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

Provider ID: _____ **Provider Assessor/CM ID:** _____

Assessor/Case Manager (CM) Name: _____ **Signature:** _____

A. DEMOGRAPHIC SECTION

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

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

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

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

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

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

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

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

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

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

26. Individual monthly income: $ _____ ☐ Refused

27. Couple monthly income: $ _____ ☐ Refused ☐ N/A

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

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

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

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

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

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

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

Notes & Summary

B. MEMORY SECTION

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

36. Have you become concerned about your memory or had problems remembering important things?
☐ No ☐ Yes

C. GENERAL HEALTH, SENSORY & COMMUNICATION IMPAIRMENT SECTION

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

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

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

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

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

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

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

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

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

Notes & Summary:

D. ACTIVITIES OF DAILY LIVING SECTION

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

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

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

Task	No assistance needed	Always has assistance	Has assistance most of the time	Rarely has assistance	Never has assistance
a. Bathing	☐	☐	☐	☐	☐
b. Dressing	☐	☐	☐	☐	☐
c. Eating	☐	☐	☐	☐	☐
d. Using the bathroom	☐	☐	☐	☐	☐
e. Transferring	☐	☐	☐	☐	☐
f. Walking/Mobility	☐	☐	☐	☐	☐

Notes & Summary:

E. INSTRUMENTAL ACTIVITIES OF DAILY LIVING SECTION

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

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

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

Task	No assistance needed	Always has assistance	Has assistance most of the time	Rarely has assistance	Never has assistance
a. Heavy chores	☐	☐	☐	☐	☐
b. Light housekeeping	☐	☐	☐	☐	☐
c. Using the telephone	☐	☐	☐	☐	☐
d. Managing money	☐	☐	☐	☐	☐
e. Preparing meals	☐	☐	☐	☐	☐
f. Shopping	☐	☐	☐	☐	☐
g. Managing medication	☐	☐	☐	☐	☐
h. Using transportation	☐	☐	☐	☐	☐

Notes & Summary:

F. HEALTH CONDITIONS & THERAPIES SECTION

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

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

F. HEALTH CONDITIONS & THERAPIES SECTION, CONTINUED

Past	Current	Health Conditions
☐	☐	Shingles
☐	☐	Stroke/CVA
☐	☐	Syphilis
☐	☐	Thyroid problems/Graves/Myxedema ☐ Hyper ☐ Hypo
☐	☐	Tumor(s), site: _____
☐	☐	Ulcer(s), site: _____
☐	☐	Urinary Tract Infection (UTI)
☐	☐	Other:

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

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

Notes & Summary:

G. MENTAL HEALTH SECTION

52. How satisfied are you with your overall quality of life? ☐ Very satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐ Dissatisfied ☐ Very dissatisfied

53. Thinking about how you were this time last year, how do you feel about the way things are now? ☐ Much better ☐ Better ☐ About the same ☐ Worse ☐ Much worse

54. Have you been diagnosed with a mental condition or psychiatric disorder by a health professional? ☐ No ☐ Yes: *List conditions:* _____

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

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

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

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

Notes & Summary:

H. NUTRITION SECTION

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

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

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

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

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

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

62. Estimate your current height and weight: Height: _____ *ft.* _____ *inches* Weight: _____ *lbs.*

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

a. How much? ☐ Less than five pounds ☐ Five to ten pounds ☐ Ten pounds or more

b. Was the weight loss/gain on purpose *(i.e., dieting or trying to lose/gain weight)?* ☐ No ☐ Yes

64. Are you on a special diet(s) for medical reasons? ☐ No *(Skip to 65)* ☐ Yes; *check any/all*:
☐ Calorie supplement ☐ Low fat/cholesterol ☐ Low salt/sodium ☐ Low sugar/carb ☐ Other

a. How long have you been on this diet? _____

b. Why are you on this diet? _____

65. Do you have any problems that make it hard for you to chew or swallow? ☐ No ☐ Yes; *check any/all*:
☐ Mouth/tooth/dentures ☐ Pain or difficulty swallowing ☐ Taste ☐ Nausea
☐ Saliva production ☐ Other, *describe*: _____

66. What working appliances do you have for storing/preparing food?
☐ None ☐ Refrigerator ☐ Microwave ☐ Toaster/Oven ☐ Stove ☐ Other: _____

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

68. How many days in a typical week do you drink alcohol?
☐ Refused *(Skip to 69)* ☐ None *(Skip to 69)* ☐ One to two ☐ Three to five ☐ Six to seven

a. On the days when you have some alcohol, about how many drinks do you usually have?
☐ One to two ☐ Three to five ☐ Six or more

b. About how many times in the last month have you had four or more drinks in a day?
☐ None ☐ One to two ☐ Three to five ☐ Six or more

Notes & Summary:

I. SOCIAL RESOURCES SECTON

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

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

a. Name: _____ b. Relationship to client: _____

c. Phone: _____

J. CAREGIVER SECTION

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

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

72. Caregiver full name: a. First: _____ b. Middle Initial: _____

c. Last: _____

73. Caregiver date of birth: *(mm/dd/yyyy)* _____

74. **ASSESSOR/CM: Caregiver identification number** _____

75. Caregiver sex: ☐ Male ☐ Female

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

77. Caregiver ethnicity: ☐ Hispanic/Latino ☐ Other

78. Caregiver primary language: ☐ English ☐ Spanish ☐ Other: _____

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

80. Caregiver address:

a. Street: _____

b. City: _____ c. State: _____ d. ZIP code: _____

81. Caregiver phone number: _____

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

J. CAREGIVER SECTION (CONTINUED)

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

84. How confident are you that you will have the ability to continue to provide care?

☐ Very confident *(Skip to 85)* ☐ Somewhat confident *(Skip to 85)* ☐ Not very confident

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

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

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

Notes & Summary:

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WHY ARE WE COLLECTING YOUR SOCIAL SECURITY NUMBER?

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

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