# Case Management Assessment Form

Welcome! Please tell us a bit about yourself so we can offer services that best meet your needs. All your personal information is confidential. Please see the attached FAQs for more information.

## Registration and Eligibility Section – Must Be Completed Prior to Service

First Name: _____Middle Name (if applicable): _____

Last Name: _____Nickname (if applicable): _____

Date of Birth: _____ Age: _____

Only individuals aged 60 and older are eligible.

## Contact Information Section

Home Phone: _____Cell Phone: _____

Email: _____

Home Address Line 1: _____

Home Address Line 2 (Apt/Unit/Floor):_____

County: _____

City: _____ State: _____Zip: _____

Mailing address is the same as home address ☐

Mailing Address Line 1: _____

Mailing Address Line 2 (Apt/Unit/Floor): _____

City: _____ State: _____ Zip: _____

## Demographics Section – Used for Anonymous Reporting to Our Funders

- Gender (select all that apply): ☐Male ☐Female ☐Non-binary/Third gender ☐Transgender ☐Another gender not listed: _____ ☐Refuse to answer question
- Ethnicity: ☐Hispanic or Latino/a/e ☐Not Hispanic or Latino/a/e ☐Refuse to answer question
- Racial Identity (select all that apply):
  ☐American Indian or Alaska Native ☐Asian or Asian American ☐Black or African American
  ☐Middle Eastern or North African ☐Native Hawaiian or Pacific Islander ☐White
  ☐Another identity not listed: _____ ☐Refuse to answer question
- Do you live alone or with others? ☐Alone ☐With others ☐Refuse to answer question
- Is your income above or at/below the amount listed for your household size in the table:
  ☐Above ☐At/below ☐Refuse to answer question

### Income Levels Table

| Household Size | Monthly Income | Annual Income |
|---|---|---|
| 1 | $1,304 | $15,650 |
| 2 | $1,763 | $21,150 |

Use the table to determine if your income is above or at/below the monthly or annual income listed for your household size. For each additional person, add $5,500 to annual income.

## Communication Section

What is your primary language?: _____

## Service Access and Support Section

- Health Insurance (select all that apply):
  ☐Medicare ☐Medicare Advantage ☐Medicaid ☐Medicaid Waiver(s) ☐VA ☐Private
  ☐None ☐Other insurance: _____ ☐Refuse to answer question
- Can you access this service through another benefit or program? For example, through Medicaid or Medicare benefits? ☐Yes ☐No ☐Refuse to answer question ☐I don't know
- Do you have reliable outside support from family, friends, or a caregiver? ☐Yes ☐No ☐Refuse to answer question
- Are you homebound? Select "Yes" if any of the following statements are true for you:
  - You need the help of another person to leave your home, or
  - You have a health condition or disability that makes it difficult to leave your home on a regular basis, or
  - You are only able to leave your home infrequently and for short periods of time

  ☐Yes ☐No ☐Refuse to answer question
- Are you isolated from community resources? Examples of community resources include stores, banks, health services, and senior center activities. Select "Yes" if any of the following statements are true for you:
  - You live in a remote area, or
  - You have a health condition or disability that makes it difficult for you to access community resources, or
  - You have financial or technology challenges that make it difficult for you to access community resources, or
  - You cannot drive or use public transportation, or
  - You do not feel welcome in your community due to cultural or language barriers

  ☐Yes ☐No ☐Refuse to answer question

## Nutrition Screening Section

### Nutrition Risk Score

Determine your nutritional health. If the statement is true for you, check the box in the "Yes" column and add the points in the "Yes Score" column to your total score.

| Nutrition Risk Score Questions | Yes | No | Refuse to Answer Question | Yes Score |
|---|---|---|---|---|
| 1. Do you have an illness or condition that has made you change the kind and/or amount of food you eat? | ☐ | ☐ | ☐ | 2 |
| 2. Do you eat fewer than 2 meals per day? | ☐ | ☐ | ☐ | 3 |
| 3. Do you eat few fruits, vegetables, or milk products? | ☐ | ☐ | ☐ | 2 |
| 4. Do you have 3 or more drinks of beer, liquor, or wine almost every day? | ☐ | ☐ | ☐ | 2 |
| 5. Do you have tooth or mouth problems that make it hard for you to eat? | ☐ | ☐ | ☐ | 2 |
| 6. Are there times you do not have enough money to buy the food you need? | ☐ | ☐ | ☐ | 4 |
| 7. Do you eat alone most of the time? | ☐ | ☐ | ☐ | 1 |
| 8. Do you take 3 or more different prescribed or over the counter drugs a day? | ☐ | ☐ | ☐ | 1 |
| 9. Without wanting to, have you lost or gained 10 pounds in the last 6 months? | ☐ | ☐ | ☐ | 2 |
| 10. Are there times you're physically unable to shop, cook, and/or feed yourself? | ☐ | ☐ | ☐ | 2 |

Total Nutrition Risk Score (Total "Yes" Score): _____

Total Nutrition Risk Score Meaning: 0-2 = No Risk, 3-5 = Moderate Risk, 6 or more = High Risk

If you are at high nutrition risk – speak with a qualified health or social service professional.

## Activities of Daily Living

For each activity, please mark the level of help you need.

| Activities of Daily Living | Independent: I don't need any help with this activity | Some help: I need some help or reminders from another person, but I can do parts of this activity on my own | Dependent: I always need help from another person to do this activity |
|---|---|---|---|
| 1. Bathing or showering | ☐ | ☐ | ☐ |
| 2. Dressing - Putting on and taking off clothing and shoes | ☐ | ☐ | ☐ |
| 3. Using the bathroom - Getting to and on/off the toilet, managing clothing, wiping | ☐ | ☐ | ☐ |

| Activities of Daily Living | Independent: I don't need any help with this activity | Some help: I need some help or reminders from another person, but I can do parts of this activity on my own | Dependent: I always need help from another person to do this activity |
|---|---|---|---|
| 4. Transferring In/Out of Bed/Chair - Getting in and out of sitting or lying positions | ☐ | ☐ | ☐ |
| 5. Walking/Getting Around the House | ☐ | ☐ | ☐ |
| 6. Eating and drinking | ☐ | ☐ | ☐ |

Comments on ADLs: _____

## Instrumental Activities of Daily Living

For each activity, please mark the level of help you need.

| Instrumental Activities of Daily Living | Independent: I don't need any help with this activity | Some help: I need some help or reminders from another person, but I can do parts of this activity on my own | Dependent: I always need help from another person to do this activity |
|---|---|---|---|
| 1. Meal Preparation – Planning, making, and cleaning up meals | ☐ | ☐ | ☐ |
| 2. Shopping – selecting and paying for food, household supplies, clothing, and other items | ☐ | ☐ | ☐ |
| 3. Medication Management – getting prescriptions filled and taking medications as prescribed | ☐ | ☐ | ☐ |
| 4. Money Management – budgeting, using cards and bank accounts, paying bills | ☐ | ☐ | ☐ |
| 5. Using a Telephone – making and receiving calls | ☐ | ☐ | ☐ |
| 6. Light Housework – tidying up, sweeping, vacuuming, mopping, cleaning kitchen and bathroom surfaces, taking out garbage | ☐ | ☐ | ☐ |

| Instrumental Activities of Daily Living | Independent: I don't need any help with this activity | Some help: I need some help or reminders from another person, but I can do parts of this activity on my own | Dependent: I always need help from another person to do this activity |
|---|---|---|---|
| 7. Heavy Housework – deep cleaning the home, moving light furniture to clean under/behind | ☐ | ☐ | ☐ |
| 8. Transportation – driving, walking, or using other forms of available transportation, like buses | ☐ | ☐ | ☐ |

Comments on IADLs: _____

- Does anyone help you with ADL or IADL activities? ☐Yes ☐No ☐Refuse to answer question

If yes, who is assisting you? _____

## Emergency Contact Section

Name: _____Phone: _____

Relationship: _____ ☐Refuse to provide contact

## Care Plan

Case Managers will create a Care Plan with the client.

## Disclosures and Waivers

I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service providers and I give my consent to do so.

Signature: _____

Date: _____

If filled out by someone other than the client (for example a caregiver or assessor, please check here ☐ and sign below)

Filled out by: _____

Date: _____

CENTRAL COLORADO AREA AGENCY ON AGING