South Carolina Department on Aging

Consent to Participate

1. The purpose of this interview is to
   - Assist us in suggesting and providing services to you
   - Help us improve the services offered within your community and the state of South Carolina

2. The information you share with us is for the purpose of documenting and identifying needs for which you may qualify for assistance. This data will be maintained with the highest regard for your security. In addition, general information without names may be used for reporting and research to support senior services.

3. You have the option to decline to answer any of the questions that you are asked.

4. You may end the interview at any time.

Do I have your consent to collect and use your information to suggest and provide services to you personally and to improve the services available within the state? Yes ☐ ◦ No ☐

Signature _____

Date _____

Print Name _____

Client Program Assessment

Interviewer	Date

Introductory Information

First Name	M.	Last Name

Physical Address / Mailing (if different)	Apt

City	State	Zip	Phone: Home • Mobile • Work
			( ) -

Phone: Home • Mobile • Work	Phone: Home • Mobile • Work	Email
( ) -	( ) -	

Age	DOB mm - dd - yyyy	ID Verified	County	Urban • Rural (circle)
		☐		☐ ☐

Reason for: Visit ☐ Call ☐ (circle) Client: New ☐ • Current ☐ • Returning ☐ • Change in Status ☐ (circle)

Demographics

Gender
☐ Female ☐ Male ☐ Trans ☐ Declined

Hispanic, Latino, or Spanish origin (If yes, what ancestry?)
☐ No ☐ Yes _____ ☐ Declined

Marital Status
☐ Married (now) ☐ Never Married ☐ Widowed
☐ Divorced ☐ Separated ☐ Other
Name of Spouse: _____ ☐ Declined

Race
☐ White, Caucasian ☐ Black, African American
☐ American Indian / Alaskan ☐ Asian Indian
☐ Hawaiian / Pacific Islander ☐ Asian
☐ Other _____ ☐ Declined

Education
☐ No formal ☐ Some College (no degree)
☐ Grade 1 to 12 _____ ☐ Associate's degree
☐ HS Diploma ☐ Bachelor's degree
☐ GED ☐ Advanced degree _____

Military Service (US Armed Forces, Reserves, or Ntl Gd)
☐ Never served ☐ Spouse of Veteran
☐ Reserves/Nat Guard ☐ Widow(er) of Veteran
☐ Past Active Duty
☐ Declined

Languages Known

Does the client speak a language other than English at home? ☐ Yes _____ ☐ No

How well does the client speak English? ☐ Very well ☐ Well ☐ Not well ☐ Not at all

Social Relations

How many different church or social activities are you involved with? _____

How often do you attend these activities? Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐

How often do you use the Internet to connect with others? Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐

What programs (apps) do you use most?

Support and Assistance

Non-Emergency Support Contact	Relationship

Phone: Home • Mobile • Work	Phone: Home • Mobile • Work	Email

How close is this support person, in miles? _____

Notes:

Client Program Assessment

Client Name / ID	

Emergency Information

Type of Home (circle) ☐ Stationary ☐ Mobile

Emergency Contact	Relationship

Phone: Home • Mobile • Work	Phone: Home • Mobile • Work	Email

Will someone check on you during an emergency?	Will you need help during an emergency?	Are you on Oxygen?

Who will help you during an emergency?

Do you have a portable medical device that requires electricity?	Do you have medication that requires refrigeration?

Will you need transportation in the event of an evacuation? ☐ None ☐ Regular ☐ Lift Accessible ☐ Ambulance

	Nutritional Screening	Y / N	Pt	Score
1	Do you have any illness or condition that made you change the kind or amount of food you eat?			
2	Do you eat fewer than 2 meals a day?			
3	Do you eat a few (three or less) fruits or vegetables, or milk products?			
4	Do you have 3 or more drinks of beer, liquor, or wine almost every day?			
5	Do you have tooth or mouth problems that make it hard for you to eat?			
6	Do you sometimes not have enough money to buy the food you need?			
7	Do you eat alone most of the time?			
8	Do you take 3 or more different prescribed or over the counter drugs per day?			
9	Without wanting to, have you lost or gained 10 pounds within the last 6 months?			
10	Are you sometimes physically unable to shop, cook, or feed yourself?			
	Have you gone without eating, because of circumstances?			
	Do you have a three day supply of meals on hand?			

Caregiving

Are you the primary caregiver for anyone? Yes ☐ • No ☐ (If yes, please specify?)

Mobility

☐ Needs assistance to go outside ☐ Difficulty walking / climbing stairs ☐ Uses cane / walker / crutch

☐ Uses wheelchair occasionally ☐ Uses wheelchair all of the time ☐ In need of a ramp

Transportation	Drives themselves	Family / friend drives them	Requires someone else to drive	Requires transportation with assistant	Requires transportation with lift
Transportation needs	☐	☐	☐	☐	☐

Homebound

This client meets the criteria to be considered homebound. ☐ Yes ☐ No Bedridden?

Considerations for Client Visits

Pets in house? Type of pet? Dog • Cat • Other _____ Quantity ____

Visits to be conducted with two people? ☐ ☐

Special considerations:

Comments

Pilot Project Questions

Do you have a problem with pests in your home?

Do you have working smoke alarms in your home?

If not, would you like a local fire department official to follow-up to discuss home fire safety issues with you?

Client Program Assessment

Client Name / ID

Activities of Daily Living (check applicable column)

ADLS	Independent	Assistive Tech (No Help)	Supervision / Coaching	Limited Assistance (Some Help)	Extensive Assistance	Total Dependence	Declined
Walking / Mobility							
Dressing							
Eating							
Toilet Use							
Transferring							
Bathing							

IADLS	Independent	Needs Some Assistance	Dependent	Declined
Preparing Meals				
Microwave Use				
Light Housekeeping				
Heavy Housekeeping				
Telephone Use				
Money Management				
Shopping				
Medication Management				
Driving / Using Public Transportation				

Continence	Continent	Usually Continent	Occasionally Incontinent	Frequently Incontinent	Incontinent	Declined
Bladder Incontinence						
Bowel Incontinence						

Health Limitations from specific and/or general diseases, disorders, and illnesses (check those that apply)

Alzheimer's, Dementia, and Related Disorders		Eye and Vision	
Arthritis		Heart	
Blind		Hypertension	
Blood		Intellectual	
Cancer		Joint replacement	
Cancer History		Kidney (renal)	
Cholesterol		Mental Health	
Chronic Obstructive Pulmonary Disease (COPD)		Neurological	
Circulatory		Physical	
Cognitive		Respiratory	
Diabetes		Speech	
Dialysis		Stroke	
Digestive system		Other:	
Ear and Hearing		**Notes:**	

Health and Safety (check or enter value)	
Number of falls experienced in the past six months?	
How many times have you been to an ER, hospital, rehab facility, or nursing home in the past 6 months?	
How many prescription medications do you take daily?	
Do you have prescriptions from more than one doctor?	
Do you have your prescriptions filled at more than one pharmacy?	

Client Program Assessment

Client Name / ID

Financial	
Have you gone without medication, because of lack of funds (or other circumstances)?	
Have you missed a rent or mortgage payment, because of lack of funds?	
Have you missed a utility payment, because of lack of funds?	
Have you missed a phone payment, because of lack of funds?	
How many other people rely on you for financial support?	

Household Size	**Income (refer to income table)**
Actual people in Household _____	☐ < 100 % ☐ < 135 % ☐ < 150 %
SCDOA adjusted Household size _____	☐ < 175 % ☐ < 200 % ☐ > 200 %
Lives Alone? ☐ Yes ☐ No	Amount _____ ☐ Declined

Observations of Housing Condition	
Hoarding	
Home has structural problems	
Inadequate lighting	
Indoor plumbing problem	
Pest problem	
Renovation needed	
Weatherization needed	
Yard work needed	

Needs:

☐ Electricity ☐ Stove ☐ Refrigerator ☐ Microwave ☐ HVAC ☐ Water

Benefits and Referral	**Currently has**	**Referred to**
Adult Protective Services		
Area Agency on Aging (AAA) Caregiver		
Council on Aging (COA)		
Dept of Disabilities and Special Needs (DDSN)		
Dept of Mental Health (DMH)		
Dept of Social Services (DSS)		
Hospice		
Hospital		
Legal Assistance / SC Bar Association		
Medicaid / Community Long Term Care (CLTC)		
Medicare / Medigap		
Medicare / Medigap		
Physician		
Private Care Agency		
Private Health Ins / Affordable Health Care		
Supplemental Nutrition Assistance Program (SNAP)		
Social Security / Federal Retirement / Railroad Retirement		
Substance Abuse Organization		
Supplemental Security Income (SSI)		
Veterans Administration / Veterans Organization		