Assessment Information	
Assessment Taken Date	
Enter Date	(Calendar drop down)
Date Status Saved in Complete	
[Will auto-populate when form saved in Complete status]	
Who Answered/Assisted	Enrollee Caregiver Other
If Other	(Free text field)
Relationship of Assistor	
Enter relationship	(Free text field)
Personal Information	
Marital Status	Never married Married Widowed Separated Divorced Other
Narrative	(Free text field)
Education	No schooling 8th grade/less 9-11 grades High school Technical or trade school Some college Bachelor's degree Graduate degree
Narrative	(Free text field)
Health Literacy	
How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	1. Never 2. Rarely 3. Sometimes 4. Often 5. Always
Narrative	(Free text field)
Additional Instructions *- Care Manager Note: Scores greater than 2 are considered positive, indicating some difficulty with reading printed health related material.*	

Race, Ethnicity, Language, and Disability		
What is your race? (Check all that apply)		Caucasian/White African American/Black American Indian or Alaska Hispanic/Latino Asian Native Hawaiian or other Unknown Declined to answer
Narrative		(Free text field)
What is your ethnicity? (Check all that apply)		Hispanic or Latino Not Hispanic or Latino Unknown Declined to answer
Narrative		(Free text field)
How well do you speak English? (Check all that apply)		Very well Well Not well Not at all Declined to answer
Narrative		(Free text field)
What is the primary language you speak? (Select one)	Arabic Burmese Cape Verdean Creole Chinese (Cantonese) Chinese (Mandarin) Croatian English French German Gujarati Haitian Creole Hmong Italian Japanese	Khmer (Cambodian) Korean Laotian; Lao Portuguese Russian Serbian Sign Language Spanish Tagalong Thai Vietnamese Other Declined to answer
Narrative		(Free text field)
Member's identified communication preference? (Check all that apply)		Language Line Interpreter None Other (please describe)
If Other	Please Describe	(Free text field)
Narrative		(Free text field)

Do you have an special circumstances or disability (Check all that apply)		Low Vision Blind Deaf Developmentally Disabled Intellectually Disabled Physically Disabled Hard of Hearing Other (please describe) None
If Other	Please Describe	(Free text field)
Narrative		(Free text field)
Do you need support services/reasonable accommodations to communicate?		Text telephone (TTY) Large print publications American Sign Language Video Relay Services (VRS) Communication Access Real Time Translations (CART) Publications in Braille Assistive Listening Device Publications in electronic format Other (please describe) None
If Other	Please Describe	(Free text field)
Narrative		(Free text field)
Communication Needs		
Hearing (With hearing appliance if used) C.1		0. HEARS ADEQUATELY - Normal talk, TV, phone, doorbell 1. MINIMAL DIFFICULTY - When not in quiet setting. 2. HEARS IN SPECIAL SITUATIONS ONLY - Speaker has to adjust tonal quality and speak distinctly 3. HIGHLY IMPAIRED - Absence of useful hearing
Making Self Understood (Expression) C.2		0. UNDERSTOOD - Expresses ideas without difficulty 1. USUALLY UNDERSTOOD - Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required 2. OFTEN UNDERSTOOD - Difficulty finding words or finishing thoughts, prompting usually required 3. SOMETIMES UNDERSTOOD - Ability is limited to making concrete requests 4. RARELY/NEVER UNDERSTOOD

Ability to Understand Others (Comprehension) C.3	0. UNDERSTANDS - Clear comprehension 1. USUALLY UNDERSTANDS - Misses some part/intent of message, BUT comprehends most conversation with little or no prompting 2. OFTEN UNDERSTANDS - Misses some part/intent of message, with prompting can often comprehend 3. SOMETIMES UNDERSTANDS - Responds adequately to simple, direct communication 4. RARELY/NEVER UNDERSTANDS
Visual Needs D.1	
Vision - Ability to see in adequate light and with glasses if used?	0. ADEQUATE - Sees fine detail, including regular print in newspapers/books 1. IMPAIRED - Sees large print, but not regular print in newspapers/books 2. MODERATELY IMPAIRED - Limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY IMPAIRED - Object identification in question, but eyes appear to follow objects 4. SEVERELY IMPAIRED - No vision or sees only light,
Living Arrangements	
I have your Home Address as: [auto-populates from member information]	
Is this your Correct Physical Address?	Yes No
Narrative	(Free text field)
What is your current living arrangement?	Alone or in a private home or apartment Alone in a senior housing building With a family member With a paid caregiver Assisted living facility Homeless Other
Narrative	(Free text field)

Home Environment - [Check any of the following that make home environment hazadarous or uninhabitable (if none apply, check NONE OF ABOVE; if temporarily in institution, base assessment on home visit)] (Check all that apply)	a. Lighting in evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors) b. Flooring and carpeting (e.g., holes in floor, electric wires where client walks, scatter rugs) c. Bathroom and toiletroom (e.g., non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, d. Kitchen (e.g., dangerous stove, inoperative refrigerator, infestation by rats or bugs) e. Heating and cooling (e.g., too hot in summer, too cold in winter, wood stove in a home with an asthmatic) f. Personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffice in street) g. Access to home (e.g. difficulty entering/leaving home) h. Access to rooms in house (e.g., unable to climb stairs) i. NONE OF ABOVE
Narrative	(Free text field)
Do you have someone to help you if you became ill?	Yes No
Narrative	(Free text field)
Who would help you if you became ill?	Spouse/significant other Child Friend Paid caregiver Family member Other
Narrative	(Free text field)
PCP Contact Info	
Do you have a primary care physician?	Yes No
Narrative	(Free text field)
If No - *Care Manager Note: Assist member in contacting Customer Service to select an in-network PCP*	
When was the last time you saw your PCP?	Within the past year Greater than 1 year ago
Support Services	
Do you attend or participate in any of the following support services?	Personal Care Attendant Adult Day Health Adult Foster Care N/A
Narrative	(Free text field)

Are you currently receiving any of the following services from an agency?	Visiting nurse Social worker Physical therapy Occupational therapy Speech therapy Home health aid Homemaker or chore service Transportation services Home delivered meals Personal Emergency N/A
Narrative	(Free text field)
Validate Services	
Member validates the above services (e.g., homemaker, PCA, etc.) are being received?	Yes No N/A
Narrative	(Free text field)
If Yes *- Care Manager Note: See OP Events on member's auth summary*	
Physical Functioning (IADL) - Do you need some assistance with any of the following activities?	
MEAL PREPARATION (e.g., planning meals, cooking, assembling ingredients, setting out food and utensils). H.1a	0. INDEPENDENT - did on own 1. SOME HELP - help some of the time 2. FULL HELP - performed with help all of the time 3. BY OTHERS - performed by others 8. ACTIVITY DID NOT OCCUR
Narrative	(Free text field)
ORDINARY HOUSEWORK (e.g., doing dishes, dusting, making bed, tidying up, laundry). H.1b	0. INDEPENDENT - did on own 1. SOME HELP - help some of the time 2. FULL HELP - performed with help all of the time 3. BY OTHERS - performed by others 8. ACTIVITY DID NOT OCCUR
Narrative	(Free text field)
MANAGING FINANCES (e.g., how bills are paid, checkbook is balanced, household expenses managed.) H.1c	0. INDEPENDENT - did on own 1. SOME HELP - help some of the time 2. FULL HELP - performed with help all of the time 3. BY OTHERS - performed by others 8. ACTIVITY DID NOT OCCUR
Narrative	(Free text field)

MANAGING MEDICATIONS (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections applying ointments). H.1d	0. INDEPENDENT - did on own 1. SOME HELP - help some of the time 2. FULL HELP - performed with help all of the time 3. BY OTHERS - performed by others 8. ACTIVITY DID NOT OCCUR
Narrative	(Free text field)
PHONE USE (e.g., how telephone calls are made or received, e.g. with assistive devices such as large numbers on telephone, amplification as needed). H.1e	0. INDEPENDENT - did on own 1. SOME HELP - help some of the time 2. FULL HELP - performed with help all of the time 3. BY OTHERS - performed by others 8. ACTIVITY DID NOT OCCUR
Narrative	(Free text field)
SHOPPING (e.g., how shopping is performed for food and household items, e.g. selecting items, managing money). H.1f	0. INDEPENDENT - did on own 1. SOME HELP - help some of the time 2. FULL HELP - performed with help all of the time 3. BY OTHERS - performed by others 8. ACTIVITY DID NOT OCCUR
Narrative	(Free text field)
TRANSPORTATION (e.g., how member travels by vehicle, e.g. gets to places beyond walking-distance). H.1g	0. INDEPENDENT - did on own 1. SOME HELP - help some of the time 2. FULL HELP - performed with help all of the time 3. BY OTHERS - performed by others 8. ACTIVITY DID NOT OCCUR
Narrative	(Free text field)

Physical Functioning (ADL) - Do you need some assistance with any of the following activities? For members who performed the activity independently, be sure to determine and record whether others encouraged the activity or were present to supervise or oversee the activity.	
MOBILITY IN BED - (Including moving to and from lying position, turning side to side, and positioning body while in bed) H.2a	0. INDEPENDENT - No help, setup, or oversight -OR- Help, setup, oversight provided only 1 or 2 times (with any task or subtask) 1. SETUP HELP ONLY - Article or device provided within reach of client 3 or more times 2. SUPERVISION - Oversight, encouragement, or cueing provided 3 or more times during last 3 days -OR- Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision. 3. LIMITED ASSISTANCE - Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times -OR- Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help) 4. EXTENSIVE ASSISTANCE - Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times: Weight-bearing support -OR- Full performance by another during part (but not all) of last 3 days 5. MAXIMAL ASSISTANCE - Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times 6. TOTAL DEPENDENCE - Full performance of activity by another 8. ACTIVITY DID NOT OCCUR (regardless of ability)
Narrative	(Free text field)
TRANSFER (Including to/from bed, chair, wheelchair, standing; excludes to/from bath/toilet) H.2b	0. INDEPENDENT - No help, setup, or oversight -OR- Help, setup, oversight provided only 1 or 2 times (with any task or subtask) 1. SETUP HELP ONLY - Article or device provided within reach of client 3 or more times 2. SUPERVISION - Oversight, encouragement, or cueing provided 3 or more times during last 3 days -OR- Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision. 3. LIMITED ASSISTANCE - Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times -OR- Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help) 4. EXTENSIVE ASSISTANCE - Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times: Weight-bearing support -OR- Full performance by another during part (but not all) of last 3 days 5. MAXIMAL ASSISTANCE - Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times 6. TOTAL DEPENDENCE - Full performance of activity by another 8. ACTIVITY DID NOT OCCUR (regardless of ability)
Narrative	(Free text field)

LOCOMOTION IN HOME (If in wheelchair, self-sufficiency once in chair) H.2c	0. INDEPENDENT - No help, setup, or oversight -OR- Help, setup, oversight provided only 1 or 2 times (with any task or subtask) 1. SETUP HELP ONLY - Article or device provided within reach of client 3 or more times 2. SUPERVISION - Oversight, encouragement, or cueing provided 3 or more times during last 3 days -OR- Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision. 3. LIMITED ASSISTANCE - Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times -OR- Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help) 4. EXTENSIVE ASSISTANCE - Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times: Weight-bearing support -OR- Full performance by another during part (but not all) of last 3 days 5. MAXIMAL ASSISTANCE - Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times 6. TOTAL DEPENDENCE - Full performance of activity by another 8. ACTIVITY DID NOT OCCUR (regardless of ability)
Narrative	(Free text field)
LOCOMOTION OUTSIDE OF HOME (If in wheelchair, self-sufficiency once in chair) H.2d	0. INDEPENDENT - No help, setup, or oversight -OR- Help, setup, oversight provided only 1 or 2 times (with any task or subtask) 1. SETUP HELP ONLY - Article or device provided within reach of client 3 or more times 2. SUPERVISION - Oversight, encouragement, or cueing provided 3 or more times during last 3 days -OR- Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision. 3. LIMITED ASSISTANCE - Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times -OR- Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help) 4. EXTENSIVE ASSISTANCE - Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times: Weight-bearing support -OR- Full performance by another during part (but not all) of last 3 days 5. MAXIMAL ASSISTANCE - Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times 6. TOTAL DEPENDENCE - Full performance of activity by another 8. ACTIVITY DID NOT OCCUR (regardless of ability)
Narrative	(Free text field)

DRESSING UPPER BODY (How member dresses and undresses - street clothes, underwear - above the waist; includes prostheses, orthotics, fasteners, pullovers, etc.) H.2e	0. INDEPENDENT - No help, setup, or oversight -OR- Help, setup, oversight provided only 1 or 2 times (with any task or subtask) 1. SETUP HELP ONLY - Article or device provided within reach of client 3 or more times 2. SUPERVISION - Oversight, encouragement, or cueing provided 3 or more times during last 3 days -OR- Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision. 3. LIMITED ASSISTANCE - Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times -OR- Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help) 4. EXTENSIVE ASSISTANCE - Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times: Weight-bearing support -OR- Full performance by another during part (but not all) of last 3 days 5. MAXIMAL ASSISTANCE - Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times 6. TOTAL DEPENDENCE - Full performance of activity by another 8. ACTIVITY DID NOT OCCUR (regardless of ability)
Narrative	(Free text field)
DRESSING LOWER BODY (How member dresses and undresses - street clothes, underwear - from the waist down; includes prostheses, orthotics, belts, pants, skirts, shoes, and fasteners) H.2f	0. INDEPENDENT - No help, setup, or oversight -OR- Help, setup, oversight provided only 1 or 2 times (with any task or subtask) 1. SETUP HELP ONLY - Article or device provided within reach of client 3 or more times 2. SUPERVISION - Oversight, encouragement, or cueing provided 3 or more times during last 3 days -OR- Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision. 3. LIMITED ASSISTANCE - Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times -OR- Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help) 4. EXTENSIVE ASSISTANCE - Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times: Weight-bearing support -OR- Full performance by another during part (but not all) of last 3 days 5. MAXIMAL ASSISTANCE - Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times 6. TOTAL DEPENDENCE - Full performance of activity by another 8. ACTIVITY DID NOT OCCUR (regardless of ability)
Narrative	(Free text field)

EATING (Including taking in food by any method, including tube feeding) H.2g	0. INDEPENDENT - No help, setup, or oversight -OR- Help, setup, oversight provided only 1 or 2 times (with any task or subtask) 1. SETUP HELP ONLY - Article or device provided within reach of client 3 or more times 2. SUPERVISION - Oversight, encouragement, or cueing provided 3 or more times during last 3 days -OR- Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision. 3. LIMITED ASSISTANCE - Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times -OR- Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help) 4. EXTENSIVE ASSISTANCE - Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times: Weight-bearing support -OR- Full performance by another during part (but not all) of last 3 days 5. MAXIMAL ASSISTANCE - Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times 6. TOTAL DEPENDENCE - Full performance of activity by another 8. ACTIVITY DID NOT OCCUR (regardless of ability)
Narrative	(Free text field)
TOILET USE (Including using the toilet room or commode, bedpan, urinal, transferring on/off toilet, cleaning self after toilet use or incontinent episode, changing pad, managing any special devices required - ostomy or catheter - and adjusting clothes) H.2h	0. INDEPENDENT - No help, setup, or oversight -OR- Help, setup, oversight provided only 1 or 2 times (with any task or subtask) 1. SETUP HELP ONLY - Article or device provided within reach of client 3 or more times 2. SUPERVISION - Oversight, encouragement, or cueing provided 3 or more times during last 3 days -OR- Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision. 3. LIMITED ASSISTANCE - Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times -OR- Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help) 4. EXTENSIVE ASSISTANCE - Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times: Weight-bearing support -OR- Full performance by another during part (but not all) of last 3 days 5. MAXIMAL ASSISTANCE - Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times 6. TOTAL DEPENDENCE - Full performance of activity by another 8. ACTIVITY DID NOT OCCUR (regardless of ability)
Narrative	(Free text field)

PERSONAL HYGIENE (Including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands - EXCLUDE baths/showers) H.2i	0. INDEPENDENT - No help, setup, or oversight -OR- Help, setup, oversight provided only 1 or 2 times (with any task or subtask) 1. SETUP HELP ONLY - Article or device provided within reach of client 3 or more times 2. SUPERVISION - Oversight, encouragement, or cueing provided 3 or more times during last 3 days -OR- Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision. 3. LIMITED ASSISTANCE - Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times -OR- Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help) 4. EXTENSIVE ASSISTANCE - Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times: Weight-bearing support -OR- Full performance by another during part (but not all) of last 3 days 5. MAXIMAL ASSISTANCE - Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times 6. TOTAL DEPENDENCE - Full performance of activity by another 8. ACTIVITY DID NOT OCCUR (regardless of ability)
Narrative	(Free text field)
BATHING (How member takes full-body bath/shower or sponge bath - EXCLUDE washing of back and hair. Include how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area) H.2j	0. INDEPENDENT - No help, setup, or oversight -OR- Help, setup, oversight provided only 1 or 2 times (with any task or subtask) 1. SETUP HELP ONLY - Article or device provided within reach of client 3 or more times 2. SUPERVISION - Oversight, encouragement, or cueing provided 3 or more times during last 3 days -OR- Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision. 3. LIMITED ASSISTANCE - Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times -OR- Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help) 4. EXTENSIVE ASSISTANCE - Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times: Weight-bearing support -OR- Full performance by another during part (but not all) of last 3 days 5. MAXIMAL ASSISTANCE - Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times 6. TOTAL DEPENDENCE - Full performance of activity by another 8. ACTIVITY DID NOT OCCUR (regardless of ability)
Narrative	(Free text field)

Medical Conditions & Treatments	
Has your doctor told you that you have any of the following health conditions?	Diabetes Heart Failure (CHF) Heart condition/Chest pain High blood pressure Emphysema or asthma Stroke Cancer (other than skin cancer) Hip fracture (within the past 12 months) Parkinson's Disease End stage renal (kidney) disease N/A
Narrative	(Free text field)
Do you receive any of the following special treatments? (May select multiple)	Tube feeding Tracheostomy care Ostomy care Wound care Chemotherapy Oxygen None
Narrative	(Free text field)
Nebulizer	Yes No
Narrative	(Free text field)
Do you use any of the following equipment? (May select multiple)	Hospital bed Hoyer lift Grab bars Bedside commode Wheelchair Walker Cane Other N/A
Narrative	(Free text field)

How would you best describe your current activities? (Select one)		Confined to bed most of the time Confined to the house most of the time Need assistance by someone to get outside the house Need the help of special equipment outside the No limitations in my
Narrative		(Free text field)
In general, how do you rate your health? (Select only one)		Very good Good Fair Poor
Narrative		(Free text field)
Is this a recent change? (Select one)		Yes No
Narrative		(Free text field)
Falls		
How many times have you fallen all the way to the ground or floor in the past 6 months?		None 1 to 3 4 or more
Narrative		(Free text field)
If 1 or more	If you have fallen, describe	(Free text field)
	Narrative	(Free text field)
Are you unsteady on your feet? (Danger of fall - unsteady gait) K.6a		Yes No
Narrative		(Free text field)
Do you limit going outdoors because you are afraid of falling? (e.g., stopped using bus, goes out only with others) K.6b		Yes No
Narrative		(Free text field)

Timed Get Up and Go Test		
Ask the member to perform the following series of maneuvers, wearing regular footwear and using 1. Sit comfortably in a straight-backed chair. 2. Rise from the chair 3. Stand still momentarily 4. Walk a short distance (approx. 10 feet) 5. Turn around 6. Walk back to the chair 7. Turn around 8. Sit down in the chair		
Timed Get Up and Go Test		Unable to perform Seconds to perform
Narrative		(Free text field)
Timed Get Up and Go Results		Normal Abnormal
Narrative		(Free text field)
Additional Instructions - *Care Manager Note: Greater than or equal to 12 seconds to complete indicates high risk for falling.*		
If Abnormal	Educated about fall risk. Consider fall reduction program.	Yes No Not applicable
	Narrative	(Free text field)
Pain		
How often do you have pain? (Frequency with which client complains or shows evidence of pain). K.4a		0. No pain 1. Less than daily 2. Daily - one period 3. Daily - multiple periods (e.g., morning and evening)
Narrative		(Free text field)
How intense is your pain? K.4b		0. No pain 1. Mild 2. Moderate 3. Severe 4. Times when pain is horrible or excruciating
Narrative		(Free text field)
Does the pain disrupt your usual activities? (From the member's point of view.) K.4c		Yes No
Narrative		(Free text field)
Is the pain in one location or multiple sites? (Character of pain) K.4d		0. No pain 1. Localized - single site 2. Multiple sites
Narrative		(Free text field)

Do medications adequately control your pain? (From member's point of view) K.4e	0. Yes or no pain 1. Medications do not adequately control pain 2. Pain present, medication not taken
Narrative	(Free text field)
Mental Health Conditions	
Has your doctor told you that you have any of the following mental health conditions?	Depression Anxiety Bipolar Schizophrenia Alzheimer's Disease Dementia Psychosis
Narrative	(Free text field)
Have you recently suffered the loss of a loved one?	Yes No
Narrative	(Free text field)
PHQ2	
Over the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things?	Not at all - 0 Several days - 1 More than half the days - 2 Nearly every day - 3
*** Create New Event - Task** (Clicking on this will open a Task associated to your Comprehensive 3.0 Assessment with the note "Conduct PHQ-9 and task BH clinican for eval"; You will need to enter the SCO Clinical Consultant's information in "To" and select "Task Type" of Other, with the comment "Positive PHQ-2".)	
Over the past 2 weeks, how often have you been feeling down, depressed, or hopeless?	Not at all - 0 Several days - 1 More than half the days - 2 Nearly every day - 3
*** Create New Event - Task** (Clicking on this will open a Task associated to your Comprehensive 3.0 Assessment with the note "Conduct PHQ-9 and task BH clinican for eval"; You will need to enter the SCO Clinical Consultant's information in "To" and select "Task Type" of Other, with the comment "Positive PHQ-2".)	
*** Click here to create a PHQ-9 Assessment** - This is offered as an option, but should only be completed by a BH Clinician	

PHQ2 POC		
If PHQ-2 Score is calculated to be 3 or more	PHQ2 Score is greater than or equal to 3. Would you like to add "PHQ2 - Positive screen for depression" as a problem to the Member's Plan of Care?	Yes No
	Note: Refer to PCP and consider BH consult.	
Health Care Utilization		
In the past year, have you been admitted to a nursing home?		Yes No
Narrative		(Free text field)
If Yes	Have you lived in a nursing home at any time during the past 5 years? CC.7	0. No 1. Yes
	Narrative	(Free text field)
How many times have you visited an emergency room in the past 6 months? (Select one)		None 1 2 3 or more
Narrative		(Free text field)
How many times have you stayed overnight in the hospital in the past 6 months? (Select one)		None 1 2 or more
Narrative		(Free text field)
How long has it been since your last hospital stay? (Time since discharge from last inpatient setting) CC.4		0. No hospitalization within 1. Within last week 2. Within 8 to 14 days 3. Within 15 to 30 days 4. More than 30 days ago
Narrative		(Free text field)
How many times have you visited a doctor or other healthcare provider in the past 6 months?		None 1 to 3 4 to 6 6 or more
Narrative		(Free text field)
Do you currently see 3 or more doctors on a regular basis?		Yes No
Narrative		(Free text field)

Medications	
How many medications do you take on a regular basis (prescription and over the counter)?	None 1 to 3 4 to 6 7 or more
Narrative	(Free text field)
Do you take injectable insulin (May select one)	Yes No
Narrative	(Free text field)
Do you have any drug or other allergies?	Yes No
Narrative	(Free text field)
If yes, Additional Instructions *- Enter on Member File*	
Nutritional Info	
Do you have any special dietary needs?	Yes No
Narrative	(Free text field)
If yes, Additional Instructions *- Enter on Member File*	
Have you lost 10 lbs. or more in the past 6 months without trying to do so? (select one)	Yes No
Narrative	(Free text field)
What is your height? (Inches)	(Free text field)
What is your weight? (Pounds)	(Free text field)
BMI	(Auto-calculated with Height and Weight)
Is the BMI > 30?	Yes No
Is the BMI < 18.5?	Yes No
Cognition/Behavior	
Cognitive Skills - How well does the member make decisions about organizing the day (e.g., when to get up or have meals, which clothes to wear or activities to do)? B.2a	0. INDEPENDENT - Decisions consistent/reasonable/safe 1. MODIFIED INDEPENDENCE - Some difficulty in new situations only 2. MINIMALLY IMPAIRED - In specific situations, decisions become poor or unsafe and cues/supervision necessary at 3. MODERATELY IMPAIRED - Decisions consistently poor or unsafe, cues/supervision required at all time 4. SEVERELY IMPAIRED - Never/rarely made decisions
Narrative	(Free text field)

BEHAVIORAL SYMPTOMS - How often does the member experience the following behavioral symptoms? If experienced, how easy was it to alter the symptom when it occurred?	
Wandering (moved with no rational purpose, seemingly oblivious to needs or safety) E.3a	0. Did not occur in last 3 1. Occurred, easily altered 2. Occurred, not easily altered
Verbally abusing (threatened, screamed at, cursed at others) E.3b	0. Did not occur in last 3 1. Occurred, easily altered 2. Occurred, not easily altered
Physically abusive (hit, shoved, scratched, sexually abused others) E.3c	0. Did not occur in last 3 1. Occurred, easily altered 2. Occurred, not easily altered
Socially inappropriate/Disruptive (disruptive sounds, noisiness, screaming, self-abusive acts, sexual behaviors or disrobing in public) E.3d	0. Did not occur in last 3 1. Occurred, easily altered 2. Occurred, not easily altered
Resists care (resisted taking medications, ADL assistance, eating, or changes in position) E.3e	0. Did not occur in last 3 1. Occurred, easily altered 2. Occurred, not easily altered
Mini-Cog Assessment - *This section is optional*	
1) I'd like you to remember these three words: Banana, Sunrise, Chair	Pass Fail
Narrative	(Free text field)
Additional Instructions - * Note to Care Manager: Ask member to repeat the words to ensure the learning was correct Allow the member 3 tries, then go to the next item	

2) Ask member to draw the face of a clock. After numbers are on the face, ask member to draw hands on the clock to read 10 minutes after 11:00 (or 20 minutes after 8:00).	Pass Fail
Narrative	(Free text field)
Additional Instructions - * Note to Care Manager: Either a blank piece of paper or a preprinted circle (other side) may be used. A correct response is all numbers placed in approximately the correct positions AND the hands These two specific times are more sensitive than others. A clock should not be visible to the patient during this task. Refusal to draw a clock is scored abnormal. Move to next step if clock not complete within three minutes.	
3) Ask the patient to recall the three words from Step 1.	Pass Fail
Narrative	(Free text field)
Add Cognitive to POC - This section is optional	
1-2 recalled words + normal CDT: Negative for cognitive impairment	Yes No
1-2 recalled words + abnormal CDT: Positive for cognitive impairment	Yes No
0 recalled words: Positive for cognitive impairment "Refer to PCP and consider BH consult"	Yes No
Substance Use	
Do you use alcohol?	Yes No
Narrative	(Free text field)
Do you currently use any street drugs or take prescription medications that were not prescribed for you or take prescription medications in larger amounts than were prescribed?	Yes No
Narrative	(Free text field)
If Yes — If yes, what drugs or medications?	(Free text field)
CAGE-AID (Only if answered "Yes" to either question in Substance Use section)	
Have you felt the need to cut down on your drinking or drug use?	Yes No
Narrative	(Free text field)
Do you feel annoyed by people complaining about your drinking or drug use?	Yes No
Narrative	(Free text field)

Do you ever feel guilty about drinking or drug use?		Yes No
Narrative		(Free text field)
Do you ever drink an eye-opener or use drugs first thing in the morning to relieve shakes, steady your nerves, or to get rid of a hangover?		Yes No
Narrative		(Free text field)
CAGE Score POC - *If CAGE Score is greater than 2*		
Cage Score is greater than or equal to 2. Would you like to add to POC "Refer to PCP and consider BH consult"		Yes No
Counseling and Smoking		
Has member been referred for counseling?		Yes No
Narrative		(Free text field)
Have you ever smoked cigarettes or used other tobacco products?		Yes No
Narrative		(Free text field)
If Yes	Have you smoked/used any in the past 30 days?	Yes No
	Narrative	(Free text field)
	If Yes	On average, how many
		(Free text field)
		How long have you been
		(Free text field)
Preventive Care		
Have you had the flu shot within the past year?		Yes No Allergic Refused
Narrative		(Free text field)
Additional Instructions *- Care Manager Note: Update Member File with Preventive Care information.*		
If Yes	Enter Date	(Calendar drop down)
Have you ever had the pneumococcal vaccine?		Yes No Allergic Refused
Narrative		(Free text field)
Additional Instructions *- Care Manager Note: Update Member File with Preventive Care information.*		
If Yes	Enter Date	(Calendar drop down)

Have you had an eye exam within the past 2 years?		Yes No Refused
Narrative		(Free text field)
Additional Instructions *- Care Manager Note: Update Member File with Preventive Care information.*		
If Yes	Which eye exam did you receive?	Dilated eye exam Glaucoma screening
	Enter Date	(Calendar drop down)
	Narrative	(Free text field)
Have you had a hearing exam within the past 2 years?		Yes No Refused
Narrative		(Free text field)
Additional Instructions *- Care Manager Note: Update Member File with Preventive Care information.*		
Have you had a colorectal cancer screening?		Yes No Refused Not applicable
Narrative		(Free text field)
Additional Instructions *- Care Manager Note: Update Member File with Preventive Care information.*		
If Yes	Which colorectal cancer screening test did you receive? (Check all that apply)	Fecal Occult Blood Test Sigmoidoscopy Colonoscopy
	Enter Dates	(Free text field)
For Women: Have you had a breast cancer screening during the past year?		Yes No Refused Not applicable
Narrative		(Free text field)
Additional Instructions *- Care Manager Note: Update Member File with Preventive Care information.*		
If Yes	Which breast cancer screening test did you receive? (Check all that apply)	Mammogram Ultrasound
	Enter Dates	(Free text field)

Advanced Directives	
Do you have a health care proxy or a durable power of attorney for healthcare decisions?	Yes No I don't know
Narrative	(Free text field)
Additional Instructions *- Care Manager Note: Try to identify if the member has someone who can make healthcare decisions if they were to become unable.*	
What are your goals of care?	Longevity Function Comfort Member does not wish to answer
Narrative	(Free text field)
Have you spoken to your family or your doctor about your healthcare wishes? (Select one)	Yes No I don't know
Narrative	(Free text field)
Are there any family traditions related to illness, death, or dying that we should be aware of?	Yes No
Narrative	(Free text field)
Caregiver Status	
Caregiver Status (Select all that apply) G.2	a. A caregiver is unable to continue in caring activities - e.g., decline in the health of the caregiver makes it difficult to continue b. Primary caregiver is not satisfied with support received from family and friends (e.g., other children of client) c. Primary caregiver expresses feelings of distress, anger, or depression d. NONE OF THE ABOVE
Narrative	(Free text field)
Safety	
Has anybody hurt you?	Yes No
Narrative	(Free text field)
Additional Instructions *- Care Manager Note: If yes, Protective Services referral and/or Social Worker consult.*	
Are you afraid of anybody?	Yes No
Narrative	(Free text field)
Additional Instructions *- Care Manager Note: If yes, Protective Services referral and/or Social Worker consult.*	

If Yes to either of the previous two questions (Has anybody hurt you? or Are you afraid of anybody?)	Are you being abused by your partner or someone important to you?	Yes No
	Narrative	(Free text field)
	Additional Instructions *- Care Manager Note: If yes, Protective Services referral and/or Social Worker consult.*	
	Within the past 12 months, have you been hit, slapped, pushed, or otherwise hurt by someone?	Yes No
	Narrative	(Free text field)
	Additional Instructions *- Care Manager Note: If yes, Protective Services referral and/or Social Worker consult.*	

Please note: After Comprehensive Assessment is marked Complete, the system will suggest a Care Level for the member.