

ADRL Intake

1. Caller Information

1.A. Caller Details

1-A-1. What is the date of the assessment?

____/____/____

1-A-2. Name of the individual conducting this assessment?

1-A-3. Referring individual's full name?

1-A-4. Referral's relationship to the individual:

1-A-5. Referral source or contact's telephone number

1-A-6. Referral source's e-mail address

1-A-7. Does the individual know a referral is being made on their behalf?

- No
 Yes
 Don't Know

1-A-8. Is the referral source willing to contact the individual being referred if previous question is answered no, or don't know?

- No
 Yes

1-A-9. Reason for the call?

1-A-10. Does the individual being referred want services?

- No
 Yes

Don't Know

1-A-11. If yes, what services?

2. Consumer Demographics

2.A. Consumer Details

2-A-1. What is the individual's first name?

2-A-2. What is the individual's middle initial?

2-A-3. What is the individual's last name?

2-A-4. What is the individual's date of birth?

____/____/____

2-A-5. Enter the age of the individual in years

2-A-6. How does the individual identify themselves?

- Female
 Male
 Other
 Unknown

2-A-7. Individual's sex at birth?

- Female
 Male

2-A-8. What is the individual's ethnicity?

- Hispanic or Latino
 Not Hispanic or Latino
 Unknown

2-A-9. What is the individual's race?

- American Indian/Native Alaskan
 Asian
 Black/African American
 Hispanic
 Native Hawaiian/Other Pacific Islander
 White/Non-Hispanic
 Other
 White-Hispanic
 Unknown

2-A-10. Tribal Enrollment

2-A-11. Is the individual a veteran?

- No
- Yes
- Dependent - Spouse
- Pending
- Unknown

2-A-12. What is the individual's home phone number?

2-A-13. What is the individual's cell phone number?

2-A-14. Enter the individual's physical street address or post office box.

2-A-15. Enter the individual's residential city or town

2-A-16. What county does the individual reside in?

2-A-17. Enter the individual's state of residence?

2-A-18. Enter the individual's residential zip code

2-A-19. Enter the individual's mailing address or post office box.

2-A-20. Enter the individual's mailing city or town.

2-A-21. Enter the county of the individual's mailing address.

2-A-22. Enter the individual's mailing state.

2-A-23. Enter the individual's mailing ZIP code.

2-A-24. What is the individual's e-mail address?

2-A-25. Name of emergency contact other than spouse/partner to contact on your behalf.

2-A-26. Emergency contact's phone number?

2-A-27. Emergency contact relationship to individual being referred?

2-A-28. Select the individual's current marital status

- Divorced
- Domestic Partner or Significant Other
- Married
- Never Married
- Other
- Separated
- Single
- Widowed

2-A-29. What is the name of the individual's spouse/partner?

2-A-30. What is the individual's primary Language?

2-A-31. Interpreter Needed

- No
- Yes

2-A-32. Can the individual read?

- No
- Yes

2-A-33. Can the individual write?

- No
- Yes

3. Decision Making / Cognition

3.A. Guardian / POA

3-A-1. Please indicate the type of informal or formal decision-making authority (check all that apply).

- Legal guardian
- Power of attorney - healthcare
- Power attorney - financial
- Representative payee
- Family member
- Supportive DecisionMaking
- Other
- None
- Unclear

3-A-2. What is the name of the informal or formal decision maker?

3-A-3. Informal or formal decision maker's phone/cell number:

3-A-4. What is the address of the informal or formal decision maker?

3-A-5. Informal or formal decision maker's relationship to the individual?

3-A-6. Informal or formal decision maker's e-mail address:

3-A-7. If there is formal legal representative for decision-making, is documentation available to validate the authority?

- No
- Yes
- Not applicable

3-A-8. Does the individual's decision-maker (informal or formal) know a referral is being made on their behalf ?

- No

- Yes

3-A-9. Have you discussed the need for services with the individual's informal or formal decision-maker?

- No
- Yes

4. Housing

4.A. Housing

4-A-1. Current type of residence:

- Own home/ apartment
- Adult Foster Care
- Adult Residential Facility
- Assisted Living
- Basic Care
- Homeless Shelter
- Senior Living Apartment
- Skilled Nursing Facility
- Other

4-A-2. Is the individual currently a resident in a nursing home, basic care, or assisted living?

- Don't know
- No
- Refused
- Yes

4-A-3. What is the individual's date of admission (to skilled nursing facility / swing bed)?

4-A-4. Does the individual want to move?

- No
- Yes

4-A-5. Where would the individual like to move to?

4-A-6. Current Living Arrangements: (Check All That Apply)

- With Children/Grandchildren
- Lives alone
- With Adult Children
- Lives with Non-Relative(s)
- Lives with Relatives
- Lives with Spouse/Partner

4-A-7. What are safety factors found in the client's home?

- Aggressive Behaviors
- Alcohol/Substance Abuse
- Any Legal Concerns
- Condition of the Home
- Does Anyone Smoke in the Home
- Pets in the Home
- Suicidal/Homicidal
- Weapons in the Home
- Inaccessible exits
- Limited phone access
- Mental Health History
- Other
- None

- Public Health
- Other
- None

5-A-3. Informal Supports (Family/Friends)

5-A-4. Is the individual currently in the hospital or had any recent hospitalizations or emergency room visits within the last 3 months?

- No
- Yes

5-A-5. When/What for/Any referrals upon discharge

5. Disability / Diagnoses

5.A. Disability / Diagnoses

5-A-1. Disability/Medical Diagnosis (Expand on each condition in the notes).

- Any psychiatric diagnosis
- Arthritis
- Auto Immune Disease
- Cancer
- Cerebral Palsy
- Chronic Pain
- Dementia with behavioral disturbances
- Dementia without behavioral disturbances
- Diabetes
- Emphysema/COPD/Asthma
- Generalized Weakness (Age related)
- Heart condition
- HIV/AIDS
- Age Related Cognitive decline
- Multiple Sclerosis
- Osteoporosis
- Other neurological (Neuropathy etc.)
- Other significant illness
- Paralysis
- Parkinson's Disease
- Renal Disease
- Stroke/ neurological problems
- Traumatic Brain Injury
- Vertigo
- Visually Impaired

5-A-2. Formal Care Currently (Provider/Agency):

- Home Health
- Hospice
- Occupational Therapy
- Physical Therapy

6. Financial

6.A. Employment

6-A-1. Is the individual deemed disabled?

- No
- Yes
- Other/In-process

6-A-2. Is the individual currently employed?

- Retired
- No
- Full time
- Other
- Part time
- Participating in pre-employment activities / supports
- Seasonal work
- Seeking employment
- Sometimes
- Temporary jobs
- Unemployed
- Volunteer

6-A-3. What is the individual's desired employment status?

- No
- Yes
- Don't Know
- Not interested

6.B. Assets

6-B-1. Is the individual on Medicaid?

- No
- Yes
- Pending
- Don't Know

6-B-2. What is the individual's ND Medicaid number?

6-B-3. Does the individual have any assets? (money in the bank, IRA, CD's, annuities, burial funds, etc.)

- \$0 - \$24,999
- \$25,000 - \$50,000
- more than \$50,000

6-B-4. Is the individual receiving SSI?

- No
- Yes
- Don't Know
- Pending

6-B-5. List Income Sources (Individual & Spouse) & monthly amounts (i.e. wages, SS, SSI, pension/retirement, IRA, VA benefits, rental income, other sources (temp disability insurance, workers comp, royalties):
*Individual Indian Monies don't count toward income

6-B-6. List monthly medical deductions (i.e. healthcare premiums, out-of-pocket prescription costs, medical supplies, other medical expenses):

6-B-7. Approximate Medical Deductions per Month:

\$

Approximate Monthly Adjusted Income (Gross less Deductions)

6-B-8. Is the individual likely eligible for Medicaid based on income and assets?

- No
- Yes

6-B-9. Is the individual eligible for or on Medicare?

- No
- Yes
- Pending
- Don't Know

6-B-10. Individual's insurance status:

- LT Coverage
- None

- Medicaid Expansion
- Other
- Prescription Coverage
- Private
- Tricare/Champ V
- Unknown
- VA

6-A-11. Does the individual have other assistance?

- LIHEAP (Heating Assistance)
- Housing
- SNAP (Supplemental Nutrition Assistance Program)
- Other
- None/No

6-B-12. How long ago was the assistance application filled out?

7. Functional Assessment

7.A. ADL's - Impairment is 2 or 3

7-A-1. Is the individual able to bathe or shower on their own or do they need assistance?

- Completely Able
- Able with aides/difficulty
- Able with helper
- Unable

7-A-2. Is the individual able to cut, chew, swallow, drink, etc., independently or do they need assistance?

- Completely Able
- Able with aides/difficulty
- Able with helper
- Unable

7-A-3. Mobility Inside (How does the individual usually get around inside the home)?

- Completely Able
- Able with aides/difficulty
- Able with helper
- Unable

7-A-4. Transfer in/out of bed/chair (is the individual able to get in and out of the bed/chair independently or do they need assistance)?

- Completely Able
- Able with aides/difficulty
- Able with helper
- Unable

7-A-5. Dress/Undress (is the individual able to dress and undress independently or do they need assistance)?

- Completely Able
- Able with aides/difficulty
- Able with helper
- Unable

7-A-6. Toileting (is the individual able to independently get to the bathroom, get on/off toilet, flush, cleanse etc., or do they need assistance)?

- Completely Able
- Able with aides/difficulty
- Able with helper
- Unable

7-A-7. Continence (Does the individual have any bladder or bowel concerns)?

- Completely Able
- Able with aides/difficulty
- Able with helper
- Unable

Number of ADL Impairments

7.B. IADL's - Impairment is 1 or 2

7-B-1. Meal prep (can the individual prepare their own meal)?

- Without help
- With help
- Can't do at all

7-B-2. Telephone/Communication (can the individual use the telephone on their own, read, write, and comprehend verbal and written information on their own, or do they need assistance)?

- Without help
- With help
- Can't do at all

7-B-3. Laundry (can the individual sort, carry, load and unload, fold and put away clothes)?

- Without help
- With help
- Can't do at all

7-B-4. Medication (can the individual take medicine by themselves or do they need assistance)?

- Without help
- With help
- Can't do at all

7-B-5. Shopping (can the individual shop for groceries and other essentials items or do they need assistance)?

- Without help
- With help
- Can't do at all

7-B-6. Mobility outside the home (can the individual move around outside to walk or by other means without assistance)?

- Without help
- With help
- Can't do at all

7-B-7. Transportation (what is the individual's ability to use transportation - get in and out of a vehicle and/or make arrangements)?

- Without help
- With help
- Can't do at all

7-B-8. Housework (can the individual do routine housework, or do they need assistance)?

- Without help
- With help
- Can't do at all

7-B-9. Money management (can the individual manage their own finances, budgeting, bill paying, or do they need assistance)?

- Without help
- With help
- Can't do at all

Number of IADL Impairments

Number of IADL Weights

8. Outcomes

8.A. Outcomes

8-A-2. Outcome(s) of Call

- Emailed/Mailed information and assistance materials
- Provided I & R only over the phone
- Requires I&A follow-up contact
- Referred to HCBS
- Referred to CSC
- Refused
- Other

8-A-2. If Other, please explain:

8-A-3. HCBS Services the individual would like to receive:

8-A-4. Is there any additional information we need to know?
