Iowa Department on Aging
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www.iowaaging.gov

*** Date (MM/DD/YYYY):** _____

Case Management Assessment Form

Prior to completing this form, please ensure the Aging & Disability Network Consumer Intake Form is complete and current. All fields on this form marked with an asterisk (*) are required fields; the form will not be considered complete unless all required fields are marked.

SECTION 1: GENERAL INFORMATION

*** Consumer name (as it appears on the Aging & Disability Network Consumer Intake Form):**

FIRST NAME	MI	LAST NAME

*** Type of assessment:** ☐ INITIAL ASSESSMENT ☐ REASSESSMENT

*** Name of person completing this assessment:**

FIRST NAME	LAST NAME

AGENCY/ORGANIZATION	PHONE NUMBER

Name and relationship to consumer of others present at this assessment:

NAME	RELATIONSHIP TO CONSUMER
NAME	RELATIONSHIP TO CONSUMER
NAME	RELATIONSHIP TO CONSUMER

Release of Information: ☐ YES ☐ NO

*** Date of consumer's next assessment (MM/DD/YYYY):**

*** Assessment referral source (select one):**

- ☐ AREA AGENCY ON AGING
- ☐ COUNTY SOCIAL SERVICES WORKER
- ☐ CHILD
- ☐ DEPARTMENT OF HUMAN SERVICES
- ☐ FAMILY MEMBER (NOT PARENT OR CHILD)
- ☐ FRIEND
- ☐ GERIATRIC CARE MANAGER
- ☐ GUARDIAN
- ☐ HEALTH PROFESSIONAL
- ☐ HEALTH SERVICES DEPARTMENT
- ☐ HOME CARE PROVIDER
- ☐ HOME HEALTH AGENCY
- ☐ HOSPITAL
- ☐ HOSPITAL DISCHARGE PLANNER
- ☐ HOUSING MANAGER
- ☐ ICF/IDD FACILITY
- ☐ INTAKE SPECIALIST
- ☐ INTERMEDIATE CARE FACILITY DISCHARGE PLANNER
- ☐ LAW ENFORCEMENT
- ☐ LEAD AGENCY
- ☐ LINKAGES PROGRAM
- ☐ PARENT
- ☐ OTHER
- ☐ UNKNOWN

Interpreter needed: ☐ YES ☐ NO ☐ UNKNOWN

Reason for interpreter: ☐ PRIMARY LANGUAGE ☐ PRIMARY LANGUAGE AT HOME ☐ SIGN LANGUAGE

Interpreter's availability: ☐ ALWAYS ☐ DAYTIME ☐ NIGHTS ☐ SOMETIMES ☐ WEEKENDS

SECTION 2: LIVING ARRANGEMENT

* **Current living arrangement:**	☐ LIVES ALONE	☐ WITH SPOUSE/PARTNER	☐ WITH SPOUSE & CHILD
	☐ WITH CHILD/CHILDREN	☐ WITH OTHERS	☐ INFORMATION UNAVAILABLE
* **Consumer other living arrangement:**	☐ ALONE	☐ SPOUSE	☐ NURSING FACILITY
	☐ CHILD	☐ HOMELESS	☐ N/A
	☐ FAMILY MEMBER	☐ ASSISTED LIVING	☐ OTHER
	☐ FRIEND	☐ ICF/IDD FACILITY	
	☐ ROOMMATE	☐ MENTAL HEALTH FACILITY	
* **Total number in household, including consumer:**			

SECTION 3: DENTAL STATUS

* **Consumer has a dentist:**	☐ YES	☐ NO	
* **Last time consumer saw a dentist:**	☐ MORE THAN 1 YEAR AGO	☐ WITHIN THE PAST YEAR	☐ WITHIN THE PAST 6 MONTHS
* **If the consumer has not seen a dentist, does he/she need assistance locating one?**	☐ YES	☐ NO	
* **Consumer has dental insurance:**	☐ YES	☐ NO	

SECTION 4: POWER OF ATTORNEY *(Data in this section not collected by the IDA)*

Consumer has a power of attorney:	☐ YES	☐ NO	☐ DON'T KNOW
Type of power of attorney:	☐ GENERAL	☐ MEDICAL	☐ GENERAL & MEDICAL
	☐ LIMITED		

Power of attorney information:

FIRST NAME	LAST NAME
PHONE NUMBER	POWER OF ATTORNEY EFFECTIVE DATE (MM/DD/YYYY)

SECTION 5: CONSUMER RESOURCES

Employment

Consumer currently employed: ☐ YES ☐ NO

Employment status:

☐ YES, FULL-TIME	☐ VOLUNTEER
☐ YES, PART-TIME	☐ DISABLED
☐ YES, FULL-/PART-TIME NOT SPECIFIED	☐ RETIRED
☐ SOMETIMES	☐ UNEMPLOYED
☐ TEMPORARY JOBS	☐ DON'T KNOW
☐ SEEKING EMPLOYMENT	☐ NO RESPONSE
☐ PARTICIPATING IN PRE-EMPLOYMENT ACTIVITIES/SUPPORTS	☐ N/A

Employment (cont.)

Consumer's desired employment status:

- ☐ FULL-TIME
- ☐ PART-TIME
- ☐ TEMPORARY JOBS
- ☐ INTERESTED IN A NEW JOB
- ☐ INTERESTED IN WORKING, BUT NEEDS EMPLOYMENT SUPPORTS
- ☐ NOT INTERESTED
- ☐ N/A DUE TO CHILD'S AGE

Financial Resources

*** Current payment source(s) for services:**

- ☐ COMMUNITY OPTIONS/COMMUNITY INTEGRATION PROGRAM
- ☐ LONG-TERM CARE INSURANCE
- ☐ LOW-INCOME SUBSIDY
- ☐ MEDICAID
- ☐ MEDICALLY NEEDY
- ☐ MEDICARE ADVANTAGE
- ☐ MEDICARE PART A
- ☐ MEDICARE PART B
- ☐ MEDICARE PART D
- ☐ MEDICARE SAVINGS PROGRAM
- ☐ OTHER GOVERNMENT (e.g., CHAMPUS, VA, etc.)
- ☐ PRIVATE INSURANCE
- ☐ PRIVATE PAY
- ☐ QMB-LIMITED MEDICAID
- ☐ SELF-PAY
- ☐ SLMB-LIMITED MEDICAID
- ☐ SSI-RELATED MEDICAID
- ☐ WORKER'S COMPENSATION

*** Income source(s):**

- ☐ ANNUITIES
- ☐ DIVIDENDS/INTEREST
- ☐ MILITARY RETIREMENT
- ☐ OTHER NON-WORK INCOME
- ☐ PENSION/RETIREMENT BENEFITS
- ☐ PUBLIC ASSISTANCE/CASH ASSISTANCE
- ☐ PUBLIC ASSISTANCE-TANF
- ☐ RAILROAD RETIREMENT BENEFITS (RRB)
- ☐ SENIOR COMMUNITY SERVICE EMPLOYMENT
- ☐ SOCIAL SECURITY (SS)
- ☐ SOCIAL SECURITY DISABILITY INCOME (SSDI)
- ☐ SUPPLEMENTAL SOCIAL SECURITY (SSI)
- ☐ UNEMPLOYMENT BENEFITS
- ☐ VETERANS BENEFITS
- ☐ WORK INCOME
- ☐ WORKER'S COMPENSATION

Self-declared assets and resources:

CONSUMER HAS STOCK/BONDS/CDS? ☐ YES ☐ NO		MONTHLY INCOME FROM STOCK/BONDS/CDS $	
CONSUMER HAS INSURANCE SETTLEMENTS? ☐ YES ☐ NO		MONTHLY INCOME FROM INSURANCE SETTLEMENTS $	
CONSUMER HAS SAVINGS ACCOUNTS? ☐ YES ☐ NO		TOTAL BALANCE OF SAVINGS ACCOUNTS $	
CONSUMER HAS CHECKING ACCOUNTS? ☐ YES ☐ NO		TOTAL BALANCE OF CHECKING ACCOUNTS $	
CONSUMER HAS IRA/PENSION ACCOUNTS? ☐ YES ☐ NO		MONTHLY INCOME FROM IRA/PENSION ACCOUNTS $	
CONSUMER HAS VETERANS BENEFITS? ☐ YES ☐ NO		MONTHLY INCOME FROM VETERANS BENEFITS $	
CONSUMER HAS SOCIAL SECURITY/SSDI/SSI BENEFITS? ☐ YES ☐ NO		MONTHLY INCOME FROM SOCIAL SECURITY/SSDI/SSI BENEFITS $	
CONSUMER RECEIVES MONTHLY INCOME FROM FARM RENTAL? ☐ YES ☐ NO	FARM PROPERTY VALUE $	MONTHLY FARM RENTAL INCOME $	
CONSUMER HAS ANNUITY INCOME? ☐ YES ☐ NO		MONTHLY INCOME FROM ANNUITIES $	

SECTION 6: PHYSICIANS/HOSPITALIZATIONS *(Data in this section not collected by the IDA unless in aggregate form)*

Physicians

Consumer has a primary care physician: ☐ YES ☐ NO

Primary care physician information:

FIRST NAME	LAST NAME

SPECIALTY

ADDRESS	CITY, STATE ZIP

PHONE NUMBER	EMAIL ADDRESS

Reason for last visit to primary care physician:

Primary care physician follow-up date (MM/DD/YYYY):

Consumer has seen other physicians/specialists in the past year (outside of a hospital or nursing facility setting): ☐ YES ☐ NO

Specialist/other physician information:

FIRST NAME	LAST NAME

PHONE NUMBER	DATE OF LAST VISIT (MM/DD/YYYY)

Reason for last visit to specialist/other physician:

Hospitalizations

Consumer's primary hospital:

Phone number:

Time elapsed since consumer was last discharged from an in-patient setting:

- ☐ CURRENTLY IN HOSPITAL
- ☐ 1-7 DAYS (WITHIN THE PAST WEEK)
- ☐ 8-14 DAYS
- ☐ 15-30 DAYS
- ☐ MORE THAN 30 DAYS
- ☐ MORE THAN 90 DAYS
- ☐ MORE THAN 180 DAYS
- ☐ NO HOSPITALIZATION

Reason(s) for consumer's hospitalization:

- ☐ CARDIAC PROBLEMS
- ☐ CHEMOTHERAPY
- ☐ DEEP VEIN THROMBOSIS/PULMONARY EMBOLISM
- ☐ GI BLEEDING OR OBSTRUCTION
- ☐ HYPO/HYPERGLYCEMIA OR DIABETES
- ☐ IMPROPER MEDICATION
- ☐ INJURY CAUSED BY FALL/ACCIDENT
- ☐ IV CATHETER-RELATED INFECTION
- ☐ MYOCARDIAL INFARCTION/STROKE
- ☐ NAUSEA/DEHYDRATION/MALNUTRITION/CONSTIPATION
- ☐ PSYCHOTIC EPISODE
- ☐ RESPIRATORY PROBLEMS
- ☐ SCHEDULED SURGICAL PROCEDURE
- ☐ UNCONTROLLED PAIN
- ☐ URINARY TRACT INFECTION
- ☐ WOUND CARE
- ☐ OTHER

Most recent discharge date (MM/DD/YYYY):

Mental Health

Ask the consumer the following questions to screen for depression:

1) ARE YOU BASICALLY SATISFIED WITH YOUR LIFE?	☐ YES = 0	☐ NO = 1
2) HAVE YOU DROPPED MANY OF YOUR ACTIVITIES AND INTERESTS?	☐ YES = 1	☐ NO = 0
3) DO YOU FEEL THAT YOUR LIFE IS EMPTY?	☐ YES = 1	☐ NO = 0
4) DO YOU OFTEN FEEL BORED?	☐ YES = 1	☐ NO = 0
5) ARE YOU IN GOOD SPIRITS MOST OF THE TIME?	☐ YES = 0	☐ NO = 1
6) ARE YOU AFRAID SOMETHING BAD IS GOING TO HAPPEN TO YOU?	☐ YES = 1	☐ NO = 0
7) DO YOU FEEL HAPPY MOST OF THE TIME?	☐ YES = 0	☐ NO = 1
8) DO YOU OFTEN FEEL HELPLESS?	☐ YES = 1	☐ NO = 0
9) DO YOU PREFER TO STAY AT HOME RATHER THAN GOING OUT AND DOING NEW THINGS?	☐ YES = 1	☐ NO = 0
10) DO YOU FEEL YOU HAVE MORE PROBLEMS WITH MEMORY THAN MOST?	☐ YES = 1	☐ NO = 0
11) DO YOU THINK IT IS WONDERFUL TO BE ALIVE NOW?	☐ YES = 0	☐ NO = 1
12) DO YOU FEEL PRETTY WORTHLESS THE WAY YOU ARE NOW?	☐ YES = 1	☐ NO = 0
13) DO YOU FEEL FULL OF ENERGY?	☐ YES = 0	☐ NO = 1
14) DO YOU FEEL THAT YOUR SITUATION IS HOPELESS?	☐ YES = 1	☐ NO = 0
15) DO YOU THINK MOST PEOPLE ARE BETTER OFF THAN YOU ARE?	☐ YES = 1	☐ NO = 0

*** Calculate the score (add total number of points from Yes/No columns above):**

0-5 = NO OR FEW SYMPTOMS OF DEPRESSION
6-10 = MILD TO MODERATE SYMPTOMS OF DEPRESSION
11-15 = SEVERE DEPRESSION SYMPTOMS

If the consumer scores 6 or above, ask the following questions:

1) OVER THE LAST TWO WEEKS, HAVE YOU HAD THOUGHTS THAT YOU WOULD BE BETTER OFF DEAD OR THAT YOU WANT TO HURT YOURSELF IN SOME WAY?	☐ YES	☐ NO
2) DO YOU FEEL THESE THOUGHTS ARE A PROBLEM FOR YOU OR SOMETHING YOU MIGHT ACT ON?	☐ YES	☐ NO

If the consumer answers "yes" to either question, direct him/her to medical attention. If intent, plan and means are indicated, refer IMMEDIATELY and contact supervisor.

Mood/Emotional Function

Has the consumer been bothered by little interest or pleasure in doing things?

- ☐ YES, OFTEN
- ☐ YES, MOST OF THE TIME
- ☐ YES, SOME OF THE TIME
- ☐ RARELY
- ☐ NO, NEVER
- ☐ UNABLE TO ASSESS
- ☐ DECLINED TO DISCLOSE

*** Have the consumer's mood indicators become worse as compared to his/her last assessment?**

- ☐ YES
- ☐ NO
- ☐ THIS IS CONSUMER'S FIRST ASSESSMENT

SECTION 7: Services

*** Consumer is participating in the following service(s) or program(s):**

- ☐ ADULT DAY CARE
- ☐ ASSISTED TRANSPORTATION
- ☐ CASE MANAGEMENT
- ☐ CHORE
- ☐ CONGREGATE MEALS
- ☐ COUNSELING
- ☐ EVIDENCE-BASED HEALTH ACTIVITIES
- ☐ HEALTH PROMOTION & DISEASE PREVENTION
- ☐ HOME-DELIVERED MEALS
- ☐ HOMEMAKER
- ☐ INFORMATION & ASSISTANCE
- ☐ LEGAL ASSISTANCE
- ☐ MATERIAL AID
- ☐ NUTRITION COUNSELING
- ☐ NUTRITION EDUCATION
- ☐ OPTIONS COUNSELING
- ☐ OUTREACH
- ☐ PERSONAL CARE
- ☐ SELF-DIRECTED CARE
- ☐ TRAINING & EDUCATION
- ☐ TRANSPORTATION
- ☐ EAPA ASSESSMENT & INTERVENTION
- ☐ EAPA CONSULTATION
- ☐ EAPA TRAINING & EDUCATION
- ☐ CG/GO COUNSELING
- ☐ CG/GO HOME-DELIVERED MEALS
- ☐ CG/GO INFORMATION SERVICES
- ☐ CG/GO OPTIONS COUNSELING
- ☐ CG/GO RESPITE
- ☐ CG/GO SUPPLEMENTAL SERVICES
- ☐ MENTAL HEALTH OUTREACH
- ☐ HOME HEALTH AIDE
- ☐ NURSING
- ☐ OTHER

*** Are the services/programs meeting his/her needs?**

- ☐ YES
- ☐ NO
- ☐ SOMETIMES
- ☐ UNCLEAR RESPONSE

*** Do any of the following help the consumer with his/her care?**

- ☐ AAA PROVIDED
- ☐ CAREGIVER
- ☐ DAUGHTER
- ☐ FRIEND
- ☐ INDEPENDENT
- ☐ PARENT
- ☐ PRIVATE PAID HELP
- ☐ RESIDENTIAL HEALTH CARE
- ☐ SIBLING
- ☐ SON
- ☐ SPOUSE
- ☐ VOLUNTEER
- ☐ OTHER RELATIVE
- ☐ SERVICE NEEDS

*** Which service(s) or program(s) does the consumer need:**

- ☐ ADULT DAY CARE
- ☐ ASSISTED TRANSPORTATION
- ☐ CASE MANAGEMENT
- ☐ CHORE
- ☐ CONGREGATE MEALS
- ☐ EVIDENCE-BASED HEALTH ACTIVITIES
- ☐ HEALTH PROMOTION & DISEASE PREVENTION
- ☐ HOME-DELIVERED MEALS
- ☐ HOMEMAKER
- ☐ INFORMATION & ASSISTANCE
- ☐ LEGAL ASSISTANCE
- ☐ NUTRITION COUNSELING
- ☐ NUTRITION EDUCATION
- ☐ OPTIONS COUNSELING
- ☐ OUTREACH
- ☐ PERSONAL CARE
- ☐ SELF-DIRECTED CARE
- ☐ TRAINING & EDUCATION
- ☐ TRANSPORTATION
- ☐ CG/GO ACCESS ASSISTANCE
- ☐ CG/GO COUNSELING
- ☐ CG/GO HOME-DELIVERED MEALS
- ☐ CG/GO INFORMATION SERVICES
- ☐ CG/GO OPTIONS COUNSELING
- ☐ CG/GO RESPITE
- ☐ CG/GO SELF-DIRECTED CARE
- ☐ CDAC SERVICES
- ☐ MENTAL HEALTH OUTREACH
- ☐ HOME HEALTH AIDE
- ☐ NURSING
- ☐ OTHER
- ☐ NO SERVICES NEEDED AT THIS TIME