Client Name	DOB	Home Phone

Followup Record - Qtrly Basic Information

Initial Information

CLS/CSC Name: Script

What is the name of the CLS who provided direct assistance to this consumer in the nursing home or in the community?
If a CLS is conducting the follow up on behalf of another CLS, the name of the CLS actually completing the call will be documented in this field.
If an administrative assistant is completing the follow up screen and/or phone call, the name of the CLS who provided the direct assistance should be indicated in this field.
If this is a naturally occurring discharge, who is the client services center specialist conducting this follow up?

- ○ Nancy Sandahl
- ○ Deb Eiler
- ○ Heather Pender
- ○ Leslie Sauve
- ○ Stephanie Larson
- ○ Melanie Spencer
- ○ Shelly Loney
- ○ Denise Dickson-Whalen
- ○ Kathy Vondrum
- ○ Erin Lawrence
- ○ Vicki French
- ○ Pam Will
- ○ Jennifer Warmka
- ○ Jen Rooney
- ○ Katelyn Kuechenmeister
- ○ Connie Pelzer
- ○ Sonia Rucks
- ○ Wendy Galanius
- ○ Lori Wacek
- ○ Jen McLaughlin
- ○ Vicki Lawrence
- ○ Jacqueline Portz
- ○ Rita Pyan
- ○ Bruce Kyllonen
- ○ Nicole Konz
- ○ Brittany Perish
- ○ Kylie Chandler
- ○ Brenda Roemhildt
- ○ Charlie Winship

CLS/CSC AAA Region: Script

What AAA office do you work at?
This will auto-populate based on the CLS/CSC Name field.

Actual Discharge Date/Support Plan Implementation Date: Script

When did the consumer discharge from the nursing home?
For those who were already in community: What is the date the support plan was considered final?

Type of Discharge: Script

Who assisted the consumer with relocating from the nursing home to a community setting? If the consumer was already residing in the community and the CLS provided direct assistance, use CLS Assisted.
CLS Assisted: Received direct assistance from a Senior LinkAge Line Community Living Specialist
Naturally Occurring: Received assistance from nursing home discharge planner, county case worker or managed care coordinator.
Moving Home Minnesota: Received assistance from county case worker or managed care coordinator and is enrolled in Moving Home Minnesota benefits through DHS.

- ○ CLS Assisted
- ○ Naturally Occurring
- ○ Moving Home Minnesota

Date of Verbal Release: Script

When did the consumer provide verbal permission to conduct the follow up call?

Date of Written Release: Script

When did the consumer sign the written release of information?

Client Name	DOB	Home Phone

Initial Information

Primary Information Source for Check In:

Script Who was the primary person who provided information during this check in?

- ◯ Adult Child
- ◯ Consumer
- ◯ Court Appointed Guardian
- ◯ Friend/Neighbor
- ◯ Grandchild
- ◯ Other Relative
- ◯ Paid Help
- ◯ Parent
- ◯ Sibling
- ◯ Spouse/Partner

Public Program Status:

Script Look up the consumer in MMIS to find out if they are on any public programs. Do not ask the consumer/caregiver.

- ◯ Alternative Care (AC)
- ◯ Brain Injury Waiver (BI)
- ◯ Community Alternative Care (CAC)
- ◯ Community Alternative for Disabled Individuals (CADI)
- ◯ Elderly Waiver (EW)
- ◯ Essential Community Supports (ECS)
- ◯ Medical Assistance
- ◯ Medical Assistance for Employed Persons with Disabilities (MA-EPD)
- ◯ Medical Assistance w/Spenddown
- ◯ MinnesotaCare
- ◯ None

Demographics

First Name:

Script Hello, My name is _____. I am calling on behalf from the Senior LinkAge Line® One Stop Shop for Minnesota Seniors. [If first interview - We are contacting you because you were recently discharged from a nursing home.] [If previously contacted - You have spoken previously with a Community Living Specialist regarding how you are doing at home after leaving the nursing home. I am following up to see how you are doing and to ask you a few questions.] We are gathering information in order to improve services for people who have returned to the community from a nursing home. We want to keep you and others successfully living at home for as long as you can. We are also calling because we would like to give you the opportunity to participate in research for the state of Minnesota. My questions will take about 30 minutes. Would you be willing to participate and answer a few questions for me?
If consumer answers yes, but has not yet signed a release form: Thank you, I need to mail you a release form that will need to be signed and mailed back to me; I will include a self-addressed stamped envelope for you to return the form. A release form is necessary because we will be collecting private data about you. You are welcome to call the Senior LinkAge Line® if you have questions about the release form once you receive it in the mail.
If consumer answers no: Thank you for your time. If you change your mind, please call the Senior LinkAge Line®. [End call and document in log notes.]
Is now a good time for you, or could I schedule a better time to call you back?
Before we get started, I just need to go over a few things. First of all, I want to let you know that your participation is strictly voluntary. You do not have to answer any of the questions or you can skip any questions you like at any time. If you'd like to stop the interview at any time, we can do that. I can always call you back to complete the interview or you can tell me that you are simply finished.
May I get your first name?

Last Name:

Script What is your last name?

Middle Name (RC):

Script May I get your middle name?

Nickname:

Script How do you prefer to be addressed?

Address

State:

Script This is in Minnesota, correct?

Zip Code:

Script So I can find services in your area, may I get your zip code?

Address

City: Script Your zip code shows that you are in (City), is this right?

County: Script And that city is in (County) county?

Address 1: Script I may need to send you some information. Please provide me with your mailing address.

Address 2: Script Do you have an apartment or house number?

TTY Phone Number:

Caller ID:

Home Phone: Script If you are calling from home, can I get your home telephone number?

Cell Phone: Script If you are calling from a cell phone, may I get your cell phone number?

E-Mail: Script I can send you information over email, can I get your email address?

Other Data

Birth Date: Script Many programs are for people who are a certain age, may I get your date of birth?

Age: Script Many programs are for people who are a certain age, can I get your age?

Social Security Number: Script What is your Social Security number?

Resident Internal ID: Script This number will auto populate when MDS profile names are uploaded to Web Referral.

Gender (RC): Script We receive funds from many sources and they like to know a little about our callers, may I verify your gender?

- ◯ Male
- ◯ Female
- ◯ Transgender- Male to Female
- ◯ Transgender- Female to Male

Marital Status: Script What is the consumer's marital status?

- ◯ Never married
- ◯ Married
- ◯ Widowed
- ◯ Separated
- ◯ Divorced
- ◯ Partner/Significant Other

Veteran: Script Are you a Veteran?

- ◯ Yes
- ◯ No

Language Spoken (RC): Script Choose the language the consumer speaks.

- ◯ American Sign Language (ASL)
- ◯ Amharic
- ◯ Arabic
- ◯ Chinese
- ◯ English
- ◯ Hmong

Other Data

- ◯ Khmer (Cambodian)
- ◯ Laotian
- ◯ Oromo
- ◯ Other
- ◯ Russian
- ◯ Serbo-Croatian (Bosnian)
- ◯ Somali
- ◯ Spanish
- ◯ Vietnamese

Language Spoken Other (RC): Script Indicate the other language the consumer speaks.

Interpreter Used?: Script Were interpreter services used to complete the consumer/caregiver interview?

- ◯ Not Applicable
- ◯ Yes
- ◯ No

Ethnicity: Script We receive funds from many sources and they like to know a little about our callers, may I ask your ethnicity?

- ☐ American Indian or Alaskan Native
- ☐ Asian Indian
- ☐ Black, African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Hispanic, Latino or Spanish Origin
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Not Collected
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Some Other Race/Ethnicity
- ☐ Vietnamese
- ☐ White, Non-Hispanic

Highest level of education: Script What is the highest level of schooling you have completed?

- ◯ No Schooling
- ◯ 8th Grade or Less
- ◯ 9-12 Grades
- ◯ High School Graduate
- ◯ Technical or Trade School
- ◯ Some College
- ◯ Bachelor's Degree
- ◯ Graduate Degree

Occupation: Script What did you do for a living or as your primary occupation?

Emergency Contacts

Emergency Contact Name: Script Do you have someone we should contact in case of an emergency?

Emergency Contact Address 1: Script What is the address for this person?

Emergency Contact Address 2: Script Does this person have an apartment number?

Emergency Contacts

Emergency Contact State: Script What states does this person live in?

Emergency Contact Zip Code: Script What is the ZIP code of this person?

Emergency Contact City: Script In which city does this person live?

Emergency Contact Relationship: Script What is your relationship to your emergency contact; are they your son, daughter, friend?

- ○ Adult Child
- ○ Friend/Neighbor
- ○ Grandchild
- ○ Other Relative
- ○ Paid Help
- ○ Parent
- ○ Sibling
- ○ Spouse/Partner

Emergency Contact Home Phone: Script What is the home number for your emergency contact?

Emergency Contact Work Phone: Script Does this person have a work phone number that we may put into our records?

Emergency Contact Cell Phone: Script Can we record this person's cell phone number?

Emergency Contact E-Mail: Script Does your emergency contact have an email address?

Emergency Contact Legal Authority: Script What type of authority does this person have?

- ☐ Conservator
- ☐ Guardian
- ☐ Health Care Proxy
- ☐ Power of Attorney (Financial)
- ☐ Unknown
- ☐ None

Emergency Contact Level of Involvement: Script What level of involvement does this person have according to the consumer?

- ○ Primary
- ○ Secondary
- ○ None

Advanced Directive Documentation

Advanced Directive Documentation: Script Do you have any of the following documents?

- ☐ Power of Attorney (Financial)
- ☐ Do Not Hospitalize
- ☐ Physician Orders Life Sustaining Treatment (POLST)
- ☐ Do Not Resuscitate (DNR) or Do Not Intubate Order (DNI)
- ☐ Health Care Directive (living will, durable power of attorney for health care)
- ☐ Do Not Know
- ☐ None

Followup Record - Qtrly Insurance & Recent Health Care Use

Medicare/Medical Assistance

Medicare or Railroad Retirement Number: Script What is your Medicare or Railroad Retirement Number?

Person Master Index (PMI) number: Script Do you know your Person Master Index (PMI) Number?

County Case Worker/Managed Care Coordinator

County Case Worker/Care Coordinator Name: Script Do you know the name of your case worker/care coordinator?

County Case Worker/Care Coordinator Phone Number: Script Do you have the phone number for your case worker/care coordinator?

Recent Nursing Facility Admission

Recent Nursing Facility Admission: Script In the last 3 months, how many times have you been admitted to a nursing facility?

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4+

Reason for Recent Nursing Facility Admission: Script Why were you admitted to a nursing facility?

- ☐ Therapy services
- ☐ Respite care
- ☐ Hospice care
- ☐ Permanent placement
- ☐ Unsafe for care at home
- ☐ Other
- ☐ UK – Unknown

Other Reason for Recent Nursing Facility Admission: Script What is the other reason the consumer was admitted to a nursing facility?

Recent Hospital Visit

Recent Hospital Visit: Script In the last 3 months, how many times have you been in the hospital? This includes any visits that were considered observation. This does not include trips to the Emergency Room.

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4+

Reason for Recent Hospital Visit: Script Why were you in the hospital?

- ☐ Accident
- ☐ Blood Pressure Low/High
- ☐ Blood Sugars Low/High
- ☐ Chest Pain/Pressure
- ☐ Dizziness
- ☐ Fall
- ☐ Fall with Injury
- ☐ Head Injury
- ☐ Lack of Caregiver

Recent Hospital Visit

- [ ] Medication Interaction
- [ ] No Medications
- [ ] Planned Surgery
- [ ] Shortness of Breath
- [ ] Uncontrolled Pain
- [ ] Viral/Bacterial Infection (Pneumonia, Cold, Flu)
- [ ] Other

Other Reason for Recent Hospital Visit: Script What is the other reason the consumer was in the hospital?

Recent Emergency Room/Urgent Care Visits

Recent ER/Urgent Care Visit: Script In the last 3 months, how many times have you been to the emergency room or urgent care?

- ○ 0
- ○ 1
- ○ 2
- ○ 3
- ○ 4+

Reason for Recent ER/Urgent Care Visit: Script Why did you go to the emergency room or urgent care?

- [ ] Accident
- [ ] Blood Pressure Low/High
- [ ] Blood Sugars Low/High
- [ ] Chest Pain/ Pressure
- [ ] Dizziness
- [ ] Fall
- [ ] Fall with Injury
- [ ] Head Injury
- [ ] Lack of Caregiver
- [ ] Medication Interaction
- [ ] No Medications
- [ ] Planned Surgery
- [ ] Shortness of Breath
- [ ] Uncontrolled Pain
- [ ] Viral/Bacterial Infection (Pneumonia, Cold, Flu)
- [ ] Other

Other Reason for Recent ER/Urgent Care Visit: Script What is the other reason the consumer went to the emergency room or urgent care?

Doctor Visits

Total Doctor Visits-Last 3 Months: Script About how many times in the last 3 months have you seen any doctor (your regular doctor, a specialist, or another medical doctor)?

- ○ 0
- ○ 1
- ○ 2
- ○ 3
- ○ 4+

Primary Care Doctor in Community

Primary Doctor Name: Script What is the name of your primary or regular doctor in the community?

Primary Doctor Clinic Name: Script What is the name of the clinic or health system your doctor is affiliated with?

Primary Doctor State: Script This field auto populates.

Primary Care Doctor in Community

- ◯ Alabama
- ◯ Alaska
- ◯ Arizona
- ◯ Arkansas
- ◯ California
- ◯ Colorado
- ◯ Connecticut
- ◯ Delaware
- ◯ Florida
- ◯ Georgia
- ◯ Hawaii
- ◯ Idaho
- ◯ Illinois
- ◯ Indiana
- ◯ Iowa
- ◯ Kansas
- ◯ Kentucky
- ◯ Louisiana
- ◯ Maine
- ◯ Maryland
- ◯ Massachusetts
- ◯ Michigan
- ◯ Minnesota
- ◯ Mississippi
- ◯ Missouri
- ◯ Montana
- ◯ Nebraska
- ◯ Nevada
- ◯ New Hampshire
- ◯ New Jersey
- ◯ New Mexico
- ◯ New York
- ◯ North Carolina
- ◯ North Dakota
- ◯ Ohio
- ◯ Oklahoma
- ◯ Oregon
- ◯ Pennsylvania
- ◯ Rhode Island
- ◯ South Carolina
- ◯ South Dakota
- ◯ Tennessee
- ◯ Texas
- ◯ Utah
- ◯ Vermont
- ◯ Virginia
- ◯ Washington
- ◯ Washington, DC
- ◯ West Virginia
- ◯ Wisconsin
- ◯ Wyoming

Primary Doctor Zip Code: Script This field auto populates.

Primary Doctor City: Script This field auto populates.

Primary Doctor County: Script This field auto populates.

Primary Care Doctor in Community

Primary Doctor Address 1: Script This field auto populates.

Primary Doctor Phone: Script This field auto populates.

Followup Record - Qtrly Health Conditions

Drug Allergies/Sensitivities

Drug Allergies/Sensitivities: Script Do you have any drug allergies or sensitivities?

- ◯ Yes
- ◯ None
- ◯ Unknown

List Drug Allergies/Sensitivities: Script What drugs are you allergic or sensitive to?

Diagnoses

Cancer: Script If first interview, What medical diagnoses do you have? If not first interview, state, The last time we talked you had these medical diagnoses. Has your health changed in the last 3 months? Has a doctor or other health professional told you that you have any other diagnoses? Have you been diagnosed with cancer?

- ☐ Cancer - with or without metastasis

Heart/Circulation: Script Have you been diagnosed with any of the following heart or circulation conditions?

- ☐ Anemia (includes Aplastic, Iron Deficiency, Pernicious, and Sickle Cell)
- ☐ Atrial Fibrillation and other Dysrhythmias (includes Bradycardias, Tachycardias)
- ☐ Coronary Artery Disease (CAD) (includes Angina, Myocardial Infarction, Atherosclerotic Heart Disease (ASHD))
- ☐ Deep Venous Thrombosis (DVT)/Pulmonary Embolus (PE) or Pulmonary Thrombo-Embolism (PTE)
- ☐ Heart Failure (includes Congestive Heart Failure (CHF), Pulmonary Edema)
- ☐ Hypertension
- ☐ Ortho-Static Hypotension
- ☐ Peripheral Vascular Disease/Peripheral Arterial Disease

Gastrointestinal: Script Have you been diagnosed with any of the following gastrointestinal conditions?

- ☐ Cirrhosis
- ☐ Gastroesophageal Reflux Disease (GERD)/Ulcer (includes Esophageal, Gastric, and Peptic Ulcers)
- ☐ Diverticulitis
- ☐ Ulcerative Colitis/Crohn's Disease/Inflammatory Bowel Disease

Genitourinary: Script Do you currently have the diagnosis or condition of any of the following?

- ☐ Benign Prostatic Hyperplasia (BPH)
- ☐ Renal Insufficiency or Renal Failure/End-Stage Renal Disease (ESRD)
- ☐ Neurogenic Bladder
- ☐ Obstructive Uropathy

Infections: Script Do you currently have the diagnosis or condition of any of the following?

- ☐ Multi-Drug Resistant Organism (MDRO)
- ☐ Tuberculosis
- ☐ Wound infection (other than foot)
- ☐ Urinary Tract Infection (UTI) (LAST 30 DAYS)
- ☐ Pneumonia
- ☐ Septicemia
- ☐ Viral Hepatitis (includes A, B, C, D, & E)

Metabolic: Script Do you currently have the diagnosis or condition of any of the following?

- ☐ Diabetes Mellitus (DM) (includes Diabetic Retinopathy, Nephropathy, and Neuropathy)
- ☐ Thyroid Disorder (includes Hypothyroidism, Hyperthyroidism, and Hashimoto's Thyroiditis)

Diagnoses

- [ ] Hyperlipidemia (includes Hypercholesterolemia)
- [ ] Hyponatremia
- [ ] Hyperkalemia

Musculoskeletal: Script Do you currently have the diagnosis or condition of any of the following?

- [ ] Arthritis (Degenerative Joint Disease (DJD), Osteoarthritis, and Rheumatoid Arthritis (RA))
- [ ] Hip Fracture (includes any hip fracture that has a relationship to current status, treatments, monitoring. Includes Sub-Capital Fractures, Fractures of the Trochanter and Femoral Neck)
- [ ] Osteoporosis
- [ ] Other Fracture

Neurological: Script Do you currently have the diagnosis or condition of any of the following?

- [ ] Alzheimer's disease
- [ ] Aphasia
- [ ] Cerebral Palsy
- [ ] Cerebrovascular Accident (CVA)/Transient Ischemic Attack (TIA)/Stroke
- [ ] Dementia (Non-Alzheimer's dementia, including Vascular or Multi-Infarct Dementia, Mixed Dementia, Frontal Temporal Dementia (e.g., Pick's Disease), and Dementia related to Stroke, Parkinson's or Creutzfeldt-Jakob diseases)
- [ ] Hemiplegia/Hemiparesis
- [ ] Huntington's disease
- [ ] Multiple Sclerosis
- [ ] Paraplegia
- [ ] Parkinson's Disease
- [ ] Quadriplegia
- [ ] Seizure Disorder
- [ ] Tourette's Syndrome
- [ ] Traumatic Brain Injury

Nutritional: Script Do you currently have the diagnosis or condition of any of the following?

- [ ] Malnutrition (protein or calorie) or at risk of malnutrition

Psychiatric/Mood Disorder: Script Do you currently have the diagnosis or condition of any of the following?

- [ ] Anxiety Disorder
- [ ] Psychotic Disorder (other than Schizophrenia)
- [ ] Post Traumatic Stress Disorder (PTSD)
- [ ] Depression (other than Bipolar)
- [ ] Manic Depression (Bipolar Disease)
- [ ] Schizophrenia (including Schizoaffective and Schizophreniform Disorders)

Pulmonary: Script Do you currently have the diagnosis or condition of any of the following?

- [ ] Asthma/Chronic Obstructive Pulmonary Disease (COPD) or Chronic Lung Disease (includes chronic Bronchitis and Restrictive Lung diseases such as Asbestosis)
- [ ] Respiratory Failure

Vision: Script Do you currently have the diagnosis or condition of any of the following?

- [ ] Cataracts, Glaucoma, or Macular Degeneration

Additional Diagnosis

Additional Diagnosis: Script Do you have any other diagnoses or conditions that we have not addressed?

Medication Management

Medication Management: Script Can you take your medications without help? This includes getting prescription refills, scheduling when you will take your medications, setting up your medications so you can take the proper dose, and taking the pills/liquids/or injections.

- ◯ I manage my own medications without help from others
- ◯ I can obtain and set up my medication, but I need someone to remind me when it is time to take them
- ◯ I need someone to obtain and setup my medications, but I can take them on my own
- ◯ I need help with both medication set-up and reminders
- ◯ Someone else gives my medication to me
- ◯ I do not take any medications

Medication Management

Blood Sugar: Script If you are diabetic, are you able to manage blood sugars on your own?

- ◯ I am not diabetic
- ◯ I do not need to manage my blood sugars
- ◯ I manage my blood sugars on my own
- ◯ I am unable to manage my blood sugars on my own

Diabetic Medication: Script If you are diabetic, are you able to manage your diabetic medications?

- ◯ I am not diabetic
- ◯ I manage sliding scale insulin and oral medications on my own
- ◯ I manage scheduled daily insulin plus daily sliding scale on my own
- ◯ I manage scheduled daily insulin on my own
- ◯ I manage oral medications on my own
- ◯ I am unable to manage my diabetic medications without assistance
- ◯ I do not take insulin or oral medications, but I am on a diabetic diet

Followup Record - Qtrly ADL/IADL/Environmental Review

ADLs

Dressing: Script When it is time to get dressed, in what ways, if any, do you need help getting dressed? By dressing, we mean laying out the clothes and putting them on, including shoes and socks, and fastening clothes. Can you get dressed without any help at all or only sometimes need help getting dressed? Do you need somebody to help you lay out clothes or give you reminders to get dressed? Or do you always need help getting dressed?

- ◯ Dress without help from others
- ◯ Sometimes needs help getting dressed
- ◯ Always needs help getting dressed

Dressing-Sometimes/Always: Script If the consumer sometimes or always needs help getting dressed, indicate all levels of assistance needed.

- ☐ Someone to help lay out clothes
- ☐ Someone to give reminders
- ☐ Someone to physically put on clothes

Grooming: Script How well are you able to manage grooming activities like combing your hair, putting on makeup, shaving, and brushing your teeth by yourself? Can you comb your hair, wash your face, shave, and brush your teeth without any help at all, or only sometimes need help? Do you need someone to help you set up or watch you while doing these activities? Do you need somebody to give you reminders to complete your grooming activities? Or do you always need help to complete grooming activities?

- ◯ Grooming without help from others
- ◯ Sometimes needs help with grooming
- ◯ Always needs help with grooming

Grooming-Sometimes/Always: Script If the consumer sometimes or always needs help with grooming, indicate all levels of assistance needed.

- ☐ Someone to set up or watch grooming
- ☐ Someone to give reminders to complete grooming activities
- ☐ Someone to physically complete grooming activities

Bathing/Showering: Script How much help, if any, do you need to bathe or shower? Bathing or showering "yourself" means running the water, taking the bath or shower without any help, and washing all parts of the body, including your hair and face. Can you bathe or shower by yourself without any help at all, or do you only sometimes need help? Do you need somebody to help you get in and out of the bath or shower? Do you need somebody to help you set up or watch you while bathing or showering? Do you need somebody to give you reminders to bathe or shower? Or do you always need physical help (wash hair, feet, or bottom) to complete a bath or shower?

- ◯ Bathing/showering without help from others
- ◯ Sometimes needs help with bathing/showering
- ◯ Always need help with bathing/showering

Bathing/Showering-Sometimes/Always: Script If the consumer sometimes or always needs help with bathing/showering indicate all levels of assistance needed.

- ☐ Someone to help get in or out of the bath or shower
- ☐ Someone to set up or watch bathing/showering
- ☐ Someone to give reminders to bathe/shower
- ☐ Someone to physically wash hair, feet, or bottom

ADLs

Eating:

Script How well can you manage eating by yourself? Eating by yourself means drinking and eating without help from anybody else, but you can use special utensils and straws. It also means cutting most foods on your own. Can you eat by yourself without any help at all, or do you only sometimes need help? Do you need someone to cut your food, butter your bread, arrange your food, or put food on the utensil? Do you need somebody to set up or food or watch you while eating? Do you need somebody to give you reminders while eating? Or do you always need to be fed completely?

- ◯ N/A: Tube feeding or IV feeding
- ◯ Eating without help from others
- ◯ Sometimes needs help with eating
- ◯ Always needs helps with eating
- ◯ Needs to be fed completely

Eating-Sometimes/Always:

Script If the consumer sometimes or always needs help with eating indicate all levels of assistance needed.

- ☐ Someone to help to cut food, butter bread, arrange food, or put food on the utensil
- ☐ Someone to set up or watch while eating
- ☐ Someone to give reminders to while eating

Bed Mobility:

Script How well can you manage sitting up or moving around in bed? Can you move in bed without any help at all, or do you only sometimes need help to sit up, turn over, or change positions in bed? Or do you always need help to sit up, be turned, or to change positions in bed?

- ◯ Moving in bed without help from others
- ◯ Sometimes needs help moving in bed
- ◯ Always needs help moving in bed

Movement out of Bed/Chair:

Script How well can you get in and out of a bed or chair? Can you get in and out of a bed or chair without any help? Do you only sometimes need help, or do you always need help? Do you need somebody to guide you, but you can move by yourself? Can you get in and out of a bed or chair but only with the help of one person? Do you need two people or a mechanical aid to move in or out of a bed or chair?

- ◯ N/A: Never gets out of bed or chair
- ◯ Moves in and out of bed/chair without help from others
- ◯ Sometimes needs help with moving in and out of bed/chair
- ◯ Always needs help with moving in and out of bed/chair

Movement out of Bed/Chair-Sometimes/Always:

Script If the consumer sometimes or always needs help with moving out of the bed or chair indicate all levels of assistance needed.

- ☐ Someone to help guide while moving in and out of bed/chair
- ☐ One person to help move in and out of bed/chair
- ☐ Two people or mechanical aid to move in and out of bed/chair

Walking:

Script How much help do you need to walk around? Walking refers to the ability to walk short distances around the house. This does not include climbing stairs. Can you walk around independently, or only sometimes need help? Can you walk without help from others, but need the help of a cane, walker, crutch, or push wheelchair? Do you always need help from one person to help you walk? Do you always need help from two people to help you walk?

- ◯ Never walks/cannot walk at all
- ◯ Walks without help from others
- ◯ Walks without help from others, but needs the help of a cane, walker, crutch, or push wheelchair
- ◯ Sometimes needs help walking
- ◯ Always needs help walking

Walking-Sometimes/Always:

Script If the consumer sometimes or always needs help with walking indicate all levels of assistance needed.

- ☐ One person to help walk
- ☐ Two people to help walk

Wheelchair:

Script Are you able to maneuver your wheelchair (manual or electric) by yourself, or do you only sometimes need help? Do you need help negotiating doorways, elevators, ramps, or locking and unlocking brakes? Or do you always need help using your wheelchair?

- ◯ N/A: Does not use a wheelchair
- ◯ Uses wheelchair without help from others
- ◯ Sometimes needs help using wheelchair
- ◯ Always needs help using wheelchair

Client Name	DOB	Home Phone

ADLs

Toilet Use: Script Now I want to ask you some sensitive questions regarding your personal hygiene. How well can you manage using the toilet? This includes adjusting clothing, getting to and on the toilet, and cleaning one's self. Can you use the toilet without help including adjusting clothing, or do you only sometimes need help? Do you need help getting to and on the toilet, adjusting your clothing, or cleaning after using the toilet? Do you need reminders to use the toilet? Or do you always need help getting to the toilet, adjusting clothing or cleaning yourself?

- ◯ Does not use the toilet
- ◯ Uses toilet without help from others
- ◯ Sometimes needs help using toilet
- ◯ Always needs help using toilet

Urine Incontinence: Script Do you ever dribble or leak urine? If yes, do you need assistance to clean and change yourself without help from others? How much assistance do you need- sometimes: no more than once a week, sometimes: more than once a week but not every day, or do you need assistance cleaning and changing after you dribble or leak urine every day?

- ◯ Does not dribble or leak urine
- ◯ Does not need assistance cleaning/changing
- ◯ Sometimes needs assistance cleaning/changing: no more than once per week
- ◯ Sometimes needs assistance cleaning/changing: more than once per week, but not every day
- ◯ Needs assistance cleaning/changing every day

Bowel Incontinence: Script Do you ever have smears of bowel in your underwear? If yes, do you need assistance to clean and change yourself without help from others? How much assistance do you need- sometimes: no more than once a week, sometimes: more than once a week but not every day, or do you need assistance cleaning and changing after you dribble or leak urine every day?

- ◯ Does not have bowel incontinence
- ◯ Does not need assistance cleaning/changing
- ◯ Sometimes needs assistance cleaning/changing: no more than once per week
- ◯ Sometimes needs assistance cleaning/changing: more than once per week, but not every day
- ◯ Needs assistance cleaning/changing every day

Catheter/Ostomy: Script If you have a catheter or ostomy, how often do you need assistance to manage it if any?

- ◯ N/A: Does not have a catheter or ostomy
- ◯ Does not need assistance
- ◯ Less than once a week
- ◯ More than once a week, but not daily
- ◯ Daily

IADLs

Answer Telephone: Script How much help do you need to answer the telephone?

- ◯ I do not answer the telephone
- ◯ I answer the telephone without help
- ◯ I sometimes need help to answer the telephone
- ◯ I always need help to answer the telephone

Telephone Calling: Script How much help do you need to make telephone calls?

- ◯ I do not make telephone calls
- ◯ I can find a number and make a telephone call without help
- ◯ I sometimes need help to find a number or make a telephone call
- ◯ I always need help to find a number or make a telephone call

Shopping: Script How well do you manage shopping by yourself? Are you able to plan and complete shopping trips or do you sometimes need help?

- ◯ I do not participate in shopping
- ◯ I am able to plan and complete shopping trips without help
- ◯ I sometimes need help planning or completing my shopping trips
- ◯ I always need someone with me when I shop

Food Preparation: Script How well are you able to prepare meals? Do you sometimes need help or does someone always help you?

- ◯ N/A: Does not prepare meals (e.g., receives meal service)
- ◯ I can plan and prepare meals without help
- ◯ I sometimes need help planning or preparing my meals
- ◯ I always need someone with me while I am planning or preparing my meals

Light Housekeeping: Script How well are you able to manage light housekeeping tasks such as dusting, sweeping, dishes, or wiping surfaces? Do you sometimes need help or does someone always help you?

IADLs

- ◯ N/A: Does not have light housekeeping tasks
- ◯ I do light housekeeping without help
- ◯ I sometimes need help to do light housekeeping
- ◯ I always need help to do light housekeeping

Heavy Housekeeping: Script How well are you able to manage heavy housekeeping tasks such as emptying the garbage, vacuuming, or cleaning the bathroom? Do you sometimes need help or does someone always help you?

- ◯ N/A: Does not have heavy housekeeping tasks
- ◯ I do heavy housekeeping without help
- ◯ I sometimes need help to do heavy housekeeping
- ◯ I always need help to do heavy housekeeping

Laundry: Script How well are you able to manage your laundry, including putting your clothes in the washer or dryer, starting and stopping the machine and removing and putting them away? Do you sometimes need help or do you always need help?

- ◯ N/A: Does not do laundry (e.g.,laundry service)
- ◯ I do laundry without help
- ◯ I sometimes need help to do laundry
- ◯ I always need help to do laundry

Money: Script How well are you able to manage your money including receiving and paying bills, balancing your checkbook, and taking care of any issues that arise regarding your finances? Do you sometimes need help or does someone always help you?

- ◯ N/A: Does not manage money
- ◯ I am able to manage my money and bills without help
- ◯ I sometimes need someone to help me or check my work when I am managing my money and bills
- ◯ I always have someone help me with my money and bills

Transportation: Script How do you get to the places you need to go, such as places of worship, shopping, doctor's appointments, or social activities?

- ☐ N/A: Does not travel within the community
- ☐ I drive myself
- ☐ Family members/friends drive me
- ☐ Public transportation (e.g.,bus)
- ☐ Paid service transportation (e.g., taxi)
- ☐ Health related transportation service (e.g., ambulance)
- ☐ Other

Other Transportation: Script What other transportation do you use?

Falls in Community

Falls in Community: Script Have you fallen in the last 3 months?

- ◯ Yes
- ◯ No
- ◯ Not Applicable-Caregiver Completed

Injury from Falls: Script Were you injured when you fell?

- ◯ Yes
- ◯ No
- ◯ Not Applicable

Balancing/Vertigo: Script Does concern about your balance or falling affect what you do each day?

- ◯ Yes
- ◯ No

Environmental Review

Safety Concerns in the Home: Script Are there any specific areas of your home you have a hard time getting around in?

- ☐ Basement
- ☐ Bathroom/Bathtub
- ☐ Bedroom
- ☐ Entrance or Exit
- ☐ Kitchen

Environmental Review

- [ ] Laundry/Utility Room
- [ ] Stairs/Stairways
- [ ] No
- [ ] Other

If Other Areas Identified: Script What other areas of your home are you concerned about?

Maintenance/Weatherizing: Script Are you concerned about maintaining or weatherizing your property? If so, what tasks are you most concerned with?

- [ ] No
- [ ] Arranging for household maintenance (plumber, electrician, etc.) when something breaks
- [ ] Arranging for weatherization, such as insulation, window covering
- [ ] Arranging for seasonal tasks, such as snow removal and lawn care
- [ ] Other

Other Maintenance/Weatherizing Needs: Script What other areas of maintenance or weatherization do you need help with?

Followup Record - Qtrly Medical Treatments

Medical Treatments/Therapies

Medical Treatments/Therapies Administered/Needed: Script Do you regularly receive/need any of the following medical treatments?

- [ ] Bedsores Treatment
- [ ] Catheter Care
- [ ] Colostomy Care
- [ ] Diabetes Education
- [ ] Dialysis at Home
- [ ] Dialysis Outpatient
- [ ] HIV Therapies
- [ ] Occupational Therapy
- [ ] Ostomy Care
- [ ] Oxygen
- [ ] Physical Therapy
- [ ] Respiratory Therapy
- [ ] Respiratory Treatment
- [ ] Restorative Therapy
- [ ] Speech Therapy
- [ ] Suctioning
- [ ] Urostomy
- [ ] Wound Care
- [ ] None
- [ ] Other

Other Treatments/Therapies Administered/Needed: Script If you use other treatments or therapies, could you please specify what these are?

Nutrition

Describe Significant Weight Change: Script Have you gained or lost 10 or more pounds in the last 6 months and why have you lost or gained this much weight? If the consumer has not had significant weight change, write, "no significant change".

Problems with Eating: Script Do you have any problems that make eating difficult?

- [ ] None
- [ ] Dental Problems/Chewing Problems

Nutrition

- [ ] Swallowing Problems
- [ ] Taste Problems
- [ ] Cannot Eat Certain Foods
- [ ] Food Allergies
- [ ] Other Problems with Eating

Other Eating Problems: Script Could you describe the other problems you are having with eating?

Special Diets: Script Are you on any of the following special diets? Such as calorie supplement, low fat, low sugar, etc.

- [ ] Calorie Supplement
- [ ] Gluten-Free
- [ ] Lactose-Free
- [ ] Low Fat, Low Carb
- [ ] Low Salt
- [ ] Low Sugar
- [ ] Mechanical Soft
- [ ] Pureed
- [ ] Thickened Food
- [ ] Thickened Liquids
- [ ] None
- [ ] Other

Other Special Diets: Script Can you describe the special diet you are on that I did not mention?

Pain

Daily Rating of Pain: Script Do you have pain that affects your daily activities? If yes, Please rate your worst pain during the last 7 days on a scale of 1 to 10; with1 being least amount of pain and 10 being the worst pain you can imagine.

- ○ I do not have daily pain
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10
- ○ Not Applicable-Caregiver Completed

Sleeping with Pain: Script During the past 7 days, has pain made it hard for you to sleep?

- ○ I do not have pain
- ○ Yes
- ○ No
- ○ Do Not Know
- ○ Not Applicable-Caregiver Completed

Pain and Activities: Script During the past 7 days, have you limited your activities because of pain?

- ○ I do not have pain
- ○ Yes
- ○ No
- ○ Do Not Know
- ○ Not Applicable-Caregiver Completed

Chest Pain: Script Do you regularly have chest pain?

- ○ Yes
- ○ No
- ○ Not Applicable-Caregiver Completed

Pain

Swollen Ankles: Script Do you have swollen ankles?

- ◯ Yes
- ◯ No

Shortness of Breath: Script Do you have shortness of breath or have difficulty breathing (prompt: rest/exertion/pain)?

- ◯ Yes
- ◯ No

Dizziness: Script Do you have dizziness (periodic or consistent)?

- ◯ Yes
- ◯ No

Emotional Health PHQ-9

Interest or Pleasure: Script In the last 2 weeks, have you had little interest or pleasure in doing things?

- ◯ Never or 1 Day
- ◯ 2-6 Days (Several Days)
- ◯ 7-11 Days (Half or More Days)
- ◯ 12-14 Days (Nearly Every Day)
- ◯ Did Not Answer
- ◯ Not Applicable-Caregiver Completed

Feeling Down, Depressed, or Hopeless: Script In the last 2 weeks, have you been feeling down, depressed or hopeless?

- ◯ Never or 1 Day
- ◯ 2-6 Days (Several Days)
- ◯ 7-11 Days (Half or More Days)
- ◯ 12-14 Days (Nearly Every Day)
- ◯ Did Not Answer
- ◯ Not Applicable-Caregiver Completed

Followup Record - Qtrly Self-Evaluation/CG Supports

Self Evaluation

Rate Your Health: Script Overall, compared to others your age, how would you rate your health?

- ◯ I am in very good health compared to others my age
- ◯ I'm about as healthy as others my age
- ◯ I am in poor health compared to others my age
- ◯ No response
- ◯ Not Applicable-Caregiver Completed

Health/Finances/Daily Activities Help: Script How much help do you need to make decisions about your health, finances, or daily activities?

- ◯ I feel safe and confident making decisions without help from others
- ◯ I feel safe and confident making decisions in familiar situations, but need help in situations that are new or different
- ◯ I sometimes need someone to help me make decisions about my daily routine
- ◯ I always need someone to help me make decisions about my daily routine
- ◯ I need someone to make most decisions for me
- ◯ Not Applicable-Caregiver Completed

Current Living Situation: Script Where are you currently living?

- ◯ Live alone in own home
- ◯ Live with family or other person(s) in consumer's own home
- ◯ Live with family or other person(s) in their home
- ◯ Live in congregate situation (e.g., assisted living)

Current Level of Assistance: Script How much help do you get with your personal care or daily living needs?

- ◯ Around the clock
- ◯ Regular daytime

Self Evaluation

- ◯ Regular nighttime
- ◯ Occasional/ short-term assistance
- ◯ No assistance

Who Are You Living With?: Script Who do you live with?

- ◯ Adult Child
- ◯ Alone
- ◯ Friend/Neighbor
- ◯ Grandchild
- ◯ Other Relative
- ◯ Paid Help
- ◯ Parent
- ◯ Sibling
- ◯ Spouse/Partner

Satisfied Where You Live: Script In the community are you satisfied with where you live or is there somewhere else you would prefer to live?

- ◯ Satisfied with current community housing
- ◯ Prefer to live somewhere else
- ◯ Do Not Know
- ◯ Not Applicable-Caregiver Completed

Communication with Others: Script Did you talk to friends, relatives, or others on the telephone as often as you would like in the past week (either they called you or you called them?) (Not applicable to paid helpers)

- ◯ Yes
- ◯ No
- ◯ Not Applicable-Caregiver Completed

Socialization with Others: Script Did you spend some time with someone who does not live with you as often as you would want? That is, you went to see them or they came to visit you or you did things together?

- ◯ Yes
- ◯ No
- ◯ Not Applicable-Caregiver Completed

Current Services in Community: Script What services are you currently receiving at home?

- ☐ Adult Day Service
- ☐ Caregiver Support Groups
- ☐ Chore Services
- ☐ Companion Services
- ☐ Congregate Dining
- ☐ Durable Medical Equipment
- ☐ Evidence Based Programs (Ex: Matter of Balance, Chronic Disease Self Mgmt.)
- ☐ Financial Assistance-Agency Referral
- ☐ Home Health Aides
- ☐ Home-Delivered Meals
- ☐ Homemaker Services
- ☐ Hospice
- ☐ Long-term Care Consultation
- ☐ Medication Management
- ☐ Personal Emergency Response System (PERS)
- ☐ Personal Care Assistant (PCA)
- ☐ Rehab Services (OT/PT/ST/RT)
- ☐ Respite Care
- ☐ Skilled Nursing
- ☐ Training for informal caregivers
- ☐ Transportation
- ☐ None

Willing to Pay?: Script Are you willing to pay for services that may be needed?

- ◯ Yes
- ◯ No

Self Evaluation

Why Not?: Script What would you not be willing to pay for?

Monthly Income: Script What is your monthly income? This will help me find services and supports that meet your budget.

- ○ $0 - $950
- ○ $951 - $1,300
- ○ $1,301 - $2,100
- ○ $2,101 - $3,000
- ○ More than $3,001
- ○ Refused to provide

Total Assets: Script How much do you have in assets? This will help us determine if you may be eligible for certain programs.

- ○ $0 - $3,000
- ○ $3,001 - $10,000
- ○ $10,001 - $25,000
- ○ $25,001 - $75,000
- ○ $75,001 - $150,000
- ○ $150,001 - $300,000
- ○ $300,001 - $600,000
- ○ $600,001 - $999,999
- ○ More than $1,000,000
- ○ Refused to provide
- ○ Don't know

Caregiver Supports

Who Helps You the Most in the Community?: Script Who would you say is the person who helps you the most with day to day activities, taking care of your home or yourself, running errands or other things?

- ☐ Adult Child
- ☐ Friend/Neighbor
- ☐ Grandchild
- ☐ No One
- ☐ Other Relative
- ☐ Paid Help
- ☐ Parent
- ☐ Sibling
- ☐ Spouse/Partner

Primary Caregiver First and Last Name: Script What is the first and last name of the person who helps you the most?

Followup Record - Qtrly Caregiver Information

Primary Caregiver Information

Primary Caregiver First and Last Name: Script The primary caregiver is the individual who assists the consumer with care or tasks that cannot be completed independently due to a disability or functional limitation. Cares or tasks could include nonmedical care such as help with bathing or dressing; medically necessary care such as assistance with medications or changing dressings; and/or assistance with instrumental activities such as transportation, appointment setting, or home cleaning/maintenance. This individual may be a relative, friend or neighbor.
The interview would NOT be conducted with a paid individual, whether a licensed professional or someone else employed by an agency, family or the consumer.
What is your name?

Primary Caregiver Relationship to Consumer: Script What is your relationship to the consumer?

- ○ Adult Child
- ○ Friend/Neighbor
- ○ Grandchild
- ○ Guardian

Primary Caregiver Information

- ◯ Parent
- ◯ Other Relative
- ◯ Sibling
- ◯ Spouse/Partner

Primary Caregiver Age: Script How old are you?

Primary Caregiver Home Phone: Script What is your telephone number?

Primary Caregiver Cell Phone: Script What is your cell phone number?

Primary Caregiver Email: Script What is your email?

Primary Caregiver Gender: Script What is your gender?

- ◯ Male
- ◯ Female
- ◯ Not Collected
- ◯ Transgender- Male to Female
- ◯ Transgender- Female to Male

Primary Caregiver Health: Script How is your health?

- ◯ Good
- ◯ Fair
- ◯ Poor
- ◯ No Response

Primary Caregiver Employment: Script Are you employed?

- ◯ Full Time
- ◯ Homemaker
- ◯ Part Time
- ◯ Retired
- ◯ Unemployed

Primary Caregiver Availability: Script First, I'd like to ask you about helping out your [Relationship of consumer -- Mom/Dad/Spouse/Friend]. When are you primarily available to provide help?

- ☐ Morning
- ☐ Afternoon
- ☐ Night
- ☐ Weekdays
- ☐ Weekends

Primary Caregiver Marital Status: Script Are you married (if not spouse of consumer)?

- ◯ Yes
- ◯ No
- ◯ Not Applicable (Spouse of Consumer)

Primary Caregiver Dependents: Script Do you have minor children or other dependents living in your home?

- ◯ 0
- ◯ 1 to 3
- ◯ 4 to 5
- ◯ More than 5

Other People to Care For: Script Are there others that you care for on a regular basis?

Primary Caregiver Information

- ◯ Yes
- ◯ No

Frequency of Care: Script How often do you provide care for (name of consumer)?

- ◯ Daily
- ◯ Less than once a week
- ◯ At least once a week
- ◯ Several times a week
- ◯ Several times a month

Symptoms of Dementia - In the last 7 days, has the consumer had problems with:

Judgment or Decision Making: Script In the last 7 days, has the consumer had problems with:

- ◯ Yes
- ◯ No
- ◯ Do not know
- ◯ Refused to answer

Less Interest or Pleasure in Doing Things, Hobbies or Activities: Script In the last 7 days, has the consumer had problems with:

- ◯ Yes
- ◯ No
- ◯ Do not know
- ◯ Refused to answer

Repeating the Same Things Over and Over Such as Questions or Stories: Script In the last 7 days, has the consumer had problems with:

- ◯ Yes
- ◯ No
- ◯ Do not know
- ◯ Refused to answer

Learning How to use a Tool, Appliance, or Gadget: Script In the last 7 days, has the consumer had problems with:

- ◯ Yes
- ◯ No
- ◯ Do not know
- ◯ Refused to answer

Forgetting the Correct Month or Year: Script In the last 7 days, has the consumer had problems with:

- ◯ Yes
- ◯ No
- ◯ Do not know
- ◯ Refused to answer

Handling Complicated Financial Affairs Such as Balancing Checkbook & Paying Bills: Script In the last 7 days, has the consumer had problems with:

- ◯ Yes
- ◯ No
- ◯ Do not know
- ◯ Refused to answer

Remembering Appointments: Script In the last 7 days, has the consumer had problems with:

- ◯ Yes
- ◯ No

Symptoms of Dementia - In the last 7 days, has the consumer had problems with:

- ◯ Do not know
- ◯ Refused to answer

Thinking or Memory: Script In the last 7 days, has the consumer had problems with:

- ◯ Yes
- ◯ No
- ◯ Do not know
- ◯ Refused to answer

Behavioral Symptoms - In the past 7 days, has the consumer had problems with:

Mental Symptoms: Script For the next group of questions, please keep in mind that we are surveying many different people across the state. Some of these people have dementia or other conditions that can lead to behavior problems. We are asking everyone these questions so we know who does and does not have behavioral problems. Specialist: Based on caregiver responses, appropriate referrals need to be made to Adult Protection and Common Entry Point. Log notes should reflect the action steps.
In the last 7 days, has the consumer had any of the following? Choose all that apply.

- ☐ Hallucinations (perceptual experiences in the absence of real external sensory stimuli)
- ☐ Illusions (misperceptions in the presence of real external sensory stimuli)
- ☐ Delusions (misconceptions or beliefs that are firmly held, contrary to reality)
- ☐ None of the above
- ☐ Do not know
- ☐ Refused to answer

Being Stubborn, Agitated, Aggressive or Resistive to Help from Others: Script In the last 7 days, has the consumer had problems with:

- ◯ Yes
- ◯ No
- ◯ Do not know
- ◯ Refused to answer

Feeling Anxious, Nervous, Tense, Fearful or Panic: Script In the last 7 days, has the consumer had problems with:

- ◯ Yes
- ◯ No
- ◯ Do not know
- ◯ Refused to answer

Believing Others are Stealing from Them or Planning to Harm Them: Script In the last 7 days, has the consumer had problems with:

- ◯ Yes
- ◯ No
- ◯ Do not know
- ◯ Refused to answer

Acting Impulsively, Without Thinking Through the Consequences of Their Actions: Script In the last 7 days, has the consumer had problems with:

- ◯ Yes
- ◯ No
- ◯ Do not know
- ◯ Refused to answer

Wandering, Pacing, or Doing Things Repeatedly: Script In the last 7 days, has the consumer had problems with:

- ◯ Yes
- ◯ No
- ◯ Do not know
- ◯ Refused to answer

Client Name	DOB	Home Phone

Types and Length of Care

Types of Care: Script Do you assist (name of consumer) with any of the following?

- ☐ Personal care (help with bathing, dressing, using the toilet, getting in and out of the bath, or help with eating)
- ☐ Housekeeping (such as help with meal preparation, cleaning and laundry)
- ☐ Transportation
- ☐ Supervision for Safety
- ☐ Shopping and Errands
- ☐ Money Management
- ☐ Medications (set up, pick up, administer)
- ☐ Other

If Other Types of Care, Specify: Script What other type of care do you expect to provide?

Length of Care: Script How long have you been helping (name of consumer) with this care?

- ○ Never Helped Before
- ○ 1-6 Months
- ○ 7-12 Months
- ○ 1-2 Years
- ○ 3-5 Years
- ○ Over 5 Years

Will Others Help You With Caregiving?: Script Will other people help you with caregiving?

- ○ Yes
- ○ No

How Often Will They Help?: Script How often do they help?

- ○ No One Will Help
- ○ Daily
- ○ At least once a week
- ○ Less than once a week
- ○ Several times a week

Current Caregiver Support Services: Script What caregiver services/supports are you presently receiving?

- ☐ None
- ☐ Care Coordination
- ☐ Care Planning
- ☐ Coaching
- ☐ Information
- ☐ Respite
- ☐ Support Groups
- ☐ Training
- ☐ Other

Other Current Caregiver Support Services: Script What other caregiving services/supports are you receiving?

Would You Like to be Contacted about Additional Caregiver Supports?: Script What types services or community support would help you to continue caring for (name of consumer) to help keep him/her living in the community? Would you like to be contacted by a community organization for information and assistance with care giving? Those are all the questions I have. Thank you very much for spending this time with me. Do you have any questions you'd like to ask me?
We plan to check back with and you in about 3 months to see how things are going. You and the other people we survey throughout the state have given us a much better understanding of the daily needs and resources of people who have left nursing homes and returned to the community. If you have any questions in the meantime, please contact the Senior Linkage Line® at 1-800-333-2433. Thank you very much for your time!

- ☐ No
- ☐ Care Coordination
- ☐ Care Planning
- ☐ Coaching

Types and Length of Care

- [ ] Information
- [ ] Respite
- [ ] Support Groups
- [ ] Training
- [ ] Other

Other Additional Caregiver Supports: Script What other supports would you find helpful?

Reason Caregiver Information Not Complete

Reason Why Caregiver Information Not Completed: Script If the Caregiver Information screen was not completed, indicate reason why.

- [ ] No Primary Caregiver Identified
- [ ] Refused to Participate
- [ ] Unable to Reach
- [ ] Consumer Refused to Provide Contact Information
- [ ] Consumer Requests No Caregiver Contact
- [ ] Other

Other Reason Why Caregiver Information Not Completed: Script If the Caregiver Information screen was not completed, indicate other reason why.

Followup Record - Qtrly Outcome of Check In

Qtrly Outcome of Check In

Services Offered to Consumer/Caregiver: Script What services were offered to the consumer/caregiver when conducting follow-up in the community?

- [ ] Advanced Care Planning (Ex: Financial Planner, Elder Law Attorney)
- [ ] Adult Day Service
- [ ] Adult Protection
- [ ] Caregiver Support Groups
- [ ] Chore Services
- [ ] Companion Services
- [ ] Congregate Dining
- [ ] Durable Medical Equipment
- [ ] Evidence Based Programs (Ex: Matter of Balance, Chronic Disease Self Mgmt.)
- [ ] Financial Assistance-Agency Referral
- [ ] Food Support (Ex: SNAP)
- [ ] Home Health Aides
- [ ] Home-Delivered Meals
- [ ] Homemaker Services
- [ ] Hospice
- [ ] Long-term Care Consultation (LTCC)/MNChoices Referral
- [ ] Medication Set Up
- [ ] Memory Support Services (Ex: Alzheimer's Association)
- [ ] Personal Emergency Response System (PERS)
- [ ] Personal Care Assistant (PCA)
- [ ] Referral to County Case Worker/Managed Care Coordinator
- [ ] Rehab Services (OT/PT/ST/RT)
- [ ] Respite Care
- [ ] Skilled Nursing
- [ ] Training for Informal Caregivers
- [ ] Transportation
- [ ] Veterans/CVSO Referral
- [ ] Not Applicable
- [ ] None

Client Name	DOB	Home Phone

Qtrly Outcome of Check In

Services Accepted by Consumer/Caregiver: Script What services were accepted by the consumer/caregiver when conducting follow-up in the community?

- [ ] Advanced Care Planning (Ex: Financial Planner, Elder Law Attorney)
- [ ] Adult Day Service
- [ ] Adult Protection
- [ ] Caregiver Support Groups
- [ ] Chore Services
- [ ] Companion Services
- [ ] Congregate Dining
- [ ] Durable Medical Equipment
- [ ] Evidence Based Programs (Ex: Matter of Balance, Chronic Disease Self Mgmt.)
- [ ] Financial Assistance-Agency Referral
- [ ] Food Support (Ex: SNAP)
- [ ] Home Health Aides
- [ ] Home-Delivered Meals
- [ ] Homemaker Services
- [ ] Hospice
- [ ] Long-term Care Consultation (LTCC)/MNChoices Referral
- [ ] Medication Set Up
- [ ] Memory Support Services (Ex: Alzheimer's Association)
- [ ] Personal Emergency Response System (PERS)
- [ ] Personal Care Assistant (PCA)
- [ ] Referral to County Case Worker/Managed Care Coordinator
- [ ] Rehab Services (OT/PT/ST/RT)
- [ ] Respite Care
- [ ] Skilled Nursing
- [ ] Training for Informal Caregivers
- [ ] Transportation
- [ ] Veterans/CVSO Referral
- [ ] Not Applicable
- [ ] None

Outcome of Check In: Script What was the end result of this check in?

- ◯ Check In Completed/Next Follow Up Scheduled
- ◯ Check In Completed/Consumer Moving Out of State
- ◯ Check In Completed/Consumer Declines Further Contact
- ◯ Check In Not Completed/Consumer Readmitted to Nursing Facility
- ◯ Check In Not Completed/Consumer Declined Contact
- ◯ Check In Not Completed/Consumer Passed Away
- ◯ Check In Not Completed/Next Follow Up Scheduled
- ◯ Check In Not Completed/Part of Sampling
- ◯ Unable to Reach-Letter Sent to Consumer/Caregiver
- ◯ Check In Not Completed/Consumer Moved Out of State