NORTH CENTRAL TEXAS COUNCIL OF GOVERNMENTS
AREA AGENCY ON AGING
Home By Choice Assessment
(Information for internal use only; protected information may not be shared without participants' consent)

Relocation Specialist:____ Section Q referral? ( ) Yes ( ) No

Referral source: ____Phone:_____________________________

Managed Care Organization (MCO): ____

MCO Service Coordinator: _______________________________________Phone: ____________________________

Does consumer have a diagnosis of intellectual/developmental disability? ( ) Yes ( ) No

If yes, local authority case manager: ________________________________Phone: ____________________________

PERSONAL DATA

Medicaid Number: ___________________ Date of Referral: _______________ Initial Contact Date: _____________

1. Name: ____ Maiden or Other:_________________________

2. Phone: ______________________________________ ( ) Consumer ( ) Other: ____________________________

3. SSN: __________/______/_______________ **4.** Date of Birth _____/____/____ Age: ______________________

5. Gender: ( ) Male ( ) Female **6.** Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widow

7. Languages spoken: ( ) English ( ) Spanish ( ) Other ____

8. Income: ( ) SS ( ) SSI ( ) SSDI ( ) Other ______________________ **9.** Eligibility: ( ) Medicaid ( ) Medicare

10. Primary diagnosis: ____

11. Other diagnoses: ____

12. Date of admission to nursing facility: ___/___/____ Previous NF admission: ( ) Y ( ) N Dates: _______________

13. Legal guardian:

a. ( ) Self ( ) Other – Name of guardian: ________________________________ Phone: _____________________

b. Type of guardianship granted by court: ( ) Guardian of the Person ( ) Guardian of the Estate

c. Power of Attorney: _______________________________________ Relationship: _________________________

14. Family/Friends/Advocates:

a. Name/Relationship: ____ Phone: ___________________________

Address: ____

Supportive of relocation? ( ) Yes ( ) No

b. Name/Relationship: ____ Phone: ___________________________

Address: ____

Supportive of relocation? ( ) Yes ( ) No

15. Is anyone telling you that you should stay at the nursing home? If so, why?

____

____

16. Primary Care Physician: ____ Phone: ___________________________

Supportive of relocation: ( ) Yes ( ) No

17. CRIMINAL HISTORY

a. Prior criminal convictions, by conviction and date: ____

b. Outcome of conviction (e.g., deferred adjudication): ____

c. Currently on parole? ( ) Yes ( ) No

If yes, parole officer's name and phone number: ____

d. Any restrictions imposed by court? ____

NURSING FACILITY INFORMATION

Name of nursing facility: ____

Address: ________________________________City: ____________________ ZIP: ___________ County: _____________

Contact/Title: ____ Phone: ___________________________

REASONS FOR ENTERING THE NURSING FACILITY (check all that apply)

A. ( ) Treatment of medical condition

Describe: ____

____

Additional treatment necessary before transition to community? ( ) Y ( ) N

Describe: ____

B. ( ) Health or personal care problems while in community

( ) Family/friends not able to provide sufficient personal care
( ) Shortage of good attendants
( ) High cost of paying attendants
( ) Lack of medical/nursing/therapy services
( ) High cost of medical/nursing/therapy services
( ) Frequent illness/hospitalization
( ) Unstable medical condition Describe: ____

Other: ____

Did you receive SPW or CLASS services before entering the nursing facility? ( ) Yes ( ) No

If yes, what agency provided those services? ____

Were you satisfied with that agency? ( ) Yes ( ) No

C. ( ) Barriers to returning home from hospital/rehabilitation facility

Name of hospital/rehab facility: ____

( ) Family/Friends not able to provide sufficient personal care
( ) Shortage of good attendants
( ) High cost of paying attendants
( ) Lack of medical/nursing/therapy services - Describe: ____
( ) High cost of medical/nursing/therapy services
( ) High cost of rent or bills
( ) Home in need of repairs/modifications – Describe: ____
( ) Need for adaptive aids or mobility devices
( ) Other ____________________________ Describe: ____

D. ( ) Difficulty in maintaining community residence

( ) Insufficient services to help maintain house or apartment
( ) Insufficient services to help with money management or decision-making
( ) Family/friends concerned about safety
( ) High cost of rent or bills
( ) Home in need of repairs/modifications
( ) Need for adaptive aids or mobility devices
( ) Other ___________________________ Describe ____

Consumer Comments (agree/disagree/explain): ____

____

Number of previous attempts to move out of nursing home: ____

Reasons move didn't work out: ____

Number of previous nursing home admissions: ____

Reasons for readmissions: ____

MEDICAL CONDITION AND PROFESSIONAL CARE NEEDS

1. Current health problems: ____

____

2. Medical symptoms (note all that are current, recent or recurring):

( ) Chest pain	( ) Constipation	( ) Cough	( ) Diarrhea
( ) Dizziness	( ) Fever	( ) Weakness	( ) Pain
( ) Joint pain	( ) Underweight	( ) Obesity	( ) Paralysis
( ) Shortness of breath	( ) Fainting	( ) Indigestion/vomiting	
( ) Other			

3. Mental Health:

( ) No problem	
( ) Hospitalization Dates:	( ) Treatment for substance abuse dates:
( ) Counseling Dates:	( ) Psychoactive medication type:

4. Cognitive/Behavior:

( ) No problem	
( ) Memory loss	( ) Difficulty organizing/planning/following through
( ) Physical aggression	( ) Social inappropriate behavior
( ) Wandering	( ) Self Abusiveness
( ) Verbal aggression	( ) Refusal to eat or take medication

5. Hearing Loss:

( ) None	( ) Mild	( ) Moderate	( ) Severe
( ) Hearing Aid	( ) Sign Language	( ) Difficulty understanding conversation	

6. Speech Impairment:

( ) None	( ) Mild	( ) Moderate	( ) Severe

7. Vision Loss:

( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Cannot read
( ) Contacts	( ) Magnifier	( ) Large print	( ) Glasses	( ) Reading Glasses

8. Continence:

( ) No problem	( ) Help with bladder	( ) Help with bowels	( ) Ostomy

9. Skin Condition:

( ) No problem	( ) Stasis ulcer (pressure sore)	( ) Currently treated	( ) Other:

10. Oral/Dental: ____

11. Movement or Motor Control:

( ) No problem	( ) Paralysis	( ) Problems with hand dexterity
( ) Balance (falling)	( ) Amputation	( ) Contractures

Consumer Comments (agree/disagree/explain): ____

____

FUNCTIONAL CONDITION AND PERSONAL CARE NEEDS

1. Personal care required at nursing facility

a. Transfer (To or from bed, wheelchair, etc.):

( ) No help	( ) Minor (one person)	( ) Full assistance (two persons)

b. Locomotion (Walking or using wheelchair, cane or other mobility appliance):

( ) No help	( ) Minor	( ) Full assistance

c. Mobility Appliance:

( ) None	( ) Wheelchair	( ) Brace/Prosthesis
( ) Cane, walker, crutch	( ) Manual life	( ) Mechanical lift

d. Eating/Preparing Food:

( ) No help	( ) Minor	( ) Full assistance	( ) I.V.
( ) Modified utensils	( ) Feeding tube	( ) Set up and/or positioning	
( ) Other/special diet:			

e. Toilet:

( ) No help	( ) Minor	( ) Full assistance

f. Medication:

( ) No help	( ) Assist/remind	( ) Full assistance

g. Personal Hygiene:

( ) No help	( ) Minor	( ) Full assistance

h. Therapies:

( ) Speech/language/audiology	( ) Psychological	( ) Occupational
( ) Physical	( ) Respiratory	( ) Radiation
( ) Chemotherapy	( ) Cognitive	( ) Dialysis
( ) Other		

2. Anticipated needs in community setting

Transfer:
Locomotion:
Mobility Appliance:
Eating:
Toilet:
Medication:
Personal Hygiene:
Therapies:

Consumer Comments (agree/disagree/explain): ____

____

HOUSING

1. Preferred living arrangement (1 = first choice, 2 = second choice)

( ) With relatives in their home	( ) Independent residence
( ) Foster care or alternate family placement	( ) Assisted living facility

2. Desired location (City/County): ____

3. Accessibility requirements (Check all that apply):

( ) Widened doorways	( ) No step entrance	( ) No stairs
( ) Bathroom handrails	( ) Roll-in shower	( ) Automatic door opener
( ) Other		

4. Require location within public transit service area? ( ) Yes ( ) No

Transit Agency: ____

5. If living arrangement has been identified:

( ) With relatives	Living with:
( ) Independent residence	Desired location:
( ) Foster care	Contact:
( ) Assisted living facility	Facility name:

Address:	City/State:	Zip:
Contact:	Phone:	

Type of residence:	( ) House	( ) Apartment	( ) Guest House
Status:	( ) Room Available	( ) Agreement	( ) Would pay rent
Roommate:	( ) Needed	( ) Available	( ) Will share rent
Condition:	( ) Modification needed	( ) Repair/renovation needed	

Consumer Comments (agree/disagree/explain): ____

____

6. Will consumer need a housing voucher in order to relocate? ( ) Yes ( ) No

7. If so, to which housing authority(ies) will application be made? _______________________________________

8. Anticipated Funding Source: ( ) TAS ( ) TLC ( ) Both

FINANCIAL – ANTICIPATED INCOME

1. Types of Income (List monthly amounts, if available):

( ) SSI $	( ) SSDI $	( ) SS Retirement $	( ) Employee Retirement $
( ) Other $	Describe:		

2. Type of Assistance:

	Needed	Available	Name
( ) Guardian	( )	( )	
( ) SSA Payee	( )	( )	
Describe:			

3. Type of Service:

	Needed	Available	Provider
( ) Bank Account	( )	( )	
( ) Bill Payer Service	( )	( )	
( ) Direct Deposit	( )	( )	
Describe:			

FAMILY SUPPORTS

Check all supports to be provided by family members:

( ) Guardianship	( ) SSA Payee	( ) Financial Management
( ) Transportation	( ) Personal Care Management	( ) Health Management
( ) Personal Care	( ) Home Maintenance	( ) Shopping
( ) Furniture	( ) Household Items	( ) Moving Assistance
Describe:		

TRANSPORTATION

1. Type:

	Available to Meet Anticipated Needs		
( ) Fixed route bus	( ) Some	( ) Most	( ) All
( ) Paratransit	( ) Some	( ) Most	( ) All
( ) Family members/friends	( ) Some	( ) Most	( ) All
( ) Taxi	( ) Some	( ) Most	( ) All
( ) Other:	( ) Some	( ) Most	( ) All

2. Assistance Needed (check all that apply):

( ) Training for fixed route buses	( ) Establishing eligibility for paratransit	( ) Scheduling paratransit	( ) Transferring in/out of vehicles
( ) Escort	( ) Locating medical transportation provider	( ) Locating non-medical transportation provider	( ) Orientation & mobility training

GOVERNMENT AND PRIVATE SUPPORTS

Type of Service Needed	Potential Providers
( ) Meal Delivery	
( ) Food Banks	
( ) Food Stamps	
( ) TANF/WIC	
( ) Medicaid Card	
( ) Grocery Delivery	
( ) Discount Phone Service	
( ) Utility Assistance	
( ) Clothing	
( ) Home Furnishings	
( ) Home Energy Assistance	
( ) Communications Equipment	
( ) Counseling/support groups	
( ) Family Counseling	
( ) Place of worship	
( ) Senior Center	
( ) Medical Alert System	
( ) IL/ADL skills training	
( ) Medical/personal care	
( ) Nursing Therapies	
( ) Recreation	

ASSISTIVE TECHNOLOGY

(Check all that apply)

Type	Available	Needed	Repair/Replace
Mobility Appliance:			
Manual Wheelchair	( )	( )	( )
Power Wheelchair	( )	( )	( )
Shower Chair	( )	( )	( )
Shower Bench	( )	( )	( )
Brace/Prosthesis	( )	( )	( )
Cane, walker, crutch	( )	( )	( )
Equipment for transfers	( )	( )	( )
Lift Chair	( )	( )	( )
Bed:			
Regular	( )	( )	( )
Semi-Automatic	( )	( )	( )
Fully Automatic	( )	( )	( )
Therapeutic Mattress	( )	( )	( )
Other:	( )	( )	( )
Eating Utensils:			
I.V. Supplies	( )	( )	( )
Modified Utensils	( )	( )	( )
Feeding Tube	( )	( )	( )
Other:	( )	( )	( )
Vision:			
Glasses	( )	( )	( )
Contact Lenses	( )	( )	( )
Other:	( )	( )	( )
Communication:			
Hearing Aid	( )	( )	( )
TTY Device	( )	( )	( )
Modified Phone	( )	( )	( )
Other:	( )	( )	( )
Cognitive/Memory:			
Planner/Organizer			
Programmable Watch			
Medication Minder			
Other:			
Medical:			
Medical alert bracelet/tags			
Describe:			
Medical supplies/equipment needed:			

Why do you wish to move to the community? ____

____

What are you willing to do to make the move successful? ____

____

COMPLEX SERVICE NEEDS/BARRIERS TO RELOCATION

( ) Resident in a nursing facility for six months or longer.

( ) Behavioral health Issues-mental health or substance abuse.

( ) Intellectual and/or developmental disabilities with other cognitive disabilities.

( ) Lack of community residence and/or affordable or accessible housing

( ) Other

SIGNATURE OF INDIVIDUAL ASSISTING WITH RELOCATION

Signature: ____ Date: _________________________

Title: ____ Phone: ________________________________

STATEMENT OF CONSUMER

( ) I participated in completing this "Inventory of Community Services and Support Needs."

( ) I choose to pursue opportunities to transition to a community living arrangement.
OR
( ) I choose NOT to pursue opportunities to transition to a community living arrangement.

Signature: ____ Date: _________________________
( ) Consumer ( ) Parent/Guardian ( ) Other Legal Representative

Print Name: ____ Phone: ________________________

Comments (Agree/Disagree/Explain): ____

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____

SIGNATURE PAGE (Optional)

Signature: ____ Date: _________________________

( ) Parent/Guardian ( ) Other Legal Representative ( ) Professional

Title: ____ Phone: _______________________________

Comments (Agree/Disagree/Explain): ____

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Signature: ____ Date: _________________________

( ) Parent/Guardian ( ) Other Legal Representative ( ) Professional

Title: ____ Phone: _______________________________

Comments (Agree/Disagree/Explain): ____

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