Client Name	DOB	Home Phone

Community Planning Tool #1 Record - Initial Information

Community Planning Tool #1 Community Living Specialist

CLS Name: Script What is the name of the CLS who is providing assistance in this particular instance with the consumer? This could be just phone calls to the nursing home or through direct assistance in the nursing home or in the community.

- ○ Nancy Sandahl
- ○ Deb Eiler
- ○ Heather Pender
- ○ Leslie Sauve
- ○ Stephanie Larson
- ○ Shelly Loney
- ○ Melanie Spencer
- ○ 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

CLS AAA Region: Script What AAA Region office do you work at?

Community Planning Tool #1 Nursing Home

Primary Reason for Referral: Script What is the primary reason the consumer was referred to the Senior LinkAge Line® for assistance?
If the consumer information was provided through the MDS Profile list, choose MDS Profile List.

- ○ Facility cannot meet medical needs of consumer
- ○ Facility is closing
- ○ MDS profile list
- ○ MDS Section Q
- ○ No longer meets nursing facility level of care
- ○ Non-payment to facility
- ○ Previously assisted by CLS
- ○ Registered HWS counseling referral
- ○ Rehab is complete
- ○ Relocate closer to family
- ○ Unhappy in current setting

MDS Profile List Counter: Script This value shows how many times the consumer has appeared on the MDS profile list. It is a read only field.

MDS ID: Script This number will auto populate based on the nursing home facility chosen from the Search Listings window.

NH Internal ID: Script This number will auto populate based on the nursing home facility chosen from the Search Listings window.

Nursing Home Name: Script What is the name of the nursing home where the consumer is currently residing?

Type Of Service: Script This field auto populates.

Client Name	DOB	Home Phone

Community Planning Tool #1 Nursing Home

Nursing Home Address 1:	Script	This field will auto populate based on the nursing home you choose.

Nursing Home Address 2:	Script	This field will auto populate based on the nursing home you choose.

Nursing Home City:	Script	This field will auto populate based on the nursing home you choose.

Nursing Home County:	Script	This field will auto populate based on the nursing home you choose.

Nursing Home State:	Script	This field will auto populate based on the nursing home you choose.

Nursing Home Zip Code:	Script	This field will auto populate based on the nursing home you choose.

Nursing Home Phone Number:	Script	This field will auto populate based on the nursing home you choose.

AAA Region: Script   Which AAA region is the nursing home located in?

- ○ Arrowhead
- ○ Central MN Council on Aging
- ○ Land of the Dancing Sky
- ○ Metro
- ○ MN River
- ○ Southeast MN

Community Planning Tool #1 Demographics

First Name:	Script	May I get your first name?

Last Name:	Script	What is your last name?

Middle Name (RC):	Script	May I get your middle name?

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

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

Medical Assistance:	Script	Do your know your Medicaid or Medical Assistance (MA) number?

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

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

Major Program: Script   If you receive Medical Assistance, do you know which type you receive? Such as Medical Assistance, MA with a spenddown, MA for Long Term Care, etc.

- ○ AC
- ○ MA
- ○ QM

Client Name	DOB	Home Phone

Community Planning Tool #1 Demographics

○ SL
○ UN

MSHO/PMAP: Script What is the Minnesota Senior Health Options (MSHO) or Prepaid Medical Assistance Program (PMAP) number?

[ ]

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

[ ]

Age: Script What is your age?

[ ]

NH Admit Date: Script What date was the consumer admitted to the nursing home?

[ ]

Admit Source: Script From where was the consumer admitted to the nursing home?

○ Acute Hospital
○ Community
○ Emergency Room
○ Hospice
○ ID/DD Facility
○ Inpatient Rehabilitation Facility
○ Long Term Care Hospital (LTCH)
○ Other
○ Other NH/Swing
○ Psych Hospital

Community Planning Tool #1 Additional Information

New Admit-No NH Use Script This data is provided through MDS upload.
< 2 Years:

○ Yes
○ No

Prior Facility ID: Script This field gives you the Facility ID of the last nursing home the consumer was in.

[ ]

Prior Facility Name: Script This field gives you the name of the nursing home the consumer resided in within the last two years.

[ ]

Prior Discharge Date: Script This field gives you the date when the consumer discharged from the previous nursing home.

[ ]

Pay Source (MDS): Script What is the consumer's current pay source for their nursing home admission?

○ Medicare
○ Medicaid
○ Other
○ Unknown

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

Community Planning Tool #1 Additional Information

☐ Samoan
☐ Some Other Race/Ethnicity
☐ Vietnamese
☐ White, Non-Hispanic

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

Target: Script   This is provided through MDS upload and tells you if the consumer meets the targeting criteria based on MDS data. This field is not required if the consumer was referred from a source other than the MDS profile list.

○ Yes
○ No

Probability % rate: Script   This is provided through MDS upload and tells you the consumer's probability of successfully discharging to the community. This field is not required if the consumer was referred from a source other than the MDS profile list.

[   ]

RUG Group: Script   This will be provided through MDS upload and tells you the consumer's RUG group based off the admission MDS assessment. This field is not required if the consumer was referred from a source other than the MDS profile list.

○ AAA
○ BA1
○ BA2
○ BB1
○ BB2
○ BC1
○ CA1
○ CA2
○ CB1
○ CB2
○ CC1
○ CC2
○ CD1
○ CD2
○ CE1
○ CE2
○ DDF
○ ES1
○ ES2
○ ES3
○ HB1
○ HB2
○ HC1
○ HC2
○ HD1
○ HD2
○ HE1
○ HE2
○ IA1
○ IA2
○ IB1

Community Planning Tool #1 Additional Information

- ◯ IB2
- ◯ LB1
- ◯ LB2
- ◯ LC1
- ◯ LC2
- ◯ LD1
- ◯ LD2
- ◯ LE1
- ◯ LE2
- ◯ PA1
- ◯ PA2
- ◯ PB1
- ◯ PB2
- ◯ PC1
- ◯ PC2
- ◯ PD1
- ◯ PD2
- ◯ PE1
- ◯ PE2
- ◯ RAA
- ◯ RAB
- ◯ RAC
- ◯ RAD
- ◯ RAE
- ◯ SE1
- ◯ SE2
- ◯ SE3
- ◯ SSA
- ◯ SSB
- ◯ SSC

Cognitive Status: Script   This is provided through MDS upload and tells you the consumer's cognitive status based on the admission MDS assessment. This field is not required if the consumer was referred from a source other than the MDS profile list.

- ◯ 0 - Intact
- ◯ 1 - Borderline Intact
- ◯ 2 - Mild Impairment
- ◯ 3 - Moderate Impairment
- ◯ 4 - Mod-Severe Impairment
- ◯ 5 - Severe Impairment
- ◯ 6 - Very Severe Impairment
- ◯ NOT SCORED

ADL Number: Script   This is provided through MDS upload and tells you the consumer's ADL score based on the admission MDS assessment. This field is not required if the consumer was referred from a source other than the MDS profile list.

- ◯ Low (0-6)
- ◯ Mod (7-12)
- ◯ Mod-Sev (13-16)
- ◯ Sev (17-22)
- ◯ Very Sev (23-28)
- ◯ NOT SCORED

Incontinent: Script   This is provided through MDS upload and tells you the consumer's incontinence status based on the admission MDS assessment. This field is not required if the consumer was referred from a source other than the MDS profile list.

- ◯ Yes
- ◯ No

Behavior Problems: Script   This is provided through MDS upload and tells you if the consumer has behavior problems based on the admission MDS assessment. This field is not required if the consumer was referred from a source other than the MDS profile list.

- ◯ Yes
- ◯ No

Community Planning Tool #1 Record - Basic Information

Community Planning Tool #1 Record - Basic Information

Community Planning Tool #1 Name

First Name: Script 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?

Community Planning Tool #1 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?

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?

Community Planning Tool #1 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?

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 your current marital status?

Community Planning Tool #1 Other Data

- ○ 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
- ○ 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

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?

[ ]

Community Planning Tool #1 Record - NH Info & Emergency Contacts

Community Planning Tool #1 Nursing Home Info

Date of Initial Visit: Script   When did you first visit the consumer in the nursing facility/their home to discuss their community options?
If the consumer name was given to you through the MDS profile, an initial visit is required if the consumer is still in the nursing facility. The visit will determine if the consumer is interested in assistance from a Community Living Specialist.

[ ]

Date of Verbal Release: Script   When did the consumer/caregiver verbally agree to assistance from the Community Living Specialist?

Community Planning Tool #1 Nursing Home Info

Date of Written Release: Script When did the consumer/caregiver sign the Return to Community Consent for Release of Records?

Nursing Home Primary Contact: Script Who is our primary nursing home contact?

Primary Contact Phone Number: Script What is the direct phone number of the primary contact?

Primary Contact Fax: Script Is there a direct fax number for the nursing home primary contact?

Primary Contact Email: Script How about an email address?

Primary Contact Position: Script What is the title of the position held by the nursing home primary contact?

Name of Primary Care Physician at NH: Script Who is the primary care physician for the consumer at the current nursing home?

Clinic or Health Care System: Script What is the clinic or health care system that the primary care physician is affiliated with at the current nursing home?

Primary Care Physician at NH Phone Number: Script What is the phone number at the current nursing home for the primary care physician?

Admit Source: Script Where was the consumer directly admitted from?

- ○ Acute Hospital
- ○ Community
- ○ Emergency Room
- ○ Hospice
- ○ ID/DD Facility
- ○ Inpatient Rehabilitation Facility
- ○ Long Term Care Hospital (LTCH)
- ○ Other
- ○ Other NH/Swing
- ○ Psych Hospital

NH Admit Date: Script What date was the consumer admitted to the current nursing home?

Date of Hospital Stay From: Script What is the date you last stayed at a hospital?

Date of Hospital Stay To: Script What is the date you left the hospital for this stay?

Community Planning Tool #1 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?

Community Planning Tool #1 Emergency Contacts

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

[   ]

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

Community Planning Tool #1 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

Client Name	DOB	Home Phone

Community Planning Tool #1 Record - Insurance

Community Planning Tool #1 Medicare/Medical Assistance

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

_____

Private Insurance or Medicare Supplement: Script   What private insurance or Medicare supplement do you have?

- ○ American Republic Corp Insurance Company America
- ○ Blue Cross & Blue Shield of MN
- ○ Colonial Penn
- ○ Combined Insurance of America
- ○ Continental Life of Brentwood Tennessee
- ○ Family Life
- ○ Gerber Life Insurance Company
- ○ Government Personnel Mutual
- ○ Health Partners
- ○ Humana Insurance Company
- ○ Individual Assurance Company
- ○ Loyal American Life Insurance Company
- ○ Loyal Christian Benefit Association
- ○ Medica
- ○ MNsure plan
- ○ Omaha Insurance Company
- ○ Preferred One
- ○ Sanford Health Plan of MN
- ○ State Farm Mutual
- ○ State Mutual Insurance Company
- ○ Sterling Life Insurance Company
- ○ TRICARE
- ○ UCare
- ○ United Health Care AARP
- ○ United World Life IC
- ○ None
- ○ Other Individual Policy

Policy Number: Script   What is your ID number for your insurance or supplemental policy?

_____

Medicare Advantage Plan: Script   Do you have a Medicare Advantage plan?

- ○ BCBS Platinum Blue Choice
- ○ BCBS Platinum Blue Choice with Rx
- ○ BCBS Platinum Blue Complete
- ○ BCBS Platinum Blue Complete with Rx
- ○ BCBS Platinum Blue Core
- ○ BCBS Platinum Blue Core Plan with Rx
- ○ EssentiaCare Grand (UCare)
- ○ EssentiaCare Secure (UCare)
- ○ Gunderson MN Senior Preferred Elite
- ○ Gunderson MN Senior Preferred Elite w/Rx
- ○ Gunderson MN Senior Preferred Value
- ○ Gunderson MN Senior Preferred Value w/Rx
- ○ HealthPartners Freedom Balance
- ○ HealthPartners Freedom Balance with Rx
- ○ HealthPartners Freedom Basic
- ○ HealthPartners Freedom Ultimate
- ○ HealthPartners Freedom Ultimate with Enhanced Rx
- ○ HealthPartners Freedom Ultimate with Rx
- ○ HealthPartners Freedom Vital
- ○ HealthPartners Freedom Vital with Rx
- ○ Humana Gold Choice PFFS

Community Planning Tool #1 Medicare/Medical Assistance

- ◯ HumanaChoice 004
- ◯ HumanaChoice 142
- ◯ HumanaChoice 143
- ◯ Medica Prime Solution Basic with Rx
- ◯ Medica Prime Solution Basic with Rx 2
- ◯ Medica Prime Solution Enhanced with Rx
- ◯ Medica Prime Solution Enhanced with Rx 2
- ◯ Medica Prime Solution Thrift with Rx
- ◯ Medica Prime Solution Thrive with Rx
- ◯ Medica Prime Solution Value with Rx
- ◯ Medica Prime Solution Value with Rx 2
- ◯ UCare for Seniors Classic - POS
- ◯ UCare for Seniors Essentials Rx - POS
- ◯ UCare for Seniors Value
- ◯ UCare for Seniors Value Plus-POS
- ◯ None

Medicare Advantage Member ID: Script   Can I have your ID number for your Medicare Advantage plan?

Medical Assistance: Script   Do your know your Medicaid or Medical Assistance (MA) number?

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

Community Planning Tool #1 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?

Community Planning Tool #1 Veterans Benefits

Veterans Benefits: Script   What type of veteran's benefits do you receive?

- ☐ CHAMPVA
- ☐ State Claims/Outreach Assistance
- ☐ State Education Assistance
- ☐ State Financial Assistance
- ☐ State Soldier's Assistance Program
- ☐ State Veteran Cemetery
- ☐ State Veteran Employment Preference
- ☐ VA Burial
- ☐ VA Compensation/Pension
- ☐ VA Education
- ☐ VA Health Care
- ☐ VA Home Loans
- ☐ VA Life Insurance
- ☐ VA Survivors' Benefit
- ☐ VA Vocational Rehab/Employment
- ☐ None

Community Planning Tool #1 Prescription Coverage

RX Coverage: Script   What type of Medicare Prescription Drug coverage, if any, do you have?

- ◯ Aetna Medicare Rx Saver PDP
- ◯ BCBS MedicareBlue Rx Premier

Community Planning Tool #1 Prescription Coverage

- ○ BCBS MedicareBlue Rx Standard
- ○ BCBS Platinum Blue Choice Plan with Rx
- ○ BCBS Platinum Blue Complete with Rx
- ○ BCBS Platinum Blue Core with Rx
- ○ Cigna - HealthSpring Rx Secure
- ○ Cigna - HealthSpring Rx Secure-Xtra
- ○ Employer/Union Plan
- ○ EnvisionRx Plus Silver
- ○ Express Scripts Medicare-Choice
- ○ Express Scripts Medicare-Value
- ○ First Health Part D Premier Plus
- ○ First Health Part D Value Plus
- ○ Gunderson MN Senior Preferred Elite
- ○ Gunderson MN Senior Preferred Value
- ○ HealthMarkets Value Rx
- ○ HealthPartners Freedom Balance with Rx
- ○ HealthPartners Freedom Ultimate with Enhanced Rx
- ○ HealthPartners Freedom Ultimate with Rx
- ○ HealthPartners Freedom Vital with Rx
- ○ Humana Enhanced
- ○ Humana Gold Choice PFFS
- ○ Humana Preferred Rx Plan
- ○ Humana Walmart- Preferred Rx Plan
- ○ HumanaChoice 004
- ○ HumanaChoice 142
- ○ HumanaChoice 143
- ○ Magellan Rx Medicare Basic
- ○ Medica Prime Solution Basic with Rx
- ○ Medica Prime Solution Basic with Rx 2
- ○ Medica Prime Solution Enhanced with Rx
- ○ Medica Prime Solution Enhanced with Rx 2
- ○ Medica Prime Solution Thrift with Rx
- ○ Medica Prime Solution Thrive with Rx
- ○ Medica Prime Solution Value with Rx
- ○ Medica Prime Solution Value with Rx 2
- ○ Silverscript Choice
- ○ Silverscript Plus
- ○ Stonebridge Transamerica MedicareRx Classic
- ○ Symphonix PremierSaver Rx
- ○ Symphonix Value Rx
- ○ UCare for Seniors Classic – POS
- ○ UCare for Seniors Essentials Rx – POS
- ○ UCare for Seniors Value Plus - POS
- ○ United American Enhanced
- ○ United American Essential
- ○ United American Select
- ○ United HealthCare AARP Medicare Rx Preferred
- ○ United HealthCare AARP Medicare Rx Saver Plus
- ○ Veterans Prescription Plan
- ○ WellCare Classic
- ○ WellCare Extra
- ○ None

RX ID number: Script   Do you know the ID number for your Rx Coverage?

Community Planning Tool #1 Other Insurance

Other Insurance: Script   Do you have any other insurance, such as Long-Term Care Partnership, Minnesota Long-Term Care, Life Insurance?

- ☐ Annuities
- ☐ Private Health (Unrelated to Medicare)

Community Planning Tool #1 Other Insurance

☐ MN LTC Partnership Policy
☐ Long-Term Care Insurance (not LTCP)
☐ Life Insurance
☐ Unknown
☐ None

Community Planning Tool #1 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.

○ 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

Community Planning Tool #1 Primary Care Doctor in Community

- ○ 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 Doctor Address 1:	Script	This field auto populates.

Primary Doctor Phone:	Script	This field auto populates.

Next Primary Doctor Visit:	Script	When is the next scheduled appointment with the primary/regular doctor once you return to the community?

Community Planning Tool #1 Record - Health Conditions/Medications

Community Planning Tool #1 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?

Community Planning Tool #1 Pharmacy

Pharmacy Name:	Script	What is the name of your pharmacy in the community?

State:	Script	What state is your pharmacy located in?

Zip Code:	Script	What is the ZIP code for your pharmacy?

City:	Script	What city is your pharmacy located in?

County:	Script	Is this pharmacy located in (name of county)?

Address 1:	Script	What is the address of the pharmacy in the community?

Phone:	Script	Do you know the phone number for this pharmacy?

Community Planning Tool #1 Medications Taken Within 5 Days of MDS Assessment

Antipsychotic:	Script	These fields are read only. The only time data will be entered into these fields is through the MDS upload process.

Client Name	DOB	Home Phone

Community Planning Tool #1 Medications Taken Within 5 Days of MDS Assessment

Antianxiety: Script These fields are read only. The only time data will be entered into these fields is through the MDS upload process.

Antidepressant: Script These fields are read only. The only time data will be entered into these fields is through the MDS upload process.

Hypnotic: Script These fields are read only. The only time data will be entered into these fields is through the MDS upload process.

Anticoagulant: Script These fields are read only. The only time data will be entered into these fields is through the MDS upload process.

Antibiotic: Script These fields are read only. The only time data will be entered into these fields is through the MDS upload process.

Diuretic: Script These fields are read only. The only time data will be entered into these fields is through the MDS upload process.

Community Planning Tool #1 Current Medications

Medications Currently Prescribed or Taking While in Community: Script What types of medications was the consumer taking while in the community or is currently prescribed?

- [ ] Psychotropics: Antipsychotics
- [ ] Psychotropics: Antidepressants
- [ ] Psychotropics: Antiepileptics
- [ ] Psychotropics: Hypnotic/Sedatives
- [ ] Oral-sulfonylureas
- [ ] Oral-non-sulfonylureas
- [ ] Injectable-short-acting insulin
- [ ] Injectable-others
- [ ] Skeletal Muscle Relaxants
- [ ] Narcotic Analgesics
- [ ] Anticholinergics: Definite/Strong Only
- [ ] Antiplatelet Agents
- [ ] Oral Anticoagulant
- [ ] Other Medications Not in Listed Classes
- [ ] None

Community Planning Tool #1 Diagnoses

Cancer: Script 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))
- [ ] 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?

Community Planning Tool #1 Diagnoses

- ☐ 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)
- ☐ 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 for 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 have a pulmonary condition or diagnosis?

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

Community Planning Tool #1 Diagnoses

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

☐ Cataracts, Glaucoma, or Macular Degeneration

Community Planning Tool #1 Additional Diagnosis

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

Community Planning Tool #1 Record - Behavioral Health

Community Planning Tool #1 History of Mental Health Service

History of Mental Health Service: Script Have you ever received mental health services, such as counseling?

○ Yes
○ No

Community Planning Tool #1 Mental Health Service History

Name of Provider: Script What is the name of the provider you have seen for mental health services?

Phone Number: Script Do you know the phone number for this provider?

Community Planning Tool #1 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

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

○ Yes
○ No

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

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

○ Yes
○ No

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

○ Yes
○ No

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

○ Yes
○ No

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

Community Planning Tool #1 Symptoms of Dementia - In the last 7 days, has the consumer had problems with:

○ Yes
○ No

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

○ Yes
○ No

Community Planning Tool #1 Behavioral Symptoms - In the last 7 days, has the consumer had problems with:

Mental Symptoms: Script 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

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

○ Yes
○ No

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

○ Yes
○ No

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

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

○ Yes
○ No

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

○ Yes
○ No

Community Planning Tool #1 Record - Assistive Devices/Medical Treatments

Community Planning Tool #1 Assistive Devices

Use/Need of Special Equipment/Assistive Devices: Script Does the consumer use or need any of the following special equipment or aids?

☐ Adaptive Eating Equipment
☐ Assistive Listening Devices
☐ Bathing Equipment
☐ Bedside Commode
☐ BiPAP/CPAP
☐ Brace (Leg, Back)
☐ Cane
☐ Dentures
☐ Glasses/Contact Lenses

Community Planning Tool #1 Assistive Devices

- ☐ Grab Bars
- ☐ Hearing Aid
- ☐ Hospital Bed
- ☐ Lift Chair
- ☐ Magnifiers for Vision
- ☐ Personal Emergency Response System (PERS)
- ☐ Prosthetics
- ☐ Raised Toilet Seat
- ☐ Walker
- ☐ Wheelchair
- ☐ None
- ☐ Other

Other Use/Need of Special Equipment/Assistive Devices: Script   What other special equipment or assistive devices does the consumer use/need?

Community Planning Tool #1 Medical Treatments

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

- ☐ Bedsores Treatment
- ☐ Bowel Care
- ☐ 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?

Community Planning Tool #1 Consumer Height/Weight

Current Weight: Script   How much do you weigh?

Height (Feet/Inches):   Script   How tall are you?

Describe Significant Weight Change: Script   How much weight have you gained or lost 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".

Community Planning Tool #1 Problems with Eating

Problems with Eating: Script   Does the consumer have any problems that make eating difficult?

Community Planning Tool #1 Problems with Eating

☐ None
☐ Dental Problems/Chewing Problems
☐ Swallowing Problems
☐ Taste Problems
☐ Cannot Eat Certain Foods
☐ Food Allergies
☐ Other Problems with Eating

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

[   ]

Community Planning Tool #1 Diets

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?

[   ]

Community Planning Tool #1 Record - BIMS/Emotional Health

Community Planning Tool #1 BIMS Mental Status Evaluation

Repeat Words: Script   I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words.

○ None
○ One
○ Two
○ Three

Year: Script   Please tell me what year it is right now.

○ Missed by > 5 Years or No Answer
○ Missed by 2 - 5 Years
○ Missed by 1 Year
○ Correct

Month: Script   What month are we in right now?

○ Missed by >1 Month or No Answer
○ Missed by 6 Days to 1 Month
○ Accurate within 5 Days

Day: Script   What day of the week is today?

○ Incorrect or No Answer
○ Correct Answer

Recall Sock: Script   Let's go back to an earlier question. What were those three words that I asked you to repeat? [You may provide a cue.]

○ No-Could Not Recall
○ Yes, After Cue ("Something to wear")
○ Yes, No Cue Required

Community Planning Tool #1 BIMS Mental Status Evaluation

Recall Blue: Script Do you remember another word I asked you to repeat? [You may provide a cue.]

- ○ No-Could Not Recall
- ○ Yes, After Cue ("A Color")
- ○ Yes, No Cue Required

Recall Bed: Script Do you remember another word I asked you to repeat? [You may provide a cue.]

- ○ No-Could Not Recall
- ○ Yes, After Cue ("Furniture")
- ○ Yes, No Cue Required

Score: Script If the consumer scores 0 – 7 (indicating severe impairment, the remainder of the planning tool should be completed with the primary caregiver. If the consumer scores 8 -15, the planning tool should be completed with the consumer.

Community Planning Tool #1 Reason BIMS Not Completed

IF BIMS Was Not Administered, Indicate Reason Why: Script If BIMS is not administered, indicate reason why.

- ☐ Acutely Ill
- ☐ Refused
- ☐ Too Severely Cognitively Impaired to Answer
- ☐ Other

Other Reason BIMS Not Administered: Script Indicate other reason why BIMS was not administered.

Community Planning Tool #1 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

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

Sleeping Too Much, Falling or Staying Asleep: Script In the last 2 weeks, have you had trouble falling or staying asleep, or sleeping too much?

- ○ 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

Tired or Little Energy: Script In the last 2 weeks, have you been feeling tired or have little energy?

- ○ 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

Poor Appetite or Over Eating: Script In the last 2 weeks, have you had a poor appetite or been over eating?

Community Planning Tool #1 Emotional Health PHQ-9

○ 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

Feelings of Failure or Disappointment Others: Script   In the last 2 weeks, have you felt bad about yourself, that you were a failure or have let your family down?

○ 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

Concentration: Script   In the last 2 weeks, have you had trouble concentrating on things, such as reading the newspaper or watching television?

○ 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

Slow Speech Pattern: Script   In the last 2 weeks, have you been moving or speaking so slowly that other people have noticed?

○ 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

Restless or Fidgety: Script   In the last 2 weeks, have you been feeling fidgety or restless so much that you are moving around more than usual?

○ 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

Personal Harm: Script   In the last 2 weeks, have you told anyone you felt life wasn't worth living, wished you were dead, or attempted to harm yourself?

○ 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

Short Tempered: Script   In the last 2 weeks, have you been short tempered or easily annoyed?

○ 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

Score: Script   The maximum score for this section is 30. If the consumer scores greater than or equal to 15 this indicates possible moderately severe to severe depression.

Community Planning Tool #1 Reason PHQ-9 Not Completed

IF PHQ-9 Was Not Administered, Indicate Reason Why: Script   If PHQ-9 is not administered, indicate reason why.

☐ Acutely Ill
☐ Refused
☐ Too Severely Cognitively Impaired to Answer
☐ Other

Community Planning Tool #1 Reason PHQ-9 Not Completed

Other Reason PHQ-9 Not Administered:
    Script   Indicate other reason why PHQ-9 was not administered.

Community Planning Tool #1 Record - Communication/ADL/IADL

Community Planning Tool #1 Communication

Speech and Verbal Expression of Language:
    Script   This question should be completed based on the interpretation of the Community Living Specialist and the conversation with the consumer as well as discussion with staff.

- ○ Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
- ○ Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
- ○ Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
- ○ Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
- ○ Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).
- ○ Patient nonresponsive or unable to speak.

Understanding of Verbal Content (With Hearing Aid or Device if Used):
    Script   This question should be completed based on the interpretation of the Community Living Specialist and the conversation with the consumer as well as discussion with staff.

- ○ Understands: clear comprehension without cues or repetitions.
- ○ Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
- ○ Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
- ○ Rarely/Never Understands
- ○ UK - Unable to assess understanding.

Community Planning Tool #1 Hearing & Vision

Ability to Hear (With Hearing Aid or Hearing Appliance if Normally Used):
    Script   This question should be completed based on the interpretation of the Community Living Specialist and the conversation with the consumer as well as discussion with staff.

- ○ Adequate: hears normal conversation without difficulty.
- ○ Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
- ○ Severely Impaired: absence of useful hearing.
- ○ UK - Unable to assess hearing

Vision (With Corrective Lenses if Normally Used):
    Script   This question should be completed based on the interpretation of the Community Living Specialist and the conversation with the consumer as well as discussion with staff.

- ○ Normal vision: sees adequately in most situations; can see medication labels, newsprint.
- ○ Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
- ○ Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.
- ○ UK - Unable to assess vision.

Community Planning Tool #1 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

Community Planning Tool #1 ADLs

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

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

Community Planning Tool #1 ADLs

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

Toilet Use:

Script　Now I want to ask you some sensitive questions regarding your personal hygiene. This will help us determine what services you may need, if any, when you return to the community. How well can you manage using the toilet? This includes adjusting clothing, getting to and on the toilet, and cleaning oneself. 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

Community Planning Tool #1 IADLs

Answer Telephone: Script   Now I want you to think about moving home and what assistance you may need, if any. I am going to ask you some questions about how you will be managing everyday tasks when you leave the nursing home, such as shopping or paying bills. Do you answer the telephone at home? Once you are at home, how much help, if any, do you believe you will need to answer the telephone? Do you think you'll be able to answer the telephone without help, or sometimes need help to answer the telephone? Do you think you will always need somebody to answer the telephone?
If consumer is living in community: 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   Will you be making telephone calls at home? Once you are at home, how much help, if any, do you need believe you will need to make telephone calls? Do you think you'll be able to find a number or make a call without help, or sometimes need help to find a number or make a call? Do you think you will always need somebody help you find a number or make a telephone call? Are you able to make a telephone call?
If consumer is living in community: 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   Will you be shopping for yourself? How well do you believe you will be able to manage shopping for food and other things that you will need while living in the community? Do you think that you will sometimes need help planning or completing shopping trips, or always need help planning or completing shopping trips? Or do you think you will be able to manage shopping by yourself?
If consumer is living in community: 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   Will you be preparing meals such as sandwiches, cooked meals, or TV dinners for yourself. Once you are at home, how much help, if any, do you need believe you will need to prepare meals? Do you think you'll be able to plan and prepare meals without help, or sometimes need help to planning or preparing what you will be eating?
If consumer is living in community: 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   Do you plan on taking care of your own light housekeeping tasks once you are living in the community, such as dusting, sweeping, dishes, or wiping surfaces? Do you think you'll be able to do any light housekeeping without help or sometimes need help? Will you always need help with your light housekeeping?
If consumer is living in community: 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?

- ○ 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   Will you be taking care of your own heavy housekeeping—activities that may be more difficult or burdensome such as emptying the garbage, vacuuming, or cleaning the bathroom? Once you are at home, how much help, if any, do you need believe you will need with heavy housekeeping tasks? Do you think you'll be able to do your own heavy housekeeping without help, or sometimes need help with heavy housekeeping? Do you think you will always need help with heavy housekeeping?
If consumer is living in community: How well are you able to manage heavy housekeeping tasks uch 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

Community Planning Tool #1 IADLs

Laundry: Script Will you be doing your own laundry once you are living in the community? How much help, if any, do you need believe you will need to put your clothes in the washer or dryer, starting and stopping the machines, and removing the clothes and putting them away? Do you think you will sometimes need help or always need help to do your laundry?
If consumer is living in community: 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 Now I will ask you about your ability to handle your regular finances. Do you take part in managing your money including receiving and paying bills, balancing your checkbook, and taking care of any issues that arise regarding your finances? Do you think you'll be doing these activities without help or do you expect you will need help managing money or bills? Will you sometimes need help? Will you always need help?
If consumer is living in community: 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 plan to get to the places you need to go, such as places of worship, shopping, doctor's appointments, or social activities?
If consumer is living in community: 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?

Community Planning Tool #1 Falls in Community and Nursing Home

Falls in Community: Script Are you concerned that you will fall once you are living in your home or while in the community?
If consumer is living in community: Are you concerned about falling at home or in other community settings?

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No

Falls in NH: Script Have you fallen during your time here in the nursing home?
If consumer is living in community: Choose "Not Applicable"

- ○ Yes
- ○ No
- ○ Not Applicable

Number of Falls Since Admit to NH: No Injury: Script If the consumer has fallen in the nursing home how many falls have occurred with no injury?
Definition: No injury- no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the consumer no change in the consumer's behavior is noted after the fall.
If consumer is living in community: Choose "Not Applicable"

- ○ Not Applicable
- ○ None
- ○ One
- ○ Two or more

Community Planning Tool #1 Falls in Community and Nursing Home

Number of Falls Since Admit to NH: Injury (Except Major):   Script   If the consumer has fallen in the nursing home how many falls have occurred with injury?
Definition: Injury (except major)- skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the consumer to complain of pain.
If consumer is living in community: Choose "Not Applicable"

○ Not Applicable
○ None
○ One
○ Two or more

Number of Falls Since Admit to NH: Major Injury: Script   If the consumer has fallen in the nursing home how many falls have occurred with major injury?
Definition: Major injury- bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.
If consumer is living in community: Choose "Not Applicable"

○ Not Applicable
○ None
○ One
○ Two or more

Community Planning Tool #1 Record - Environmental Review/Med Management

Community Planning Tool #1 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
☐ Laundry/Utility Room
☐ Stairs/Stairways
☐ Unknown at this time
☐ 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?

_____

Community Planning Tool #1 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

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

○ I am not diabetic

Community Planning Tool #1 Medication Management

○ 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

Community Planning Tool #1 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; with 1 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

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

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

Chest Pain: Script   Do you regularly have chest pain?

○ Yes
○ No

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

Frequency of Alcohol Consumption: Script   On average, counting beer, wine, and other alcoholic beverages, how many drinks do you have each day?

○ None
○ Less than once a week
○ 1-3 a day

Community Planning Tool #1 Pain

- ○ 3-5 a day
- ○ More than 5 a day

Issues with Alcohol: Script Has alcohol caused you any problems?

- ○ Not Applicable
- ○ Yes
- ○ No

Smoking Quantity: Script How much do you smoke or use tobacco and how often?

- ○ None
- ○ Daily
- ○ Weekly
- ○ Monthly

Addiction Services: Script Are you interested in receiving help or talking to someone about addiction? This refers to any sort of addiction.

- ○ Not Applicable
- ○ Yes
- ○ No

Community Planning Tool #1 Record - Self Evaluation/CG Supports

Community Planning Tool #1 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

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

Living Situation Prior to NH Admission/Current Situation in Community: Script Before you entered the nursing home, where did you live?
In your own home, in the home of a family member or friend, or in a special housing arrangement such as assisted living or a board and care home?
Were you living alone, OR with a family member or another person?
If consumer is living in community: What is your current living situation?

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

Level of Assistance Prior to NH Admission/Current Level in Community: Script How much help did you get with your personal care or daily living needs? Around the clock, regular daytime, regular nighttime, occasional help, or no assistance at all?
If consumer is living in community: How much help are you receiving with your personal care or daily living needs?

- ○ Around the clock
- ○ Regular daytime
- ○ Regular nighttime
- ○ Occasional/short-term assistance
- ○ No assistance

Who Were/Are You Living With?: Script Who were you living with before your hospitalization/moving to the nursing home?
If consumer is living in community: Who are you currently living with?

- ☐ Adult Child
- ☐ Alone
- ☐ Friend/Neighbor

Community Planning Tool #1 Self Evaluation

- ☐ Grandchild
- ☐ Other Relative
- ☐ Paid Help
- ☐ Parent
- ☐ Sibling
- ☐ Spouse/Partner

Reason(s) Consumer Admitted to the Nursing Home:

Script   Why was the consumer admitted to the nursing home? If consumer is living in the community, choose "Not Applicable-Living in Community."

- ☐ Therapy services
- ☐ Respite care
- ☐ Hospice care
- ☐ Permanent placement
- ☐ Unsafe for care at home
- ☐ Other
- ☐ UK – Unknown
- ☐ Not Applicable-Living in Community

If Other Reason for NH Admit:

Script   What is the other reason the consumer was admitted to the nursing home?

[   ]

Projected Living Situation After NH Discharge/Support Plan Development:

Script   When you leave the nursing home, where do you plan to live? In your own home, in the home of a family member or friend or in a special housing arrangement such as assisted living or a board care home?
Will you be living alone, OR with a family member or another person?
If consumer is living in community: Where do you plan on living after the support plan is implemented?

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

Projected Level of Assistance After NH Discharge/Support Plan Development:

Script   How much help will you get with your personal care or daily living needs? Around the clock, regular daytime, regular night time, occasional help, or no assistance at all?
If consumer is living in community: How much help will you get with your personal care or daily living needs after we implement your support plan?

- ○ Around the clock
- ○ Regular daytime
- ○ Regular nighttime
- ○ Occasional/short-term assistance
- ○ No assistance

Who Do You Plan on Living With?:

Script   Who do you plan to live with when you leave the nursing home?
If consumer is living in community: Who will you live with after the support plan is implemented?

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

Community Planning Tool #1 Caregiver Supports

Who Helps/Will Help You the Most When Living 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

Community Planning Tool #1 Caregiver Supports

- ☐ Paid Help
- ☐ Parent
- ☐ Sibling
- ☐ Spouse/Partner

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

[   ]

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

Willing to Pay?: Script   In the community, are you willing to pay for services that may be needed?

- ○ Yes
- ○ No

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

Community Planning Tool #1 Do Not Involve In My Care

First and Last Name: Script   Who would you not want involved in your care?

[   ]

Relationship: Script   How is this person related to you?

- ☐ Adult Child
- ☐ Friend/Neighbor
- ☐ Grandchild
- ☐ Other Relative
- ☐ Not Applicable
- ☐ Paid Help
- ☐ Parent
- ☐ Sibling
- ☐ Spouse/Partner

Community Planning Tool #1 Record - Discharge Information

Community Planning Tool #1 MDS Admission Section Q Responses

Community Planning Tool #1 MDS Admission Section Q Responses

Resident participation?:   Script   This field is part of MDS Admission Assessment and is provided through MDS uploads. If consumer is a referral from a source other than MDS profile lists, choose "Not Applicable".

○ Yes
○ No
○ Not Applicable

Family or significant other participation?:   Script   This field is part of MDS Admission Assessment and is provided through MDS uploads. If consumer is a referral from a source other than MDS profile lists, choose "Not Applicable".

○ Yes
○ No
○ No family or significant other
○ Not Applicable

Guardian or legal rep. participation?:   Script   This field is part of MDS Admission Assessment and is provided through MDS uploads. If consumer is a referral from a source other than MDS profile lists, choose "Not Applicable".

○ Yes
○ No
○ No guardian or legally authorized representative
○ Not Applicable

Overall expectation for discharge: Script   This field is part of MDS Admission Assessment and is provided through MDS uploads. If consumer is a referral from a source other than MDS profile lists, choose "Not Applicable".

○ Expects to be discharged to the community
○ Expects to remain in this facility
○ Expects to be discharged to another facility/institution
○ Unknown or uncertain
○ Not Applicable

Information source for expectations: Script   This field is part of MDS Admission Assessment and is provided through MDS uploads. If consumer is a referral from a source other than MDS profile lists, choose "Not Applicable".

○ Resident
○ If not resident, then family or significant other
○ If not resident, family, or significant other, then guardian or legally authorized representative
○ Unknown or uncertain
○ Not Applicable

Active DC plan in place?:   Script   This field is part of MDS Admission Assessment and is provided through MDS uploads. If consumer is a referral from a source other than MDS profile lists, choose "Not Applicable".

○ No
○ Yes
○ Not Applicable

Resident response-talking to someone about DC: Script   This field is part of MDS Admission Assessment and is provided through MDS uploads. If consumer is a referral from a source other than MDS profile lists, choose "Not Applicable".

○ No
○ Yes
○ Unknown or uncertain
○ Not Applicable

Referral to local contact agency?:   Script   This field is part of MDS Admission Assessment and is provided through MDS uploads. If consumer is a referral from a source other than MDS profile lists, choose "Not Applicable".

○ No-referral not needed
○ No-referral is or may be needed
○ Yes-referral made
○ Not Applicable

Community Planning Tool #1 Discharge Dates

Date of Death: Script   When did the consumer pass away?

Community Planning Tool #1 Discharge Dates

False Positive DC Date: Script   When did the consumer discharge from the nursing home? A false positive is defined as someone who appeared on the MDS profile list but was discharged prior to being in the nursing home for 45 days.

Support Plan Implementation Date: Script   What date did the consumer/caregiver/designated representative sign and approve the Community Living Support Plan to consider it "final" based on preferences and needs? This date will be used to schedule time sensitive follow-ups in Web Referral.
This field will only be used for consumers are referred to the Senior LinkAge Line® for assistance from a Community Living Specialist and are not living in a nursing home.

Actual Discharge Date: Script   What date did the consumer discharge from the nursing home?
This field will be completed for consumers who were directly assisted by a CLS with discharge assistance from a nursing home, naturally discharged without assistance from CLS, those who returned to hospital and do not have bed hold at nursing home and those who transferred to another nursing home.

Type of Discharge: Script   CLS Assisted- MDS Profile List- Consumer name was obtained through the MDS profile list.
CLS Assisted- MDS Section Q- Consumer was referred to the Senior LinkAge Line because the consumer indicated they wanted to speak to someone about returning to a community setting.
CLS Assisted-NH Referral- Consumer was referred by the NH for discharge assistance.
CLS Assisted-Ombudsman Referral- Consumer was referred by the Ombudsman for discharge assistance.
CLS Assisted-SLL Referral- Consumer/caregiver called the SLL and asked for discharge assistance or SLL identified consumer due to 2nd admit in calendar year.
Naturally Occurring- Consumer was discharged without direct assistance of the Community Living Specialist.
OR
Consumer has discharged to hospital from nursing home and does not have bed hold.
OR
Referral obtained through MDS profile list and consumer transferred to another nursing home.

- ○ CLS Assisted-MDS Profile List
- ○ CLS Assisted-MDS Section Q
- ○ CLS Assisted-NH Referral
- ○ CLS Assisted-Ombudsman Referral
- ○ CLS Assisted-SLL Referral
- ○ Naturally Occurring

Discharge Location: Script   Where did the consumer discharge after their nursing home stay? If consumer went to hospital and does not have a bed hold at current nursing home, choose "Hospital" as the discharge location.
If consumer transferred to another nursing home, choose "Another nursing home."

- ○ Adult child's home
- ○ Adult foster home
- ○ Another nursing home
- ○ Assisted living
- ○ Group home
- ○ Homeless shelter
- ○ Hospice House
- ○ Hospital
- ○ Other relative/friend's home
- ○ Private residence lives alone
- ○ Private residence with other caregiver
- ○ Private residence with spouse/partner
- ○ Subsidized housing
- ○ Temporary Housing (i.e. extended stay hotel)

Services Offered to Consumer/Caregiver: Script   What services were offered to the consumer/caregiver when planning for discharge from the nursing home?
For consumers living in the community: What services were offered to the consumer/caregiver when developing the Community Living Support Plan?

- ☐ Adult Day Service
- ☐ Adult Protection
- ☐ Advanced Care Planning (Ex: Financial Planner, Elder Law Attorney)
- ☐ Caregiver Support Groups
- ☐ Chore Services
- ☐ Companion Services
- ☐ Congregate Dining
- ☐ Durable Medical Equipment

Community Planning Tool #1 Discharge Dates

- [ ] 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 Care Assistant (PCA)
- [ ] Personal Emergency Response System (PERS)
- [ ] Rehab Services (OT/PT/ST/RT)
- [ ] Respite Care
- [ ] Skilled Nursing
- [ ] Training for Informal Caregivers
- [ ] Transportation
- [ ] Veterans/CVSO Referral
- [ ] Not Applicable
- [ ] None

Services Accepted by Consumer/Caregiver: Script For consumers discharging from the nursing home or already residing in the community: What services were accepted by the consumer/caregiver as a part of the Community Living Support Plan?

- [ ] Adult Day Service
- [ ] Adult Protection
- [ ] Advanced Care Planning (Ex: Financial Planner, Elder Law Attorney)
- [ ] 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 Care Assistant (PCA)
- [ ] Personal Emergency Response System (PERS)
- [ ] Rehab Services (OT/PT/ST/RT)
- [ ] Respite Care
- [ ] Skilled Nursing
- [ ] Training for Informal Caregivers
- [ ] Transportation
- [ ] Veterans/CVSO Referral
- [ ] Not Applicable
- [ ] None

Reasons Why Services Not Arranged: Script Why didn't the consumer/caregiver accept the suggested services as part of their Community Living Support Plan? If all services were accepted, choose "Not Applicable-All Services Accepted". If no services were offered, choose "Not Applicable-No Services Offered".
Otherwise choose appropriate reasons why services were not arranged based on the "Services Offered to Consumer/Caregiver" field but were not accepted.

- [ ] Could Not Afford
- [ ] Did Not Feel Necessary
- [ ] Does Not Financially Qualify
- [ ] Does Not Medically Qualify

Community Planning Tool #1 Discharge Dates

- ☐ Not Interested at this Time
- ☐ Services Not Available
- ☐ Waiting List
- ☐ Not Applicable-All Services Accepted
- ☐ Not Applicable-No Services Offered

Community Planning Tool #1 Reasons Consumer Staying Long Term

Reasons Consumer Staying Long Term: Script   Why have you decided to remain in the nursing home?

- ☐ Actively dying-hospice care
- ☐ Caregiver exhaustion
- ☐ Caregiver temporarily unavailable
- ☐ Caregiver no longer available
- ☐ Doctor recommended
- ☐ Does not qualify for public programs
- ☐ Family refused/acted as decision maker
- ☐ Health status declined-requires 24 hour supervision
- ☐ Health status declined-CVA
- ☐ Health status declined-injurious fall
- ☐ Health status declined-cardiac event
- ☐ Health status declined-other
- ☐ Lack of housing
- ☐ Legal, commitment, pending guardianship
- ☐ Memory concerns/dementia, not appropriate to move to new setting
- ☐ Mental health/psych-unstable to leave
- ☐ Personal choice-socialization
- ☐ Personal choice-safety
- ☐ Personal choice- access to health care
- ☐ Personal choice-spouse lives in facility
- ☐ Services not available
- ☐ Vulnerable situation

Source-Reasons Consumer Staying Long Term: Script   Who reported the reasons why the consumer is staying long term in the nursing home?

- ☐ Consumer
- ☐ Family Member
- ☐ Health Care Proxy
- ☐ Legal Guardian
- ☐ Nursing Home Discharge Planner
- ☐ Other Nursing Home Staff
- ☐ Physician/Nurse Practitioner
- ☐ POA-Financial/Conservator

Community Planning Tool #1 Record - Caregiver Information

Community Planning Tool #1 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
- ○ Grandchild

Community Planning Tool #1 Primary Caregiver Information

○ Friend/Neighbor
○ Spouse/Partner
○ Parent
○ Guardian
○ Other Relative
○ Sibling

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

Caregiver Health:

Script   How is your health?

○ Good
○ Fair
○ Poor
○ No Response

Primary Caregiver Employment:

Script   Are you employed?

○ Full Time
○ Unemployed
○ Retired
○ Part Time
○ Homemaker

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
☐ Week days
☐ 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

Community Planning Tool #1 Primary Caregiver Information

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

○ 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

Community Planning Tool #1 Types and Length of Care

Expected Types of Care: Script   What kind of help do you expect to give (name of consumer)? Will you give [list options]?

☐ Personal care (help with bathing, dressing, using the toilet, getting in and out of the bath, or assistance 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 will they help you?

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

Community Planning Tool #1 Caregiver Difficulties and Support

What Do You Think Will Be Difficult When Caregiving?:   Script   What do you think will be difficult when caregiving?

☐ Don't Expect Any Difficulties
☐ Alone
☐ Burden on the Rest of My Family
☐ Do Not Have Needed Skills
☐ Don't Want to Help
☐ Emotional Stress
☐ Job Limitations-Interfering with Employment
☐ Limited Finances
☐ Long Distance Caregiving
☐ Not Enough Time

Community Planning Tool #1 Caregiver Difficulties and Support

☐ Poor Health
☐ Poor Relationship with Care Receiver
☐ Unable to Meet Needs

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   Would you like to be contacted by a community organization for information and assistance with care giving?

○ Yes
○ No

Community Planning Tool #1 Reason Caregiver Information Not Completed

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
☐ Other

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

[   ]