

## Care Recipient Assessment

Welcome! Please tell us a bit about yourself so we can offer services that best meet your needs. We ask for demographic information to meet requirements from our funders. All your personal information is confidential. Please see the attached FAQs for more information and guidance on filling out this form.

### Contact & Demographic Information:

**First Name:** \_\_\_\_\_ **Middle Name:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_ **Nickname:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Home Address Line 1:** \_\_\_\_\_

Line 2 (Apt/Unit/Floor #): \_\_\_\_\_ City: \_\_\_\_\_

Zip: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_

**Mailing Address Line 1:** \_\_\_\_\_

Line 2 (Apt/Unit/Floor #): \_\_\_\_\_ City: \_\_\_\_\_

Zip: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_

**Location Comments** (additional directions for home or mailing address): \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Gender:**  Male  Female  Non-Binary/Third Gender

**Identify as:**  Transgender  Cisgender (identify with your gender from birth)

Gender not listed: \_\_\_\_\_

**Ethnicity:**  Hispanic or Latino  Not Hispanic or Latino

**Race, select all that apply:**

American Indian or Alaska Native  Middle Eastern or North African

Asian or Asian American  Native Hawaiian or Pacific Islander

Black or African American  White

Race not listed: \_\_\_\_\_

**Do you live:**  Alone  With Others

**Number of people in your household** (including you): \_\_\_\_\_

**Is your income above or below the amount listed for your household size:**

Above  At/Below

Household Size	Monthly Income	Annual Income
1	\$1,215.00	\$14,580.00
2	\$1,643.00	\$19,720.00
3	\$2,072.00	\$24,860.00
For each additional person, add \$5,140 to annual income		

## Communication & Service Needs:

### Health Insurance (select all that apply):

Medicare  Medicare Advantage  Medicaid  Medicaid Waiver  
 None  Other: \_\_\_\_\_

Would you like to hear about other services?  Yes  No

If yes, how can we contact you?  Email  Mail  Phone

What services are you interested in? \_\_\_\_\_

## Emergency Contact:

Name:

Phone:

Relationship:

## Nutrition Screening:

Determine your nutritional health. If the statement is true for you, check the box in the "Yes" column and add the points in the "Yes Score" column to your total score.

Nutrition Risk Score Questions	Yes	No	Yes Score
Do you have an illness or condition that has made you change the kind and/or amount of food you eat?	<input type="checkbox"/>	<input type="checkbox"/>	2
Do you eat fewer than 2 meals per day?	<input type="checkbox"/>	<input type="checkbox"/>	3
Do you eat few fruits, vegetables, or milk products?	<input type="checkbox"/>	<input type="checkbox"/>	2
Do you have 3 or more drinks of beer, liquor, or wine almost every day?	<input type="checkbox"/>	<input type="checkbox"/>	2
Do you have tooth or mouth problems that make it hard for you to eat?	<input type="checkbox"/>	<input type="checkbox"/>	2
Are there times you do not have enough money to buy the food you need?	<input type="checkbox"/>	<input type="checkbox"/>	4
Do you eat alone most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	1
Do you take 3 or more different prescribed or over the counter drugs a day?	<input type="checkbox"/>	<input type="checkbox"/>	1
Without wanting to, have you lost or gained 10 pounds in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	2
Are there times you're physically unable to shop, cook, and/or feed yourself?	<input type="checkbox"/>	<input type="checkbox"/>	2
<b>Total Nutrition Risk Score</b>	<i>Total "Yes" Score:</i>		

Total Nutrition Risk Score: 0-2 = No Risk, 3-5 = Moderate Risk, 6 or more = High Risk

If you are at high nutrition risk – take action! Speak with a qualified health or social service professional about your nutritional health. Providers – if the client is at high nutrition risk, please make a case note and appropriate referral.

Are you interested in receiving nutrition counseling?  Yes  No

## Activities of Daily Living and Instrumental Activities of Daily Living:

For each activity, please mark the level of help you (or the client) needs.

**Independent:** no help needed

**Verbal assistance:** needs direction, intermittent monitoring or reminder to complete activity

**Some human help:** needs some assistance, constant supervision not required

**Lots of human help:** needs assistance and supervision to complete most parts of activity

**Dependent:** totally dependent on help for completing activity, needs constant supervision

Activities of Daily Living (ADLs)	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the Bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring In/Out of Bed/Chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking/Getting Around the House	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments on ADLs: \_\_\_\_\_

Instrumental Activities of Daily Living (IADLs)	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Money Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using a Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments on IADLs: \_\_\_\_\_

Are you receiving assistance with ADLs or IADLs from anyone?  Yes  No

If yes, who is assisting you: \_\_\_\_\_

## In Home Services Eligibility:

Can the client perform chore activities without help?  Yes  No

Comment on the client's inability to perform chore services: \_\_\_\_\_

Client requires Home Health Aide based on physician's orders?  Yes  No

Does the client have cognitive impairment  None  Mild  Moderate  Severe

## Disclosures and Waivers

*I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service provider and I herewith give my consent to do so.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **For Office Use Only –**

*(If filled out by assessor or via phone, please have assessor check here and sign below )*

**Filled Out By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

#### Home Delivered Meal NSIP Eligibility

- Individual Aged 60+
- Self-Declared Spouse of individual aged 60+
- Volunteer for the meal programs
- Individual with disabilities living with individual aged 60+ and individual 60+ receives home delivered meals
- Tribal Age Specification

#### In-Home Services Eligibility (Adult Day, Home Health Aide, Homemaker, Personal Care)

- 2+ ADLs (adult day, home health aide, personal care)
- 2+ IADLs (homemaker only)
- and/or*  Cognitive impairment (all)
- and*  Physician's order (home health aide only)

#### Chore Eligibility:

- Unable to perform chores without help

#### Case Management Services Eligibility:

- Individual Aged 60+

## Client Information and FAQs Sheet

We are so glad you found us! Please keep this information for your records.

### Area Agency on Aging Information:

Your local Area Agency on Aging: Vintage – [www.yourvintage.org](http://www.yourvintage.org)

### What is an Area Agency on Aging?

We're glad you asked! The Area Agency on Aging (AAA) is a regional agency that is designated by the state to administer federal, state, and local funding to meet the needs of older adults in their community. The AAA provides programs and services to older adults and caregivers directly and through contracts with community provider agencies. AAAs also serve as advocates for older adults.

### Service Information:

The service you are requesting is funded through the Older Americans Act (OAA) and/or Older Coloradans Act (OCA) funding. This federal and state funding helps older adults, 60+, remain in their homes and communities of choice. Requests for services are processed as funds allow. We can provide you with referrals to other resources in your area, but we will not reach out to them without your permission.

### What is the purpose of this form?

We ask you to fill-in this form for several reasons:

- To help us learn about you so we can offer services that best meet your needs
- To help us understand the needs of older adults in our community
- To help us show the need for funding our programs
- To help us meet reporting requirements from our funders

Taxpayer money funds these programs. We must prove that the funding only serves eligible clients and targets older adults and caregivers most in need of services. This paperwork helps us meet that level of accountability. Income information is not used to determine your eligibility for services. Income and other demographic information (e.g. gender, race, ethnicity) are collected for anonymous demographic reporting purposes. None of your personal information, such as your name or date of birth is disclosed in reporting. You can refuse to provide any of the information requested on the form.

### What happens with my information?

We enter your information into a secure state database. As you receive services, we record the services you received in the database. This helps us prove how we spent the funding. The database is secured to the standards outlined in Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH). This means your data remains safe and confidential.

### Will you sell my information?

No. We will never sell your information.

## How do I provide feedback?

We love hearing how we can improve. Contact your service provider or your local Area Agency on Aging at **970-468-0295** or [yourvintage@nwccog.org](mailto:yourvintage@nwccog.org). Because we value your input, we may at times send you a survey to ask for your feedback.

## How do I file a complaint, grievance, or appeal?

Complaint/Grievance/Appeal Procedure:

You have the right to file a complaint or grievance with the organization asking you to fill out this form. If you are not satisfied with the organization's decision, you can appeal the decision to your local Area Agency on Aging (AAA), and/or the State Unit on Aging (SUA). The complete Complaint/Grievance/Appeal Procedures are available upon request by contacting your local AAA and/or the SUA as follows:

<p><b>Vintage</b> PO Box 2308 Silverthorne, CO 80498 970-468-0295 <a href="mailto:yourvintage@nwccog.org">yourvintage@nwccog.org</a></p>	<p><b>Colorado Department of Human Services, State Unit on Aging</b> 1575 Sherman Street, 10<sup>th</sup> Floor Denver, CO 80203 303.866.2800</p>
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## Can I make a donation?

We accept donations and gifts to contribute towards the cost of services and to support our efforts. Every dollar we receive goes back into the programs and services. Donations are voluntary and are not required to receive services.

You can send to donations to Northwest Colorado Council of Governments, PO Box 2308, Silverthorne CO 80498. **Please make checks payable to NWCCOG.**

## What other resources are available?

Feel free to reach out to your Area Agency on Aging to get more information about the services available in your region. We love to help!

**Services available in our region include:** *Case Management, In-home Services Voucher, Congregate & Home Delivered Meals, Medicare Counseling, Falls Prevention, Information Resources, Legal Assistance, Dental & Vision Voucher, Nutrition Counseling & Education, Transportation, Reassurance Calls, Caregiver Services, Long Term Care Ombudsman, Elder Abuse Prevention Information.*

**AAA Contact Information for services:** [www.yourvintage.org](http://www.yourvintage.org) / 970-468-0295

You can also call the statewide Aging and Disability Resources for Colorado (ADRC) for information about resources in your area: 1-844-COL-ADRC / 1-844-265-2372

**Zero tolerance for elder abuse:** Report abuse to your County Adult Protection Services

## How can I help?

We couldn't meet the needs of older adults in our communities without the amazing help from volunteers and members of our Regional Advisory Councils. Reach out to either your provider or your AAA to see how you can help make a difference in the lives of older adults in our community.