

Florida Department of Elder Affairs
701S Screening Form
Rule: 58-A-1.010, F.A.C.

Provider ID: _____

Provider Screener ID: _____

Screener Name: _____

Signature: _____

1. **SCREENER: What is the purpose of this assessment?**

- Initial Annual Health Living situation Caregiver Environment Income

2. Social Security number: _____

We are required to explain that your Social Security number is being collected pursuant to Title 42, Code of Federal Regulations, Section 435.910, to be used for screening and referral to programs or services that may be appropriate for you. The provision of your Social Security number is voluntary, and your information will remain confidential and protected under penalty of law. We will not use or give out your Social Security number for any other reason unless you have signed a separate consent form that releases us to do so.

3. Name: a. First: _____ b. Middle initial: _____

c. Last: _____

4. Medicaid number: _____

5. Phone number: _____

6. Date of birth (mm/dd/yyyy): _____

7. Sex: Male Female

8. Race (Mark all that apply.): White Black/African American Asian
 American Indian/Alaska Native Native Hawaiian/Pacific Islander Other

9. Ethnicity: Hispanic/Latino Other

10. Primary language: English Spanish Other: _____

11. Does client have limited ability reading, writing, speaking, or understanding English? No Yes

12. Marital status: Married Partnered Single Separated Divorced Widowed

13. **SCREENER: Current Physical Location Address** (If type is a facility, enter facility name.)

a. Street: _____

b. City: _____ c. ZIP code: _____

d. Type: Private residence Assisted living facility (ALF) Nursing facility
 Hospital Adult day care Other

e. Name: _____

14. Home Address (If different from current physical location)

a. Street: _____

b. City: _____ c. ZIP code: _____

15. Mailing Address (If different from current physical location)

a. Street: _____ b. City: _____

c. State: _____ d. ZIP code: _____

16. **SCREENER: Assessment date:** (mm/dd/yyyy) _____

17. **SCREENER: Referral date:** (mm/dd/yyyy) _____

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

19. **SCREENER: Transitioning out of a nursing facility?** No Yes

20. **SCREENER: Imminent risk of nursing home placement?** No Yes

21. Is there a primary caregiver? No Yes

22. Living situation: With primary caregiver With other caregiver With other Alone

23. Individual monthly income: \$ _____ Refused

24. Couple monthly income: \$ _____ Refused N/A

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

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

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

28. Do you need other assistance for food? No Yes (*complete Nutritional Risk Score Section*)

29. **SCREENER: Is someone besides the client providing answers to questions?** No (*Skip to 30*) Yes:
a. Name: _____ b. Relationship: _____

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

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

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

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

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

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

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

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

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

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

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

Task	No assistance needed	Always has assistance	Has assistance most of the time	Rarely has assistance	Never has assistance
a. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Using the bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Walking/Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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

Task	No assistance needed	Always has assistance	Has assistance most of the time	Rarely has assistance	Never has assistance
a. Heavy chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Light housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Using the telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Managing money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Managing medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Using transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

42. Have you been told by a physician that you have any of the following health conditions?

SCREENER: Indicate whether a problem occurred in the past by marking the first box and when a problem is current by marking the second box. Mark all that apply.

Past	Current	Health Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Acid reflux/GERD
<input type="checkbox"/>	<input type="checkbox"/>	Allergies, list: _____
<input type="checkbox"/>	<input type="checkbox"/>	Amputation, site: _____
<input type="checkbox"/>	<input type="checkbox"/>	Anemia <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis, type: _____
<input type="checkbox"/>	<input type="checkbox"/>	Bed sore(s) (Decubitus), location: _____
<input type="checkbox"/>	<input type="checkbox"/>	Blood pressure <input type="checkbox"/> High <input type="checkbox"/> Low
<input type="checkbox"/>	<input type="checkbox"/>	Broken bones/fractures, location: _____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, site: _____
<input type="checkbox"/>	<input type="checkbox"/>	Chlamydia
<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol <input type="checkbox"/> High <input type="checkbox"/> Low
<input type="checkbox"/>	<input type="checkbox"/>	Dehydration
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes <input type="checkbox"/> IDDM <input type="checkbox"/> NIDDM
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness <input type="checkbox"/> Constant <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional <input type="checkbox"/> Rare
<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder <input type="checkbox"/> Removal <input type="checkbox"/> Problems
<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea
<input type="checkbox"/>	<input type="checkbox"/>	Heart problems <input type="checkbox"/> Pacemaker <input type="checkbox"/> CHF <input type="checkbox"/> MI <input type="checkbox"/> Other
<input type="checkbox"/>	<input type="checkbox"/>	Head, brain, or spinal cord trauma
<input type="checkbox"/>	<input type="checkbox"/>	Herpes
<input type="checkbox"/>	<input type="checkbox"/>	Human Immunodeficiency Virus (HIV)
<input type="checkbox"/>	<input type="checkbox"/>	Human Papillomavirus (HPV)/Genital warts

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Past	Current	Health Conditions, continued				
<input type="checkbox"/>	<input type="checkbox"/>	Incontinence, Bladder	<input type="checkbox"/> Constant	<input type="checkbox"/> Frequent	<input type="checkbox"/> Occasional	<input type="checkbox"/> Rare
<input type="checkbox"/>	<input type="checkbox"/>	Incontinence, Bowel	<input type="checkbox"/> Constant	<input type="checkbox"/> Frequent	<input type="checkbox"/> Occasional	<input type="checkbox"/> Rare
<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems or Renal disease		End stage?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>	Liver problems	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Hepatitis		
<input type="checkbox"/>	<input type="checkbox"/>	Lung problems	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> COPD
<input type="checkbox"/>	<input type="checkbox"/>	Lupus				
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis				
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy				
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis				
<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease				
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/> Full	<input type="checkbox"/> Partial	<input type="checkbox"/> Local, site: _____	
<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder, type & frequency:	_____			
<input type="checkbox"/>	<input type="checkbox"/>	Shingles				
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/CVA				
<input type="checkbox"/>	<input type="checkbox"/>	Syphilis				
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems/Graves/Myxedema		<input type="checkbox"/> Hyper	<input type="checkbox"/> Hypo	
<input type="checkbox"/>	<input type="checkbox"/>	Tumor(s), site:	_____			
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer(s), site:	_____			
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infection (UTI)				
<input type="checkbox"/>	<input type="checkbox"/>	Other:	_____			

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

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

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44. Caregiver full name: a. First: _____ b. Middle Initial: _____
 c. Last: _____

45. Caregiver phone number: _____

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

47. Considering other aspects of your life, rate the level of difficulty in your physical health:
 No difficulty Little difficulty Some difficulty Moderate difficulty A lot of difficulty

48. How confident are you that you will have the ability to continue to provide care?
 Very confident (*Skip to 49*) Somewhat confident (*Skip to 49*) Not very confident

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

49. **SCREENER: Is the caregiver in crisis?** No Yes; *check all that apply:*
 Financial Emotional Physical

Nutritional Risk Score Section

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

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

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

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

54. Have you lost or gained weight in the last few months? Unsure (*Skip to 55*) No (*Skip to 55*) Yes
 a. How much? Less than five pounds Five to ten pounds Ten pounds or more
 b. Was the weight loss/gain on purpose (*i.e., dieting or trying to lose/gain weight*)? No Yes

55. Are you on a special diet(s) for medical reasons? No (*Skip to 56*) Yes; *check any/all:*
 Calorie supplement Low fat/cholesterol Low salt/sodium Low sugar/carb Other
 a. How long have you been on this diet? _____
 b. Why are you on this diet? _____

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

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

58. How many days in a typical week do you drink alcohol?
 Refused (*Skip a-b*) None (*Skip a-b*) One to two Three to five Six to seven
 a. On the days when you have some alcohol, about how many drinks do you usually have?
 One to two (*Skip b*) Three to five Six or more
 b. About how many times in the last month have you had four or more drinks in a day?
 None One to two Three to five Six or more