DAAS
09/01/2009

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

MISSISSIPPI CONSUMER INFORMATION FORM

Area Agency on Aging ______________________ Date ______________________

1. CLIENT IDENTIFICATION

Prefix Client's Lastname First Name

Middle Initial Suffix Client also known as/Nickname

Date of Birth* ______________________

Social Security Number ______________________

Email Address ______________________

☐Homeless ☐Requires Assistance in an Emergency

Case Manager ______________________

Family Members ______________________

Address of Client ☐Unknown ☐Home County ______________________

Physical Address City State Zipcode

Mailing Address City State Zipcode

Directions to Client's Home ______________________

Phone (1) ______________ Type ______________

Phone (2) ______________ Type ______________

(Options, See Instructions)

2. ADDITIONAL CONTACT INFORMATION

Contact Type ______________________

Relationship to Client

(Options, See Instructions)

Name (Last, First, M.I.) ______________________

Address ______________________

City State Zip

Phone (1) ______________ Type ______________

Phone (2) ______________ Type ______________

Email 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 ☐Live with Client

Race?* ______________________

Ethnicity?* ☐Hispanic ☐Non-Hispanic

4. IS THE CLIENT MINORITY?

☐Yes: Score = (3)

5. CLIENT PRIMARY LANGUAGE

(Options, See Instructions)

☐Need Translation ☐Limited English ☐English Fluent

☐English Literate ☐Illiterate

6. RELATIONSHIP STATUS

☐Divorced ☐Married

☐Decline 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 ADDRESS RURAL?

☐Yes Score: (3)

(Options, See Instructions)

10. HOUSING TYPE

☐Home/Own ☐Home/Rent

☐Other ☐Apartment/Duplex

☐Adult Care Residence/Personal Care/Assisted Living

11. LIVE WITH*

☐Lives Alone ☐Other Family

☐With Spouse ☐Other Non-relative

12. REFERRAL SOURCE

(Options, See Instructions)

13. SOURCE 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

☐SS Retirement ☐SS Disability

☐Receive SSI ☐ Receives Private Pension

18. MEDICARE

PART

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. ASSESSMENT OF DAILY LIVING

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 - Need Assistance Sometimes
- ☐ 2 - Need Assistance Most of the Time
- ☐ 3 - Completely Dependent
- ☐ 4 - Activity Does Not Occur

HEAVY HOUSEWORK
- ☐ 0 - Independent
- ☐ 1 - Supervision
- ☐ 2 - Minimal Assistance Required
- ☐ 3 - Mostly Dependent
- ☐ 4 - Activity Does Not Occur

LIGHT HOUSEWORK
- ☐ 0 - Independent
- ☐ 1 - Need Assistance Sometimes
- ☐ 2 - Need 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 of each Yes is in the parenthesis. Total YES answers only and assign a NUTRITION RISK SCORE based on scoring below

Question			
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 (Such as milk, yogurt, or cheese) every day?	☐ 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)
12. Does the Client have diabetes?	☐ Unknown	☐ No	☐ Yes (6)

ADDITIONAL COMMENTS: ______________________ **TOTALS:** ________

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

NUTRITION RISK SCORE: ________

24. SERVICE REQUESTED

			NOTES:
	SERVICE Start Date:	SERVICE Start Date:	
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

______________________ Signature or Mark of Consumer/Client ______________________ Date

Service Start Date: ______________________ Service Provider ______________________

End Date: ______________________ Contact Person ______________________

Service Denied Date: ______________________ (Date Entered into Mississippi Gethelp) ________

25. CONSUMER SCORE

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

Minority Status   Rural Status   Income Status

TOTAL CONSUMER SCORE

ADL Score   IADL Score   Nutrition Risk

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

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 Caregiver providing care to disabled? ☐ Yes ☐ No

Care Recipient's Name ______________________

Is the Caregiver's Care Recipient under age 19? ☐ Yes ☐ No

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) Most of 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**	**HOUSE WORK**	**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 other family members negatively….	☐ (4) Yes	☐ (0) No
Stressed for caregiving and meeting other responsibilities	☐ (4) Yes	☐ (0) No			
Feels burdened……………….	☐ (4) Yes	☐ (0) No			

SCORE: ________

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