in the last five years?

Description: To prevent someone from hiding their assets by giving them to a friend or family member, TennCare does not allow individuals to participate in CHOICES if they have transferred a substantial amount of property or other resources in the previous five years. This also applies if the individual sold property or other assets for significantly less than it is worth.

Instructions: Select whether the individual has transferred property or other resources in the last five years.

5 While you are more likely to get more services sooner by getting CHOICES, getting CHOICES also means that any property and assets you have are subject to Estate Recovery. Knowing this, would you still like to be screened for CHOICES?

Description: CHOICES services can be very costly, and TennCare is required to attempt to recover those costs from the estates of individuals receiving CHOICES services after they pass away. While there are instances where an individual is exempt from TennCare Estate Recovery requirements, the individual should be aware that it is a possibility that they may be subject to it. Older Americans Act and state-

funded Options services do not have this requirement, but funds for these alternative services are extremely limited.

Instructions: Select whether or not the individual understands and agrees to Estate Recovery as part of participation in CHOICES.

6 What is the date of the client's last medical evaluation by a physician?

Description: The CHOICES application requires a recent (i.e. the last 365 days) medical history and physical. This is also an indicator of whether or not the individual has access to and receives regular medical care.

Instructions: Enter the date of the last medical evaluation the individual received from a physician. If exact date is not known, enter closest approximation.

7 What is the name of the client's primary care physician? / 8 The work phone number for the client's primary care physician.

Description: Part of the CHOICES eligibility determination process may involve contacting the individual's primary care physician.

Instructions: Enter the name and phone number of the individual's primary care physician.

Observations (Section P)

1 Client is assigned for in-depth assessment for the following additional programs: *

Instructions: Following a screening, note the programs services that the individual appears to be eligible for/ should be referred to.

2 Enter intake/referral comments.

Instructions: Note any other important or useful observations made during the screening process.

Prioritization (Section Q)

1 Is this an APS Referral?

Description: See TCAD Policy and Procedure Chapter 16-1-.08 for guidance on prioritizing APS referrals.

Instructions: Select if this was an APS referral or not.

2 Other Factors

Instructions: If other factors are taken into consideration when determining the individual's score, these factors must be documented in this section.

3 Enter the Total Priority Score as calculated above

Description: Score is automatically calculated within the assessment based on answers to key questions in the Intake Screening. This negates the need for a separate prioritization form.

Instructions: Enter the Total Priority Score calculated above.

4 Total Risk Level

Instructions: Choose the appropriate level of Risk based on calculated score. Low Risk will have a score 1 to 15. Moderate Risk will have a score 16 to 30. High Risk will have a score 31 to 70.