NYSOFA246 (04/13)

COMPASS – Comprehensive Assessment for Aging Network

Community-Based Long Term Care Services

INTAKE INFORMATION

A. Person's Name:

B. Address:

C. Phone #: H: _____ C: _____ E-mail: _____

D. Date of Referral:

E. Referral Source *(Specify Name, Agency and Phone):*

F. Presenting Problem/Person's Concern(s):

G. Does the person know that a referral has been made? [ ]Yes [ ] No if no why not?

H. Intake Workers Name: _____ E-mail:_____

The client information contained in this assessment instrument is confidential and may be shared with others only as necessary to implement the client's care plan and comply with program requirements, including but not limited to monitoring, research and evaluation.

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CASE IDENTIFICATION

Client Case
Assessment Date: Assessor Name:

Assessment Agency:

Reason for COMPASS Completion:
[ ] Initial Assessment
[ ] Reassessment

Next Assessment Date: _____

I CLIENT INFORMATION

A. Person's Name:
B. Address (including zip code):
C. E-mail:
D. Telephone No:
E. Social Security No.:

F. Marital Status: (Check one)
[ ] Married [ ] Widowed [ ] Domestic Partner or Significant Other [ ] Divorced
[ ] Separated [ ] Single

G. Sex:
What was your sex at birth (on your original birth certificate)?
[ ] Female [ ] Male

H. Transgender - Gender Identity or Expression
Some people describe themselves as transgender when they experience a different gender identity from their sex at birth. For example, a person, born into a male body, but who feels female or lives as a woman. Do you consider yourself to be transgender?
[ ]No;
[ ]Yes, transgender male to female;
[ ]Yes, transgender female to male;
[ ]Yes, transgender, do not identify as male or female.
[ ]Did not answer.

I. Birth Date (mm/dd/yyyy): _____ Age: _____

J. Race/Ethnicity Check one
[ ] American Indian/Native Alaskan [ ] Asian [ ] Black, Non-Hispanic
[ ] Native Hawaiian/Other Pacific Islander [ ] White (Alone) Hispanic [ ] Other Race [ ] 2 or More Races
[ ] White, Not Hispanic [ ] Hispanic

K. Sexual Orientation
Do you think of yourself as:
[ ] Heterosexual or Straight [ ] Homosexual or Gay [ ] Lesbian

[ ] Bisexual [ ] Not Sure [ ] Did Not Answer [ ] Other

L. Creed: [ ] Christianity [ ] Islam [ ] Hinduism [ ] Buddhism [ ] Judaism [ ] Did Not Answer [ ] Other

M. National Origin: _____

N. Primary Language (Check all that apply)

	English	Spanish	Chinese	Russian	Italian	French\Haitian Creole	Korean	Other
Speaks	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Reads	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Understands orally	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

O. Client does not speak English as their primary language and has **ONLY** a limited ability to read, speak, write or understand English. [ ] Yes [ ] No

P. Living-Arrangement: (Check all that apply)
[ ] Alone [ ] With Spouse [ ] With Spouse & others [ ] With Relatives [ ] With Non-Relative(s), Domestic Partner [ ] Others

Q. During the last 6 months have you experienced any of the following forms of abuse?

[ ] Physical Abuse
[ ] Sexual Abuse
[ ] Emotional Abuse
[ ] Financial Exploitation
[ ] Active and Passive Neglect
[ ] Self Neglect
[ ] Domestic Violence
[ ] Other (e.g. Abandonment)

Was this referred to:

[ ] Adult Protective Services
[ ] Police Agency
[ ] Domestic Violence Service Provider
[ ] AAA
[ ] Other _____
[ ] Not Referred

R. Emergency Contact: _____

Primary
Name:
Address:
Relationship:
Home Phone:
Cell Phone:

Secondary
Name:
Address:
Relationship:
Home Phone:
Cell Phone:

A. Type of Housing Check):
[ ] multi-unit housing [ ] single family home other
B. Person (check): [ ] owns [ ] rents [ ] other Specify
C. Home Safety Checklist: (Check all that apply)[ ] Accumulated garbage

[ ] Bad odors
[ ] Carbon monoxide
[ ] Detector not present/not working
[ ] Doorway widths are inadequate
[ ] Floors and stairways dirty and cluttered
[ ] Loose scatter rugs present in one or more rooms
[ ] No lights in the bathroom or in the hallway
[ ] No handrails on the stairway
[ ] No lamp or light switch within easy reach of the bed
[ ] No locks on doors or not working
[ ] No grab bar in tub or shower
[ ] No rubber mats or non-slip decals in the tub or shower
[ ] Smoke detectors not present/not working
[ ] Stairs are not lit
[ ] Stairways are not in good condition
[ ] Telephone and appliance cords are strung across areas where people walk, traffic lane from the bedroom to the bathroom is not clear of obstacles
[ ] Other (specify)

D. Is neighborhood safety an issue? [ ] Yes (If Yes, Describe [ ] No

Comments

A. Primary Physician: _____
Clinic/HMO: _____
Hospital: _____
Other: _____

B. Indicate date of last visit to primary medical provider: Month _____ Year _____

C. Does the person have a self-declared chronic illness and/or disability? (Check all that apply)

[ ] alcoholism	[ ] diarrhea	[ ] paralysis
[ ] Alzheimer's	[ ] digestive problems*	[ ] Parkinson's
[ ] anorexia	[ ] diverticulitis	[ ] Pernicious anemia
[ ] arthritis	[ ] fractures (recent)	[ ] renal disease
[ ] cancer	[ ] frequent falls	[ ] respiratory problems
[ ] cellulitis	[ ] gall bladder disease	[ ] shingles
[ ] chronic obstructive pulmonary disease (COPD)	[ ] hearing impairment	[ ] smelling impairment
[ ] chronic pain	[ ] heart disease	[ ] speech problems
[ ] colitis	[ ] hiatal hernia	[ ] stroke
[ ] colostomy	[ ] high blood pressure	[ ] swallowing difficulties
[ ] congestive heart failure	[ ] high cholesterol*	[ ] taste impairment
[ ] constipation	[ ] hypoglycemia	[ ] traumatic brain injury
[ ] decubitus ulcers	[ ] HIV/AIDS	[ ] tremors
[ ] dehydration	[ ] legally blind	[ ] ulcer
[ ] dental problems*	[ ] liver disease	[ ] urinary Tract infection
[ ] developmental disabilities	[ ] low blood pressure	[ ] visual impairment
[ ] diabetes	[ ] osteoporosis	[ ] other (Specify)
[ ] dialysis	[ ] oxygen dependent	

*May indicate need for assessment by nutritionist

D. Does the person have an assistive device? [ ] Yes (If yes, check all that apply) [ ] No

[ ] Accessible vehicle	[ ] Hearing Aid
[ ] Bed rail	[ ] Lift chair
[ ] Cane	[ ] Scooter
[ ] Denture: [ ] Full [ ] Partial	[ ] Walker
[ ] Glasses	[ ] Wheelchair\Transportable folding

E. Does the person need an assistive device? [ ] Yes [ ] No (If yes, specify device)

F. Does the person and/or caregiver need training on the use of an assistive device? [ ] Yes (If yes describe training needs) [ ] No

G. Has the person been hospitalized in the last 6 months?

[ ] Yes (If yes, describe the reason for the recent hospitalization) Month: Year:

[ ] No

H. Has the person been taken to the emergency room within the last 6 months?

[ ] (If yes, describe the reason for the most recent ER visit) Month: Year: [ ] No

I. Has a PRI and/or DMS-1 been completed in the past 6 months? [ ] Yes (If Yes, describe the reason for, completion) [ ] No

____DMS-1
Score:
Completed by _____
(Name and Affiliation)
Month: Year
____PRI Score:
Completed by: _____
(Name and Affiliation)

Month: Year:

Comments

J. Alcohol Screening Test - The CAGE Questionnaire
Check all that apply

Have you ever felt you should cut down on your drinking? [ ]

Have people annoyed you by criticizing your drinking? [ ]

Have you ever felt bad or guilty about your drinking? [ ]

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)? [ ]

A Person's height Source:
B. Person's weight Source:
C. Body Mass Index __ calculated from height and weight as follows: weight in pounds x 703: Divide this number by height in Inches then divide by height in Inches again. Healthy older adults should have a BMI between 22 and 27. A BMI outside of this range may indicate the need for a referral to a dietitian.)

D. Are the person's refrigerator/freezer and cooking facilities adequate? [ ] Yes [ ] No if no, describe
E. Is the person able to open containers/cartons and cut up food? [ ] Yes [ ] No if no, describe
F. Does the person have a physician prescribed modified therapeutic diet [ ] Yes [ ] No

(If yes, check all that apply)
[ ] Texture-Modified [ ] Calorie Controlled Diet [ ] Sodium Restricted
[ ] Fat Restricted [ ] High Calorie [ ] Renal
[ ] Other {Specify}
(If No, Check all that apply} [ ] Regular [ ] Special Diet (Check all//that apply)
[ ] Ethnic/Religious (specify) [ ] Vegetarian
G. Does the person have a physician-diagnosed food allergy [ ] Yes (If yes, describe) [ ] No
H. Does the person use nutritional supplements? [ ] Yes (If yes specify who described and the supplement) [ ] No

I. Nutritional Risk Status
Check all that apply and circle the corresponding number at right

	Score
Person an illness or conditions that made me change the kind and/or amount of food I eat.	2
Eats fewer than 2 meals per day.	3
Eats few fruits or vegetables, or milk products.	2
Has 3 or more drinks of beer, liquor, or wine almost every day.	2
Has tooth or mouth problems that make it hard for me to eat.	2
Does not always have enough money to buy the food I need.	4
Eat alone most of the time.	1
Take 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I lost or gained 10 or more pounds in the last 6 months.	2
Not always physically able to shop, cook, and/or feed myself.	2

NSI Score: _____

A score of 6 or more indicates "High" nutrition risk. 3-5 Indicates "Moderate "' nutrition risk, and 2 or less Indicates “Low” nutritional risk

Conclusion: Based on the NSI score, this person is at check one [ ] High Risk [ ] Moderate Risk [ ] Low Risk

Comments

A. Psycho-Social Condition
Does the person appear, demonstrate and/or report any of the following (check all that apply)

[ ] alert	[ ] impaired decision making	[ ] self-neglect
[ ] cooperative	[ ] lonely	[ ] suicidal behavior

[ ] dementia
[ ] depressed
[ ] disruptive socially
[ ] hallucinations
[ ] hoarding
[ ] memory deficit
[ ] physical aggression
[ ] sleeping problems
[ ] suicidal thoughts
[ ] verbal disruption
[ ] worried or anxious
[ ] other (specify)

B. Evidence of substance abuse problems [ ] Yes (if yes describe) [ ] No
C. Problem behavior reported [ ] Yes (if yes describe) [ ] No
D. Diagnosed mental health problems [ ] Yes (if yes describe) [ ] No
E. History of mental health treatment [ ] Yes (if yes describe) [ ] No
F. Does it appear that a mental health evaluation is needed [ ] Yes (If Yes note Referral Plan In the Care Plan) [ ] No

Comments

A. MEDICATIONS.

Name	Dose/Frequency	Reason Taken

B. Primary Pharmacy Name Phone

C. Does the person have any problems taking medications?

Adverse reactions/allergies/sensitivities [ ] Yes, if Yes. Describe [ ] No

Cost of medication [ ] Yes, if Yes. Describe [ ] No

Obtaining medications [ ] Yes if Yes. Describe [ ] No

No Other (Describe)

Comments

Activity Status: *(Use for Sec. VII & VIII)*

1=Totally Able
2=Requires intermittent supervision and/or minimal assistance.
3=Requires continual help with all or most of this task
4=Person does not participate; another person performs all aspects of this task.

Check if assistance is/will be provided by

Activity: *What can person do?* Enter Person's Activity Status

	Activity Status	Informal Supports	Formal Services	**Comments**: *Describe limitations, parts of tasks to be done and responsibilities of informal supports and forma! Services.*
A. Housework/cleaning				
B. Shopping				
C. Laundry				
D. Use transportation				
E. Prepare & cook meals				
F. Handle Personal business/finances				
G. Use Telephone	`			
H. Self-admin of medications				
ARE CHANGES IN IADL CAPACITY EXPECTED IN THE NEXT 6 MONTHS? □ **Yes** *(If Yes describe)* □ **No**				

Check if assistance is/will be provided by

Activity: *What can person do?* Enter Person's Activity Status

	Activity Status	Informal Supports	Formal Services	Comments *Describe limitations, parts of tasks to be done and responsibilities of informal supports and forma! services.*
A. Bathing 1. Requires no supervision or assistance. May use adaptive equipment. 2. Requires intermittent checking and observing/minimal assistance at times. 3. Requires continual help. 4. Person does not participate				
B. Personal Hygiene 1. Requires no supervision or assistance 2. Requires intermittent supervision and/or minimal assistance. 3. Requires continual help with all or most of personal grooming. 4. Person does not participate; another person performs all aspects of personal hygiene.				
C. Dressing 1. Needs no supervision or assistance. 2. Needs intermittent supervision/minimal assistance at times. 3. Requires continual help and/or physical assistance. 4. Person does not participate, is dressed by another, or bed gown is generally worn due to condition of person.				
D. Mobility 1. Walks with no supervision or assistance. May use adaptive equipment. 2. Walks with intermittent supervision. May require human assistance at times. 3. Walks with constant supervision and/or physical assistance. 4. Wheels with no supervision or assistance, except for difficult maneuvers, or is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.				
E. Transfer 1. Requires no supervision or assistance. May use adaptive equipment. 2. Requires intermittent supervision. May require human assistance at times. 3. Requires constant supervision and/or physical assistance. 4. Requires lifting equipment and at least one person to provide constant supervision and/or physically lift, or cannot and is not taken out of bed.				
F. Toileting 1. Requires no supervision or physical assistance. May require special equipment, such as raised toilet or grab bars. 2. Requires intermittent supervision and/or minimal assistance. 3. Continent of bowel and bladder. Requires constant supervision and/or physical assistance. 4. Incontinent of bowel and/or bladder.				
G. Eating 1. Requires no supervision or assistance. 2. Requires intermittent supervision and/or minimal physical assistance. 3. Requires continual help and/or physical assistance. 4. Person does not manually participate. Totally fed by hand, a tube or parental feeding for primary intake of food,				

ARE CHANGES IN ADL CAPACITY EXPECTED IN THE NEXT 6 MONTHS? □ **Yes *(If Yes, describe)*** □ **No**

IX. SERVICES CLIENT CURRENTLY IS RECEIVING

A. What formal service(s) does the person currently receive? *(Check all that apply)*

[ ] none utilized

Provider Information

[ ] adult day health care
[ ] assisted transportation
[ ] caregiver support
[ ] case management
[ ] community-based food program
[ ] consumer directed in-home services
[ ] congregate meals
[ ] equipment/supplies
[ ] friendly visitor/telephone reassurance
[ ] health promotion
[ ] health Insurance counseling
[ ] home health aide
[ ] home delivered meals
[ ] hospice
[ ] housing assistance
[ ] legal services
[ ] mental health services
[ ] nutrition counseling
[ ] occupational therapy
[ ] outreach
[ ] personal care level 1
[ ] personal care level 2
[ ] personal emergency response system (PERS)
[ ] protective services
[ ] respite
[ ] respiratory therapy
[ ] senior center
[ ] senior companions
[ ] services for the blind
[ ] shopping
[ ] skilled nursing
[ ] social adult day care
[ ] speech therapy
[ ] transportation
[ ] other (specify)_____

X. INFORMAL SUPPORT STATUS

A. Does the person have family, friends and/or neighbors who help or could help with care?
B. [ ] Yes [ ] No (If No, skip to question D of this section)

Primary Informal Support

1. Name:
Address:
Relationship:

Home Phone: Work Phone: Cell Phone:
E-mail:

Involvement: (Type of help/frequency)

1. a. Does the person appear to have a good relationship with this person [ ] Yes [ ] No (Explain)

1. b. Would the person accept help, or more help, from this person In order to remain at home and/or maintain independence? (Check one)
[ ] willing to accept help
[ ] unwilling to accept any help

1. c. Are there any factors that might limit this person's Involvement? (Check all that apply)
[ ] job [ ] finances [ ] family [ ] responsibilities [ ] physical burden [ ] transportation
[ ] emotional burden [ ] health problems [ ] reliability [ ] living distance

1. d. Is Caregiver relief needed? [ ] Yes [ ] No

If yes, when? [ ] Morning [ ] Afternoon
[ ] Evening [ ] Overnight
[ ] Weekend [ ] Other

1. e. Would this person be considered the caregiver? [ ] Yes [ ] No

Secondary Informal Support:

2. Name:
Address:
Relationship:
Home Phone: Work Phone: Cell Phone:
E-mail:

Involvement: (Type of help/frequency)

2. a. Does the person appear to have a good relationship with this person? [ ] Yes [ ] No
(Explain)

2. b. Would the person accept help, or more help, from this person In order to remain at home and/or maintain Independence? (Check one)
[ ] willing to accept help (Describe)
[ ] unwilling to accept any help (Describe)

2. c. Are there any factors that might limit this person's involvements (Check all that apply)

[ ] job [ ] finances [ ] family [ ] responsibilities [ ] physical burden [ ] transportation
[ ] emotional burden [ ] health problems [ ] reliability [ ] living distance

2. d. Is Caregiver relief needed? [ ] Yes [ ] No
If yes, when? [ ] Morning [ ] Afternoon
[ ] Evening [ ] Overnight
[ ] Weekend [ ] Other
2. e. Would this person be considered the caregiver? [ ] Yes [ ] No

C. Can other Informal supports) provide temporary care to relieve the caregiver(s)? [ ] Yes (if yes, describe) [ ] No

D. Does the person have any community, neighborhood or religious affiliations that could provide assistance? [ ] Yes (If Yes, describe who might be available, when they might be available and what they might be willing to do)

Comments:

XI. MONTHLY INCOME

A.

	Monthly Income
Social Security (net)	$
SSI	
Personal Retirement Income	
Interest	
Dividends	
Salary/Wages	
Other	

B. Total Monthly Income $
C. [ ] Check if person will provide no financial information (Describe)

XII. BENEFITS/ENTITLEMENTS

Benefit Status Code must be noted:	A. Has the benefit/entitlement
	B. Does not have the benefit/entitlement
	C. May be eligible and is willing to pursue benefit/entitlement
	D. Refuses to provide Information

Benefit	Benefit Status Code	Comments
Income Related Benefits		
Social Security		
SSI*		
Railroad retirement		
SSD		
Veteran's Benefits (Specify)		
Other (Specify)		
Entitlements		
Medicaid Number		
Food Stamps (SNAP)		
Public Assistance		
Other (Specify)		
Health Related Benefits		
Medicare Number		
QMB		
SLIMB		
EPIC		
Medicare Part D		
Medigap Insurance/HMO (Specify)		
Long Term Care Insurance (Specify)		
Other Health Insurance (Specify)		
Housing Related Benefits		
SCRIE		
Section 8		
IT214		
Veteran Tax Exemption		
Reverse Mortgage		
Real Property Tax Exemption (STAR)		
HEAP		
WRAP		
Other		

*Persons receiving SSI is categorically eligible for Medicaid and should have a Medicaid card.

Person's Name: _____ Date: _____

Address: _____ Prepared by: _____

_____ Person's Phone: _____

A. Is the person self-directing/able to direct care? [ ] Yes [ ] No *(If No, who will provide direction?)*

B. Problems to be addressed?	Goals	Care Plan Objectives	Proposed Time Frame

C. What are the person's preferences regarding provision of services?

D. Types of services to be provided	How Much? When? Frequency	Start Date	Projected End Date	Informal/ Formal	Provider

E. Problems to be referred	Referred to:	(Reminders - some possible referrals)
		Hospital, Nursing Home, Adult Home, Health Assessment, Long Term Care Home Health Care Program, Personal Care Program, Mental Health Assessment, Housing Assessment, Certified Home Health Agency, Licensed Home Care Services Agency, Protective Services for Adults, Other

F. Information/special Instructions that have direct bearing on Implementation of the care plan:

G. Has person been placed on waiting list for any service need? [ ] Yes (If Yes List) [ ] No

Service	Provider	Date Placed on List

H. Plan has been discussed and accepted by client and/or Informal supports? [ ] Yes [ ] No (If No, explain)

I. Plan approved by: _____ Date: / / Phone:_____

Signature and Title

A. What is being terminated? Services(s) Care Plan
If Service, Specify which one(s)

B. Termination Date:

C. Reason for termination: (Check all that apply)

[ ] Goal Met: (Specify)
[ ] Independence
[ ] Client Request
[ ] Client Relocated
[ ] Hospitalization
[ ] Nursing Facility/Assisting Living
[ ] Death
[ ] Other: (specify) _____

D. Service of Care Plan Related Client Outcome(s) Statements: _____
_____
_____

E. Terminated by: _____

_____ _____
Signature Title

_____ _____ _____ _____
Date: Work Phone: Cell Phone: E-mail