NEBRASKA CARE MANAGEMENT PROGRAM

Client Name: _____

Client ID Number: _____

Care Manager Name: _____

Units: _____ Date: _____

Contents

Basic Information

Assessment Date*: _____ Date of Update: _____

First Name: _____ Middle Initial/Name: _____

Last Name: _____ **Gender*:** _____

Date Of Birth*: _____ **Age*:** (calculated in PeerPlace)

Occupation: _____

Mailing Address

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____

Zip Code: _____ County: _____

Home Address

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____

Zip Code: _____ County: _____

Work Address

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____

Zip Code: _____ County: _____

Home Phone: _____ Work Phone: _____

Email Address: _____

Race*: ____ American Indian/Native Alaskan ____ Asian ____ Black/African American

____ Native Hawaiian/Other Pacific Islander ____ Not Available ____ 2+ Races

____ White Hispanic ____ White Non-Hispanic

____ Other: _____

Ethnicity: ____ Hispanic ____ Non-Hispanic ____ Unknown

Lives With: ____ Child/Children ____ Lives Alone ____ Others

____ Refused ____ Spouse and Child ____ Spouse/Partner

Referred to Care Management By:

____ Family ____ Friend ____ Home Health Agency ____ Hospital

____ No Response ____ Nursing Facility ____ Self ____ Other

____ Other Human Services Agency ____ Physician ____ Religious Organization

____ Senior Center ____ Veteran's Services

Living Arrangement:

____ Assisted Senior Housing ____ Home Owner/Co-Owner ____ Independent Senior Housing

____ No Response ____ Nursing Facility/Institution ____ Other

Marital Status:

____ Married ____ Divorced ____ Single ____ Never Married

____ Separated ____ Widowed ____ Domestic Partner/Significant Other

Spouse's Name: _____

Emergency Contact: _____ Relation:_____

Education Level:

____ Did Not Finish High School ____ HS Diploma/GED ____ Some College ____ 2-Year College

____ 4-Year College ____ Master's Degree or Higher

____ Unknown/Unsure ____ No Response

Veteran ____ Yes ____ No ____ N/A Spouse of Veteran: ____ Yes ____ No ____ N/A

Assessment Location: _____

Others Present: _____

Other Basic Information Details:

Support Information

Do you receive any of the following assistance?

____ Maintenance	____ Laundry	____ Money Management	____ Personal Care
____ Taking Medications	____ Home-Delivered Meal	____ Meal Preparation	____ Shopping/Errands
____ Transportation	____ Housekeeping	____ Medical Treatments	____ Supervision
____ Other	____ No Response		

Assistance Details:

Do you receive help from a Case Manager? ____ Yes ____ No ____ No Response

Case Manager Name: _____

How many children do you have? _____

Do you receive significant help on a regular or daily basis from family, friends or neighbors?

____ Yes ____ No ____ No Response If Yes, Details:

Do you have family away from your community with whom you have contact?

____ Yes ____ No ____ No Response If Yes, Details:

Are there any persons you are very close to with whom you can talk to about your feelings, problems, or concerns?

____ Yes ____ No ____ No Response If Yes, Details:

Are there groups you belong to that you enjoy participating in?

____ Yes ____ No ____ No Response If Yes, Details:

Other Support Information Details:

Health

How do you rate your health at the present time? ____ No Response

____ Excellent ____ Good ____ Fair ____ Poor

Do you have any health problems that keep you from doing things that you need or want to do?

____ Yes ____ No ____ No Response If Yes, Details:

Have you fallen in the past six months? ___ Yes ___No ___ No Response

If Yes, how many times? _____

Do you use any tobacco products? ___ Yes ___No ___ No Response

Tobacco Usage Details: _____

Have you been in the hospital in the past six months? ___ Yes ___No ___ No Response

Hospital Stay Details: _____

Do you have any other concerns about your health and safety? ___ Yes ___No ___ No Response

Safety Concern Details:

Health Problems or Conditions

Describe the health problems or conditions (if any) that keep you from doing the things that you need or want to do.

Health Problem/Condition	Details

Medications

List drugs that are currently being taken. If prescribed drugs are not being taken properly, use the code to indicate the reason for non-compliance in the details column.

Expense (E) Side Effects (S) Forget (F) Not Needed (N) Other (O)

Prescription Name	OTC	RX	Dosage/Frequency	Health Condition	Details
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

Assistive Devices

Equipment	Uses	Obtain	Neither	Supply Company	Phone Number
Back Brace					
Cane					
Crutches					
Dentures					
Glasses or Contact Lenses					
Hearing Aid					
Hospital Bed					
Leg Brace					
Magnifying Glass					
Walker					
Wheel Chair					
Bathing Aids					
Emergency Response System					
External Urinary Devices					
Grab Bars					
Indwelling Catheter					
Ostomy Equipment					
Other					
Oxygen					
Portable Commode					
Speech Aid					
Other					
Toilet Riser					

Medical Information

Physicians

Do you have a primary health care provider? ___ Yes ___No ___ No Response

Primary Care Physician Name: _____

When did you last see your primary care physician? _____

Do you have any other health care physicians? ___ Yes ___No ___ No Response

Other Physician Details:

Insurance

Medicaid Eligibility: ___ Insufficient Information ___No Response ___ Not Appropriate

___ Referred to Application ___ Yes, Enrolled

Medicaid Contact: _____ Medicaid Number: _____

Do you have Medicare? ___ Yes ___No ___ No Response Supplemental Insurance? ___Yes ___No

Medicare Number: _____ Company: _____

Premium Amount: _____

Other Insurance Details:

Pharmacy

Pharmacy Name: _____ Pharmacy Phone: _____

How much do you pay for medications per month? _____

Other Medication Details:

Cognitive

Complete the SLUMS Assessment on the following page. If the assessment is being completed with an individual who experiences a visual impairment, please complete section below.

Visual Impairment Exception

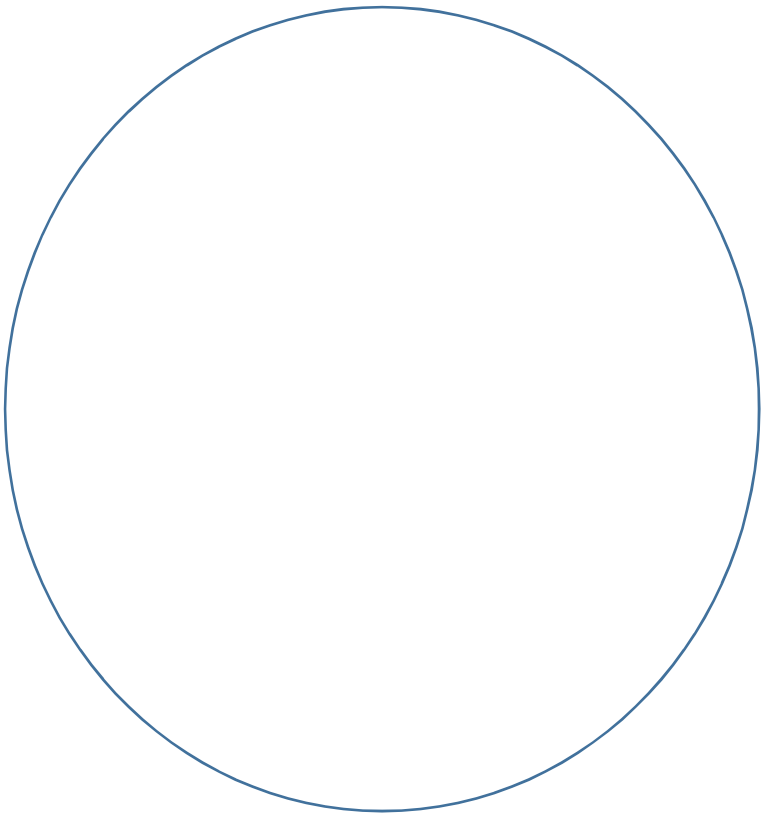
Individual experiences a visual impairment? ___ No ___ Yes

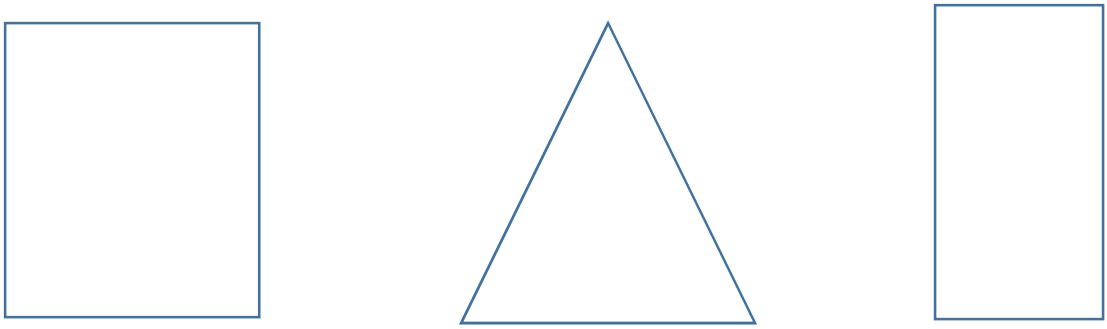
If the individual completing the assessment experiences a visual impairment, please eliminate questions 9 and 10 which reduces the scoring from 30 to 24. Please utilize the following scoring ranges:

If the client has a visual impairment, score as follows:

If the client has a high school diploma or GED, score 21 – 24 = Normal, 15 – 20 = MNCD, 1 – 14 = Dementia.

If the client does not have a high school diploma or GED, score 19 - 24 = Normal, 14 – 18 = MNCD, 1 – 13 = Dementia.





VAMC
SLUMS EXAMINATION

Questions about this assessment tool? E-mail aging@slu.edu

Name_____ Age_____

Is the patient alert?_____ Level of education_____

__/1 (1) **1. What day of the week is it?**

__/1 (1) **2. What is the year?**

__/1 (1) **3. What state are we in?**

4. Please remember these five objects. I will ask you what they are later.
Apple Pen Tie House Car

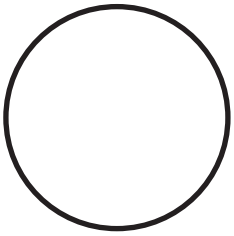
5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.
(1) **How much did you spend?**
__/3 (2) **How much do you have left?**

6. Please name as many animals as you can in one minute.
__/3 (0) 0-4 animals (1) 5-9 animals (2) 10-14 animals (3) 15+ animals

__/5 **7. What were the five objects I asked you to remember? 1 point for each one correct.**

8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.
__/2 (0) 87 (1) 648 (1) 8537

9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.



(2) Hour markers okay
__/4 (2) Time correct

(1) **10. Please place an X in the triangle.**

__/2 (1) **Which of the above figures is largest?**

11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.

Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

(2) **What was the female's name?** (2) **What work did she do?**
__/8 (2) **When did she go back to work?** (2) **What state did she live in?**

_____ **TOTAL SCORE**

SCORING

High School Education		Less than High School Education
27-30	Normal	25-30
21-26	Mild Neurocognitive Disorder	20-24
1-20	Dementia	1-19

CLINICIAN'S SIGNATURE DATE TIME

SH Tariq, N Tumosa, JT Chibnall, HM Perry III, and JE Morley. The Saint Louis University Mental Status (SLUMS) Examination for detecting mild cognitive impairment and dementia is more sensitive than the Mini-Mental Status Examination (MMSE) - A pilot study. *Am J Geriatr Psych* 14:900-10, 2006.

PHQ-2/9 (Mental Health/Depression Screening)

Patient Health Questionaire-9 (PHQ-9) is a brief screening tool used to identify symptoms of depression and the severity of those symptoms.

____ Initial Screening ____ Follow Up Screening

Ask the client: "Over the last two weeks, how often have you been bothered by any of the following?"

1. Little interest or pleasure in doing things.

___ Not at all ___ Several days ___ ***More than half the days**** ___ ***Nearly every day****

2. Feeling down, depressed, or hopeless:

___ Not at all ___ Several days ___ ***More than half the days**** ___ ***Nearly every day****

Skip the rest of this section if both answers are **Not at all** or **Several Days** or a combination.

If **More than half the days** or **Nearly every day** is checked for either answer, **continue**:

3. Trouble falling or staying asleep, or sleeping too much:

___ Not at all ___ Several days ___ More than half the days ___ Nearly every day

4. Feeling tired or having little energy:

___ Not at all ___ Several days ___ More than half the days ___ Nearly every day

5. Poor appetite or overeating:

___ Not at all ___ Several days ___ More than half the days ___ Nearly every day

6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down:

___ Not at all ___ Several days ___ More than half the days ___ Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television:

___ Not at all ___ Several days ___ More than half the days ___ Nearly every day

8. Moving or speaking so slowly that other people could have noticed? Or the opposite being so fidgety or restless that you have been moving around a lot more than usual:

___ Not at all ___ Several days ___ More than half the days ___ Nearly every day

9. Thoughts that you would be better off dead or of hurting yourself in some way:

___ Not at all ___ Several days ___ More than half the days ___ Nearly every day

If you checked off any problems, how difficult have these made it for you to do work/take care of things at home:

___ Not Difficult ___ Somewhat Difficult ___ Very Difficult ___ Extremely Difficult

Comments:

Would you consider a mental health evaluation or counseling? ___ Yes ___No ___ No Response ___ N/A
(care manager ask now, copy response to p. 13 (Cognitive & Mental Health) for data entry)

Cognitive and Mental Health Follow Up

Cognitive Health

Does the client exhibit memory loss, disorientation, difficulty with problem solving, impaired judgement, or other cognitive impairment?

___ Yes ___No ___ No Response

Could there be a medication management problem that may be contributing to cognitive impairment?

___ Yes ___No ___ No Response

Other Cognitive Health Details:

Mental Health

Would you consider a mental health evaluation or counseling?

___ Yes ___No ___ No Response ___ Not Applicable

Other Mental Health Details:

Nutrition

Would you be open to Nutrition Counseling?

___ Yes ___No ___ No Response ___ Not Applicable

How is your appetite?

___ Fair ___ Poor ___ Good ___ No Response

Check factors that may impact the client's nutrition: ___ No Response

___ Appetite Not Known

___ Adequate kitchen facilities

___ Difficulty with constipation or diarrhea

___ Dietary Supplements (If yes, please list)

___ Difficulty with nausea or vomiting

___Drink 6-8 cups of non-alcoholic beverages daily

If Dietary Supplements Yes, Please list:

Are you on a special diet? ___ Yes ___No ___ No Response

Other Nutritional Details:

NSI (Nutrition Screening Initiative)

Has an illness or conditions that made you change the kind and/or amount of food you eat:	___ No	___ Yes	❷
Eats fewer than 2 meals per day:	___ No	___ Yes	❸
Eats few fruits or vegetables, or milk products:	___ No	___ Yes	❷
Has 3 or more drinks of beer, liquor, or wine almost every day:	___ No	___ Yes	❷
Has tooth or mouth problems that make it hard for me to eat:	___ No	___ Yes	❷
Does not always have enough money to buy the food I need:	___ No	___ Yes	❹
Eat alone most of the time:	___ No	___ Yes	❶
Takes 3 or more different prescribed or over-the-counter drugs a day:	___ No	___ Yes	❶
Without wanting to, lost or gained 10 or more pounds in the last 6 months:	___ No	___ Yes	❷
Not always physically able to shop, cook, and/or feed themselves:	___ No	___ Yes	❷

Total Score ☐

Details:

BMI

___ Refused BMI Screening

Height: _____ Feet x 12 + _____ Inches = _____ Total Inches

Weight: _____ lbs.

BMI Score: _____ See next page for BMI Table.

Body Mass Index Table

	Normal						Overweight					Obese										Extreme Obesity																
BMI	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**	**39**	**40**	**41**	**42**	**43**	**44**	**45**	**46**	**47**	**48**	**49**	**50**	**51**	**52**	**53**	**54**
Height (inches)	**Body Weight (pounds)**																																			
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

Source: Adapted from *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report*.

Activities of Daily Living (ADLs)

Independent - Help or oversight required fewer than 1-2 times in a week
Supervision - Oversight, encouragement, cueing 3+ times or physical assistance 1-2 times in a week
Limited Assistance - Help in maneuvering limbs 3+ times in a week or more help 1-2 times in a week
Extensive Assistance - Weight-bearing assistance 3+ times in a week, but not at all times
Total Dependence - Complete assistance at all times

Bathing

___ Independent 0 ___ Supervision 1 ___ Limited Assistance 1

___ Extensive Assistance 1 ___ Total Dependence 1 ___ No Response 0

Details:

Dressing

___ Independent 0 ___ Supervision 1 ___ Limited Assistance 1

___ Extensive Assistance 1 ___ Total Dependence 1 ___ No Response 0

Details:

Eating

___ Independent 0 ___ Supervision 1 ___ Limited Assistance 1

___ Extensive Assistance 1 ___ Total Dependence 1 ___ No Response 0

Details:

Locomotion

___ Independent 0 ___ Supervision 1 ___ Limited Assistance 1

___ Extensive Assistance 1 ___ Total Dependence 1 ___ No Response 0

Details:

Toileting

___ Independent 0 ___ Supervision 1 ___ Limited Assistance 1

___ Extensive Assistance 1 ___ Total Dependence 1 ___ No Response 0

Details:

Transfer

___ Independent 0 ___ Supervision 1 ___ Limited Assistance 1

___ Extensive Assistance 1 ___ Total Dependence 1 ___ No Response 0

Details:

Total Score: _____

Instrumental Activities of Daily Living (IADLs)

1. Do you need assistance with heavy housework? ___ Yes 1 ___No 0 ___No Response 0 Details:
2. Do you need assistance with light housework? ___ Yes 1 ___No 0 ___No Response 0 Details:
3. Do you need assistance with medication management? ___ Yes 1 ___No 0 ___No Response 0 Details:
4. Do you need assistance with managing money? ___ Yes 1 ___No 0 ___No Response 0 Details:
5. Do you need assistance with transportation? ___ Yes 1 ___No 0 ___No Response 0 Details:
6. Do you need assistance preparing meals? ___ Yes 1 ___No 0 ___No Response 0 Details:
7. Do you need assistance with shopping/running errands? ___ Yes 1 ___No 0 ___No Response 0 Details:
8. Do you need assistance with using the phone? ___ Yes 1 ___No 0 ___No Response 0 Details:

Total Score: _____

Bodily Function

Bladder ___ No Response

___ Continent (Complete Control)

___ Usually Continent (Incontinent less than once a week)

___ Occasionally Continent (Incontinent 1+ per week)

___ Usually Incontinent (With or Without control present)

___ Incontinent & Inadequate Control Present

___ External Catheter

___ Indwelling Catheter

Details:

Bowel ___ No Response

___ Continent (Complete Control)

___ Usually Continent (Incontinent less than once a week)

___ Occasionally Continent (Incontinent 1+ per week)

___ Usually Incontinent (With or Without control present)

___ Incontinent & Inadequate Control Present

___ Ostomy

Details:

Movement ___ No Response

___ Contractures to arms/legs/shoulders/hands

___ Arm – partial or total loss voluntary movement

___ Leg – unsteady gait

___ Leg – partial or total loss voluntary movement

___ Hand – lack of dexterity

___ Hemiplegia/Hemiparesis

___ Trunk – loss of ability to position or turn

___ Quadriplegia

Details:

Housing

Do you own your home? ___ No Response

___ Co-Owner ___ Owner ___ Rent ___ Other

If Renting, Landlord Name: _____ Landlord Phone: _____

Is the rent subsidized? ___ Yes ___No ___No Response

Rent Subsidized Amount: _____

Potential Housing Problems:

___ Apparent natural gas leakage ___ Entryway does not provide security ___ Evidence of air or water leakage

___ Inadequate kitchen facilities ___ Exterior maintenance needed ___ No carbon monoxide detector

___ No smoke detector ___ Interior environment poses risk of fall ___ Plumbing is not in working order

___ # of Pets_____ ___ Problems with interior accessibility ___ Rodent or insect infestation

___ Room temperature is not appropriate ___ Risk of fire/inadequate alarm system

Are there repairs to your home that are needed, but have not been completed?

___ Yes ___No ___No Response

Are you satisfied with your current housing situation?

___ Yes ___No ___No Response

Current Housing Details:

Housing Details:

Legal

Do you have an attorney or know who you would get legal assistance from if you needed to?

___ Yes ___No ___No Response

Details:

Do you feel that anyone is taking advantage of you physically, emotionally or in any other way?

___ Yes ___No ___No Response

Details:

Do you feel that you need legal assistance with any of the following issues? Check any issues mentioned:

___ Conservator/Representative Payee

___ Defense Against Guardianship

___ DPOA (Durable Power of Attorney)

___ Division of Resources

___ DPOA Healthcare

___ Insurance Claims

___ Living Will

___ No Response

___ Other Legal Matters

___ Will

Details:

Do you have a power of attorney? ___ Yes ___No ___No Response

POA Name: _____

Do you have a power of attorney for health care decisions? ___ Yes ___No ___No Response

Healthcare POA Name: _____

Other Legal Details:

Financial

Do you handle your own finances including paying bills and making most major purchases?

___ Yes ___No ___No Response

If No, who assists? _____ Relationship to Client: _____

Is it difficult for you to meet your living expenses:

___ Yes ___No ___No Response

If Yes, are any expenses particularly hard to meet? Check all that apply: ___ No Response

___ Food ___ Insurance ___ Medical Bills ___ Not Known

___ Other ___ Prescription Drugs ___ Rent ___ Utilities

Do you have significant outstanding debt? ___ Yes ___No ___No Response

If Yes, Are you using credit counseling? ___ Yes ___No ___No Response

Other Asset Details:

Is there any indication that the client could benefit from the following programs? Check all that apply:

___ Commodities ___ DPFS ___ Energy Assistance ___ Food Stamps

___ Homestead Exemption ___ Medicaid Waiver ___ Medicaid/GA ___ Other Program

___ QMB ___ Rental Assistance ___ Respite ___ SSBG

___SSD ___ SSI

Program Details:

What is the source of your income? Number in Household: _____

SS Income: _____ Pension: _____

Supplemental SS Income: _____ Interest Income: _____

Dividend Income: _____ Salary Income: _____

Other Income: _____ Rent Income: _____

Total Monthly Income: _____ Fee Rate %: _____

Monthly Income Details: