

INTAKE & PRE-SCREENING TOOL

Tracker: DS3: _____ SM: _____ MiCIL: _____
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A. INTAKE INFORMATION

Name:	Date:
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1. Intake Type

- Telephone
- In-person

DSID#:	DOB:
2 WK Follow-up: Date: _____ DS3: ____ SM: ____ MiCIL: _____	
30 Day Cust. Satis Survey: Date: _____ DS3: ____ SM: ____ MiCIL: _____	

2. Staff person conducting intake:

3. Date Intake Conducted:

MM DD YYYY

Current Date: / /

4. Intake Start Time:

HH MM AM/PM

Current Time: : -

5. How did you find out about the ADRC? (Check all that apply)

- Family Personal Care Agency
- Friend Care Coordinator
- Doctor Other Social Service Agency
- Hospital/Clinic
- Senior Center
- Alaska 211
- Newspaper
- Government office
- Clergy
- Adult Protective Services
- Brochure
- Phone book
- A website

Other (please specify)

B. INDIVIDUAL AND REPRESENTATIVE CONTACT

6. Who is seeking services?

- Caller - Self (Skip to Q #10)
- Another Individual (Continue to next question)

7. What is the relationship of the caller to the person requesting supports?

- Self
- Spouse
- Partner/Significant Other
- Child or Child-in-law
- Other relative
- Neighbor
- Parent/Guardian
- Friend
- Other informal helper
- Service/Provider Agency

8. Caller's Contact Information

Name:

Address:

Address 2:

City/Town:

State:

ZIP:

Country:

Email Address:

Phone Number:

9. Caller's Agency (if applicable):

10. Contact information of person needing/seeking supports:

First Name

Middle Name

Last Name

Address:

Address 2:

City/Town:

State:

Zip:

Phone Number:

11. Date of Birth of person seeking/needng supports:

MM DD YYYY
 / /

12. Current living situation/location of person needing/seeking supports:

- Private home
- Nursing Home
- Assisted Living Home
- Hospital
- Public Housing
- Homeless
- Don't Know (Don't read answer choice. Ask, "What is your best guess")
- Refused (Don't read answer choice)

C. CODING REASON FOR CONTACT

13. What is the individual's reason for contacting us?

- Potential ADL or IADL need?
- Potential PCA or Waiver need?

14. Ask the following, "Do you have any concerns about your safety (physical, personal, etc.)?"

- Yes (Continue to next question)
- No (Skip to Q #16)

15. What safety concerns do you have? Please describe:

16. Is immediate referral required?

- Yes (Continue to next question)
- No (Skip to Q #19)

17. An immediate referral will be made to: [Select all that apply]

- Emergency Assistance [contact 911 and collect contact information for follow-up]
- Crisis Services
- Child or Adult Protective Services
- Other (please specify)

18. Describe actions taken [Make the immediate referral for the high risk/crisis situation. Continue with Intake based on staff judgment.]:

19. Has the individual mentioned any behavioral health or substance abuse issues?

- Yes (Check box for Behavioral Health or Substance Abuse options)
- No

20. Has your work, family life, or health been affected by substance use in the past month?

- Yes (Check Box for Behavioral Health or Substance Abuse options)
- No

21. In the past month, have you often or very often felt one of the following?

Any "yes" answer - (Check Box for Behavioral Health Options)

- | | | |
|---------------------|---------------------------|--------------------------|
| Nervous | <input type="radio"/> Yes | <input type="radio"/> No |
| Hopeless | <input type="radio"/> Yes | <input type="radio"/> No |
| Restless or Fidgety | <input type="radio"/> Yes | <input type="radio"/> No |
| Depressed | <input type="radio"/> Yes | <input type="radio"/> No |
| Worthless | <input type="radio"/> Yes | <input type="radio"/> No |

22. Individual currently:

- Receives substance abuse services
- Receives mental health services
- Receives neither
- Don't know (don't ask. "what is your best guess?")
- Refused (don't ask)

Additional Comments

23. Individual refused:

- Substance abuse service options
- Mental health service options
- Refused neither
- Don't know (don't ask. "what is your best guess?")
- Refused to answer question (don't ask)

Additional Comments

24. Is the individual requesting information on Medicare or long-term care insurance?

- Yes (Check Box for MEDICARE/SHIP Options)
- No

25. "Are you able to bathe, dress, feed, toilet, and move around your house without assistance?"

- Yes
- No (Check Box for Potential ADL/IADL assistance)

26. "Are you able to go shopping, pay bills, fix meals, manage your medication, and do routine housekeeping without assistance?"

- Yes (if yes to Q #22 & #23 Check Box for General Information and Assistance Skip to Q #61)
- No (Check Box for Potential ADKL/IADL Assistance - continue with intake)

D. INFORMATION ABOUT INDIVIDUAL NEEDING SUPPORTS

27. Do you need assistance with communication or making independent decisions?

- Yes (Continue to next question)
- No (Skip to Q #31)

28. Describe the assistance the individual needs

29. Do you need or want someone else to be present while making decisions, such as, a family member or a power of attorney for the remainder of the screening?:

- Yes (Continue to next question)
- No (Skip to Q #31)

30. Substitute Decision Maker Information

Name:

Address:

Address 2:

City/Town:

State:

ZIP:

Email Address:

Phone Number:

31. Individual's Physical Address and Information

Street Address:

Street Address 2:

City/Town:

State:

ZIP:

32. Please add instructions if difficult to find or other information is provided such as dog, unpaved roads, etc. (if not applicable leave blank)

33. Individual's Mailing Address (If different than physical)

Mailing Address:

Mailing Address 2:

City/Town:

State:

ZIP:

34. Type of residence:

- Private residence
- Group home
- ALF
- NF
- Other (please specify)

35. Gender:

- Male
- Female

36. Marital Status:

- Married
- Married (Separated)
- Civil Union
- Single (Divorced)
- Single (Never Married/No Significant Other)
- Single (Widowed)
- Single (Significant Other)

37. Race [Select all that apply]:

- Alaskan Native
- American Indian
- Native Hawaiian/Other Pacific Islander
- Asian
- Black/African American
- White
- Hispanic, Latino, or Spanish origin
- Refused
- Other (please specify)

38. Any part Alaska Native heritage? [This question is for federal funding purposes]:

- Yes
- No/ Unsure
- Refused

39. Which Alaska Native Tribe(s)? [This question is for federal funding purposes]:

40. Spoken language(s):

- English
- Spanish
- ASL
- Other (please specify)

41. U.S. Citizen or legal resident of the US?:

- Yes
- No

42. Alaskan Resident?:

- Yes
- No

43. Individual or individual's spouse served in the U.S. military?:

- Yes
- No

44. Individual needs hands-on assistance in activities of daily living [check all that apply]:

- Bed Mobility: (How person moves to and from lying position, turns side to side, & positions body while in bed) **(Skip to Q#49)**
- Transfers: (How person moves between surfaces - to/from bed, chair, wheelchair, standing position (Exclude to/from bath/toilet)) **(Skip to Q#49)**
- Locomotion: (How person moves between locations in his/her room and other areas on the same floor. If in wheelchair, self-sufficiency once in chair) **(Skip to Q#49)**
- Eating: (How person eats and drinks regardless of skill) **(Skip to Q#49)**
- Toilet Use: (How persons uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes) **(Skip to Q#49)**
- None of the Above **(Continue to next question)**

45. Individual needs hands-on assistance in activities of daily living [check all that apply]:

- Bathing: (How person takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (Exclude washing of back and hair)). **(Skip to Q#46)**
- Dressing: (How person puts on, fastens, and takes off all items of street clothing, including donning/removing) **(Skip to Q#46)**

- Personal Hygiene: (How person maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (Exclude baths and showers) (Skip to Q#46)
- None of the above (Skip to Q#47)

46. Make a note to provide information on personal care services and agency options.

- (Check Box to provide information on personal care services and agency options) (Skip to Q#48)

47. Make a note to provide information on other program options such as Senior Grants/Title III/Pioneer Homes/General Relief programs, and complete the rest of the intake:

- (Check Box to provide individual information on other programs) (Skip to Q#50)

48. Individual has received any of the following services or treatments two times or more in the last 7 days? [Check all that apply]:

- Injections/IV feeding: Injections/IV feeding for an unstable condition (excluding daily insulin for a person whose diabetes is under control).
- Feeding Tube: Feeding tube for a new/recent (within 30 days) or an unstable condition.
- Suctioning/Trach Care.
- Treatment/Dressings: Conditions for which the physician has prescribed irrigation, application of medications, or sterile dressings and which requires the skill of an RN.
- Oxygen Administration: Administration of oxygen on a regular and continuing basis when recipient's condition warrants professional observation for a new/recent (within 30 days) condition.
- Assessment/Management: Professional nursing assessment, observation and management required for unstable medical conditions. Observation must be needed at least once every 8 hours.
- Catheter: Insertion and maintenance of a urethral or suprapubic catheter as an adjunct to a disease or a medical condition.
- Comatose: Professional care is needed to manage a comatose condition.
- Ventilator/Respirator: Care is needed to manage ventilator/respirator equipment.
- Uncontrolled Seizure Disorder: Direct assistance from others is needed for safe management of an uncontrolled seizure disorder.
- Therapies provided by a qualified therapist: Physical, speech/language, occupational, or respiratory
- None of the Above (Skip to Q#50)

49. Make a note that individual is potentially eligible for NFLOC, provide information on waiver services and complete the rest of the intake.

- (Check Box for Waiver - individual may be potentially eligible for NFLOC)

50. Individual has a developmental disability determination from SDS.

- Yes (check box for **STAR or CDDG.**) (Skip to Q #54)
- No (check box for **STAR** if appropriate.) (Continue with next question)
- Unsure (check box for **STAR** if appropriate.) (Continue with next question)

51. Instrumental Activities of Daily Living that individual has difficulty with:

- Meal Preparation
- Light Housework: such as dishes, dusting (on daily basis), making own bed.
- Managing Finances: including banking, handling checkbook, paying bills.
- Routine Housework: such as vacuuming, cleaning floors, trash removal, cleaning bathroom, as needed.
- Grocery Shopping: Does grocery shopping as needed (excluding transportation).
- Telephone: Uses telephone as necessary, e.g., able to contact people in an emergency.
- Laundry
- None of the Above (Skip to Q#53)

52. Make a note to provide information on Personal Care Services and agency options after finishing intake (Skip to Q #54)

- Check box to provide information on **personal care services and agency options.**

53. Make a note to provide information on other program options such as Senior Grants/Title III/Pioneer Homes/General Relief programs, and complete the rest of the intake:

- Check Box to provide information on **other programs** (Skip to Q #61)

E. MEDICAID ENROLLMENT

54. Individual's Medicaid Status & Actions to be completed prior to assessment: (may be in DS3):

- No action/Medicaid enrolled
- No action/Medicaid Application started
- Medicaid Application Needed (Check Box)
- Assistance or advocacy with Medicaid Application needed (Check Box)

55. Individual having any other medical insurance/coverage (Check all that apply):

- Medicare
- Private Insurance
- Medicare Savings Program
- VA
- Indian Health Services
- Not Insured

56. Who will provide assistance with the Medicaid application process?:

57. History of receiving services from the State? (may be in DS3):

- Yes (Continue to next question)
- No (Skip to Q #61)

58. Describe history of receiving services from the State:

59. Receives supports from the Indian Health Service? (may be in DS3):

- Yes (Continue to next question)
- No (Skip to Q #61)
- Unsure (Skip to Q #61)

60. Describe supports received from the Indian Health Service? (May be in DS3):

61. Screener – choose one:

- General Information and Assistance provided
- Options Counseling provided
- Neither Provided

62. Actions Taken and Options Counseling

Emergency Referral

General Information and Assistance

- | | |
|---|--|
| <input type="checkbox"/> Accessibility | <input type="checkbox"/> Housing Options |
| <input type="checkbox"/> DPA | <input type="checkbox"/> Independent Living Services |
| <input type="checkbox"/> DME | <input type="checkbox"/> Medicare/SHIP |
| <input type="checkbox"/> Energy Assistance | <input type="checkbox"/> Mini-Grants |
| <input type="checkbox"/> Guardianship/Decision Making Options | <input type="checkbox"/> Senior Benefits |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> STAR or <input type="checkbox"/> CDDG |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Senior Benefits |
| <input type="checkbox"/> Other (please specify) | |

Long Term Supports and Services

- | | |
|---|---|
| <input type="checkbox"/> Substance Abuse Options | <input type="checkbox"/> Waiver Services |
| <input type="checkbox"/> Behavioral Health Options | <input type="checkbox"/> Medicaid |
| <input type="checkbox"/> Medicare/SHIP | ___Application needed |
| <input type="checkbox"/> Potential ADL/IADL Assistance | ___Assistance or advocacy w/application needed |
| <input type="checkbox"/> Personal Care Services | <input type="checkbox"/> Medical Provider Options |
| <input type="checkbox"/> Other (Grants: senior In-home, meals, transportation, adult day, family caregiver, pioneer home, general relief) | <input type="checkbox"/> Natural Supports |
| | <input type="checkbox"/> Long-Term Care Insurance |
| | <input type="checkbox"/> Assisted Living |

Other (please specify)

62. Is additional follow-up needed (some option items checked on list)?:

- Yes
- No

63. Describe additional follow up:

64. Summary of option Information Provided:

65. This is the end of the Intake. Please note the time at which you finished:

Current Time **HH** **MM** **AM/PM**
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