DAAS
09/1/2009

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES - DIVISION OF AGING AND ADULT SERVICES

MISSISSIPPI GETHELP CONSUMER INFORMATION FORM

Area Agency on Aging _____ Date _____

1. CLIENT IDENTIFICATION (Record Client's Answers)

_____ / _____ / _____
Prefix Client's Last Name First Name

_____ / _____ / _____
Middle Initial Suffix Client also known as/Nickname

Date of Birth* _____
Social Security Number _____
E-mail Address _____
☐ Homeless ☐ Requires Assistance in an Emergency
Case Manager _____
Family Members _____
Address of Client ☐ Unknown ☐ Home County: _____

_____ / _____ / MS / _____
Physical Address City State Zip Code

_____ / _____ / MS / _____
Mailing Address City State Zip Code

Directions to Client's Home _____

Phone (1) _____ Type _____
Phone (2) _____ Type _____
(Options, See Instructions)

2. ADDITIONAL CONTACT INFORMATION

Contact Type _____ / _____
(Options, See Instructions) Relationship to Client
Name (Last, First, M.I.) _____
Address _____ / _____ / _____ / _____
City State Zip
Phone (1) _____ Type _____
Phone (2) _____ Type _____
E-mail address _____
Physician Contact # _____
Physician's Name (Last, First, M.I.) _____

3. DEMOGRAPHICS

Gender* ☐ M - Male ☐ F - Female
Client less than 60 ☐ Spouse ☐ Meal Volunteer
☐ Disabled Lives in Elder housing ☐ Lives with Client
Race?* _____ *(Options, See Instructions)*
Ethnicity ?* ☐ Hispanic ☐ Non-Hispanic

4. IS THE CLIENT A MINORITY? ☐ Yes: Score = (3)

5. CLIENT'S PRIMARY LANGUAGE *(Options, See Instructions)*

☐ Needs Translation ☐ limited English ☐ English Fluent
☐ English Literate ☐ Illiterate

6. RELATIONSHIP STATUS ☐ Divorced ☐ Married

☐ Declined to State ☐ Separated ☐ Single/Never Married
☐ Widowed

7. EMPLOYMENT STATUS _____ *(Options, See Instructions)*

8. VETERAN STATUS ☐ Yes ☐ No

☐ Spouse of Veteran ☐ Child of Veteran

9. IS THE CLIENT'S ADDRESS RURAL? ☐ Yes: Score = (1)

(Options, See Instructions)

10. HOUSING TYPE ☐ Home/Own ☐ Home/Rent

☐ Other ☐ Apartment/Duplex
☐ Adult Care Residence/Personal Care/Assisted Living

11. LIVES WITH * ☐ Lives Alone ☐ Other Family

☐ With Spouse ☐ Other Non-relative

12. REFERRAL SOURCE _____ *(Options, See Instructions)*

13. SOURCES OF SUPPORT (LIST) _____ *(Options, See Instructions)*

14. PRIMARY TRANSPORTATION _____ *(Options, See Instructions)*

15. CLIENT'S MONTHLY INCOME $

16. INCOME BELOW THE NATIONAL POVERTY LEVEL?* ☐ Yes: Score = (3)

(Options, See Instructions)

17. SOCIAL SECURITY? ☐ No ☐ SS Retirement ☐ SS Disability

☐ Receives SSI ☐ Receives Private Pension

18. MEDICARE? # _____ Part A B C D

(Circle one)

19. MEDICAID? # _____

20. GUARDIAN INFORMATION ☐ Yes, Voluntary ☐ Yes Involuntary ☐ No

Name of Person/Organization _____
Guardian/Conservator Type _____
Durable Power of Attorney _____
(Options, See Instructions)

21. ACTIVITIES OF DAILY LIVING (ADL)

Assessment Date: _____

BATHING
☐ 0 - Independent
☐ 1 - Supervision
☐ 2 - Require Assistance Sometimes
☐ 3 - Mostly Dependent
☐ 4 - Totally Dependent
☐ 5 - Activity Does Not Occur

DRESSING
☐ 0 - Independent
☐ 1 - Supervision
☐ 2 - Limited Assistance
☐ 3 - Extensive Assistance
☐ 4 - Totally Dependent
☐ 5 - Activity Does Not Occur

TOILET USE
☐ 0 - Independent
☐ 1 - Supervision
☐ 2 - Sometimes Dependent
☐ 3 - Mostly Dependent
☐ 4 - Totally Dependent
☐ 5 - Activity Does Not Occur

TRANSFER MOBILITY
☐ 0 - Independent
☐ 1 - Supervision
☐ 2 - Minimal Assistance Required
☐ 3 - Mostly Dependent
☐ 4 - Totally Dependent
☐ 5 - Activity Does Not Occur

EATING
☐ 0 - Independent
☐ 1 - Supervision
☐ 2 - Sometimes Dependent
☐ 3 - Mostly Dependent
☐ 4 - Totally Dependent
☐ 5 - Activity Does Not Occur

WALKING IN HOME
☐ 0 - Independent
☐ 1 - Supervision
☐ 2 - Limited Assistance
☐ 3 - Extensive Assistance
☐ 4 - Totally Dependent
☐ 5 - Activity Does Not Occur

PLEASE LIST OTHER OBSERVATIONS OF ACTIVITIES OF DAILY LIVING

Total (ADL) Score

22. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

During the past seven days, and considering all episodes, how would you rate the Client's ability to perform the following:

MEAL PREPARATION
☐ 0 - Independent
☐ 1 - Sometimes Dependent
☐ 2 - Mostly Dependent
☐ 3 - Totally Dependent
☐ 4 - Activity Does Not Occur

MANAGING MEDICINES
☐ 0 - Independent
☐ 1 - Needs Reminders
☐ 2 - Somewhat Dependent
☐ 3 - Totally Dependent
☐ 4 - Activity Does Not Occur

MANAGING MONEY
☐ 0 - Completely Independent
☐ 1 - Needs Assistance Sometimes
☐ 2 - Needs Assistance Most of the Time
☐ 3 - Completely Dependent
☐ 4 - Activity Does Not Occur

HEAVY HOUSEWORK
☐ 0 - Completely Independent
☐ 1 - Needs Assistance Sometimes
☐ 2 - Needs Assistance Most of the Time
☐ 3 - Unable to perform Task
☐ 4 - Activity Does Not Occur

LIGHT HOUSEWORK
☐ 0 - Independent
☐ 1 - Needs Assistance Sometimes
☐ 2 - Needs Assistance Most of the Time
☐ 3 - Unable to perform Task
☐ 4 - Activity Does Not Occur

SHOPPING
☐ 0 - Independent
☐ 1 - Somewhat Dependent
☐ 2 - Mostly Dependent
☐ 3 - Totally Dependent
☐ 4 - Activity Does Not Occur

TRANSPORTATION
☐ 0 - Independent
☐ 1 - Somewhat Dependent
☐ 2 - Mostly Dependent
☐ 3 - Totally Dependent
☐ 4 - Activity Does Not Occur

TELEPHONE
☐ 0 - Independent
☐ 1 - Needs Verbal Assistance
☐ 2 - Needs Some Human Help
☐ 3 - Needs a lot of Human Help
☐ 4 - Cannot Perform Function at all w/o Help

Comments _____

Total (IADL) Score

23. NUTRITION RISK ASSESSMENT

The Score for each Yes answer is in parentheses. Total YES answers only and assign a NUTRITION RISK SCORE based on the scoring scale below.

1. Has the Client made any changes in lifelong eating habits because of health problems?	☐ Unknown	☐ No	☐ Yes (1)
2. Does the Client eat fewer than 2 meals per day?	☐ Unknown	☐ No	☐ Yes (3)
3. Does the Client eat fewer than 5 servings of fruits or vegetables every day?	☐ Unknown	☐ No	☐ Yes (1)
4. Does the Client eat fewer than 2 servings of dairy products every day (Such as milk, yogurt, or cheese)?	☐ Unknown	☐ No	☐ Yes (1)
5. Does the Client sometimes not have enough money to buy food?	☐ Unknown	☐ No	☐ Yes (4)
6. Does the client have trouble eating well due to problems with chewing/swallowing?	☐ Unknown	☐ No	☐ Yes (2)
7. Does the Client eat alone most of the time?	☐ Unknown	☐ No	☐ Yes (1)
8. Without wanting to, has the Client lost or gained 10 pounds in the past 6 months?	☐ Unknown	☐ No	☐ Yes (2)
9. Does the Client need help to shop, cook and/or feed themselves (or get someone to do it for them)?	☐ Unknown	☐ No	☐ Yes (2)
10. Does the Client have 3 or more drinks of beer, liquor or wine almost every day?	☐ Unknown	☐ No	☐ Yes (2)
11. Does the Client take 3 or more different prescribed or over the counter drugs per day?	☐ Unknown	☐ No	☐ Yes (1)

ADDITIONAL COMMENTS: _____ TOTALS _____

SCORE 0 - 5: LOW (SCORE = 0) | SCORE 6 - 20: HIGH RISK (SCORE = 6)

NUTRITION RISK SCORE: ☐

24. SERVICES REQUESTED

SERVICE _____ Start Date:	SERVICE _____ Start Date:	SERVICE _____ Start Date:	NOTES:
SERVICE _____ Start Date:	SERVICE _____ Start Date:	SERVICE _____ Start Date:	
SERVICE _____ Start Date:	SERVICE _____ Start Date:	SERVICE _____ Start Date:	

I certify that all the information I have given on this form is true and complete to the best of my knowledge. In applying for services through the Division of Aging and Adult Services and its providers, I give my permission for the information on this form to be shared with appropriate providers.

Signature or Mark of Consumer/Client _____ Date _____

I certify that information concerning this client will not be disclosed except with the written consent of the client.

Signature of Person Completing Form _____ Date _____

Service Denied Date: _____ (Date Entered into Mississippi Gethelp) _____

25. CONSUMER SCORE:

Circle the score from questions 4, 9, 16 and 23 add ADL's and IADLs scores for Total Consumer Score

Minority Status 0 or 3 Rural Status 0 or 1 Income Status 0 or 3

TOTAL CONSUMER SCORE _____

ADL Score _____ IADL Score _____ Nutrition Risk 0 or 6

FAMILY CAREGIVER SUPPORT CAREGIVER ASSESSMENT [FILL IN ONLY IF CLIENT IS A CAREGIVER] (Record Caregiver answers)

Type of Assessment ☐ Initial ☐ Reassessment Assessment Date: _____

Where does the Caregiver live ☐ With Care recipient ☐ Separate residence, close proximity ☐ Separate residence, over 1 hour away?

Is the Caregivers providing care to disabled ☐ Yes ☐ No

Is the caregiver's Care Recipient under age 19? ☐ Yes ☐ No Care Recipient's Name _____

Does the Caregiver provide assistance with the following services to the recipient?

BATHING	DRESSING	TOILET USE	TRANSFER MOBILITY	EATING	WALKING IN THE HOME
☐ (0) Independent	☐ (0) Independent	☐ (0) Independent	☐ (0) Independent	☐ (0) Independent	☐ (0) Independent
☐ (1) Sometimes	☐ (1) Sometimes	☐ (1) Sometimes	☐ (1) Sometimes	☐ (1) Sometimes	☐ (1) Sometimes
☐ (2) most of the time	☐ (2) most of the time	☐ (2) most of the time	☐ (2) most of the time	☐ (2) most of the time	☐ (2) most of the time
☐ (3) All the time	☐ (3) All the time	☐ (3) All the time	☐ (3) All the time	☐ (3) All the time	☐ (3) All the time

MEAL PREPARATION	MANAGING MONEY	HOUSEWORK	SHOPPING	TRANSPORTATION	TELEPHONE
☐ (0) Independent	☐ (0) Independent	☐ (0) Independent	☐ (0) Independent	☐ (0) Independent	☐ (0) Independent
☐ (1) Sometimes	☐ (1) Sometimes	☐ (1) Sometimes	☐ (1) Sometimes	☐ (1) Sometimes	☐ (1) Sometimes
☐ (2) most of the time	☐ (2) most of the time	☐ (2) most of the time	☐ (2) most of the time	☐ (2) most of the time	☐ (2) most of the time
☐ (3) All the time	☐ (3) All the time	☐ (3) All the time	☐ (3) All the time	☐ (3) All the time	☐ (3) All the time

MANAGING MEDICINE ☐ (0) Independent ☐ (1) Sometimes ☐ (2) most of the time ☐ (3) All the time SCORE ☐

As a result of Caregiving, has the Caregiver had any of the following challenges?

Social life has suffered	☐ (3) Yes	☐ (0) No	Feels angry toward client	☐ (4) Yes	☐ (0) No
Not enough money	☐ (3) Yes	☐ (0) No	Health has suffered from caregiving...	☐ (4) Yes	☐ (0) No
Not enough privacy	☐ (4) Yes	☐ (0) No	Caregiving has affected relationship with with other family members negatively.....	☐ (4) Yes	☐ (0) No
Stressed from caregiving and meeting other responsibilities	☐ (4) Yes	☐ (0) No			
Feels burdened	☐ (4) Yes	☐ (0) No			

SCORE ☐

ADD THE TWO SCORES TO GET TOTAL NATIONAL FAMILY CAREGIVER PROGRAM SCORE ☐