

MARC CLIENT INTAKE FORM - IN-HOME SERVICES

Client Information Information Provided by: Client Other

Last Name: _____ First Name: _____ MI: _____

Gender: M F DOB: ___/___/___ SSN: _____ DCN: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____ Living Alone: Y N

County: Cass Clay Jackson Platte Ray Other:

Marital Status: Single Married Divorced Partnered Separated Widowed (date of spouse's death): _____

Primary Language: English Spanish Other:

Legal Status: Responsible for Self Power of Attorney Guardian

Name: _____ Phone Number: _____

Eligibility: Age

Veteran: Yes No Branch: _____ Discharge Date: _____

Spouse/Widow of Veteran? Yes No

Ethnicity: Hispanic/Latino Not Hispanic/Latino **Citizenship Status**

Race (mark more than one if necessary): African-American Am. Indian/Native Alaskan Asian Native Hawaiian/Pacific Islander White Other: _____

US Citizen Permanent Res.

Income: Subsidized/Low-Income Housing Medicaid SSI Food Stamps Low Income Other:

Primary Emergency Contact:

Name: _____ Aware they are emergency contact? Y N

Home Number: _____ Work Phone: _____ Relationship: _____

Cell Number: _____ Email: _____

Address: _____ City: _____ Zip: _____

Second Emergency Contact:

Name: _____ Aware they are emergency contact? Y N

Home Number: _____ Work Phone: _____ Relationship: _____

Cell Number: _____ Email: _____

Address: _____ City: _____ Zip: _____

Service Information

MARC Service Area: _____ Service(s): _____

Service Provider: _____

Referral Information				
<input type="checkbox"/> Abuse/Neglect	<input type="checkbox"/> Adult Day Care	<input type="checkbox"/> Advocacy	<input type="checkbox"/> Animal Services	<input type="checkbox"/> Case Mgmt
<input type="checkbox"/> Caregiver Services	<input type="checkbox"/> Property Tax Credit	<input type="checkbox"/> Dental	<input type="checkbox"/> Disabilities	<input type="checkbox"/> Food
<input type="checkbox"/> Funeral	<input type="checkbox"/> Health Centers	<input type="checkbox"/> Hearing	<input type="checkbox"/> Home Health	<input type="checkbox"/> Homemaker
<input type="checkbox"/> Home Repairs	<input type="checkbox"/> Home Del. Meals	<input type="checkbox"/> Housing Options	<input type="checkbox"/> Legal Services	<input type="checkbox"/> Mental Hlth Svcs.
<input type="checkbox"/> Ombudsman	<input type="checkbox"/> Personal Care	<input type="checkbox"/> Senior Center	<input type="checkbox"/> Transportation	<input type="checkbox"/> Veterans
<input type="checkbox"/> Vision	<input type="checkbox"/> Other:			

Nutritional Status		
	Yes	Comment
I have an illness or condition that made me change the kind/amount of food I eat.	2	
I eat fewer than 2 meals per day.	3	
I eat few fruits, vegetables, or milk products.	2	
I have 3 or more drinks of beer, liquor, or wine almost everyday.	2	
I have tooth or mouth problems that make it hard for me to eat.	2	
I don't always have enough money to buy the food I need.	4	
I eat alone most of the time.	1	
I take 3 or more different prescribed or over-the-counter drugs a day.	1	
Without wanting to, I have gained or lost 10 pounds in the past 6 months	2	Change:
I am not always physically able to shop, cook or feed myself.	2	Which:
Total score for each Yes response (0-2: low risk; 3-5 moderate risk; 6 or more high risk)		Risk level:

Client Signature	Date
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Intake Worker Signature	Date
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Referral Source:	Telephone Number:
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Notes:

FUNCTIONAL ASSESSMENT**Levels of Assistance:****0 = Independent** - Completes the task independently**3 = Minimum Assistance** - Occasional assistance or supervision may be necessary**6 = Moderate Assistance** - Assistance or supervision is always necessary**9 = Maximum Assistance** - Totally dependent on others

- For each activity check the box indicating the assistance needed.
- If assistance is needed, indicate the source of help (**be specific: spouse, family, friend, paid help, volunteer, professional**)
- In the comments section indicate the type of assistance provided and how often it is provided. Also indicate if the client needs further help.

ACTIVITIES OF DAILY LIVING

Activity	Ind 0	Min. Assist 3	Mod. Assist 6	Max Assist 9	Primary Source of Help	Comments / Other Sources
Eating						
Bathing						
Grooming						
Dressing						
Toilet Use						
Mobility						
Transferring						

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Activity	Ind 0	Min. Assist 3	Mod. Assist 6	Max Assist 9	Primary Source of Help	Comments / Other Sources
Laundry						
Shopping						
Light Housework						
Heavy Housework						
Telephone						
Financial Management						
Transportation						
Meal Preparation						
Medication Management						

Adaptive Equipment	Has	Has, Does Not Use	Needs	Comments
Bathing Equip (bath bench, grab bars, etc)				
Brace (leg, back) prosthesis				
Cane, Crutches, Walker				
Diabetic Supplies				
Dentures				
Railings				
Hospital Bed				
Medical Phone Alert				
Toilet Equipment (ie, raised commode)				
Wheelchair (manual, power)				
Other (specify)				

HOUSEHOLD CONVENIENCES

	Client Has	Client Needs	Observation: Does the client's home have health and safety issues related to any of the following?
Electricity			General repair of home exterior
Gas, Propane			Yard Condition
Heating System (type?)			Sidewalk, exterior stairs
Air Conditioner (window or central)			Exterior Lighting
Fan			Odors (urine, garbage, pets)
Flush Toilets			General Repair of Home Interior
Tub, Shower			Interior Clutter
Piped water, hot/cold			Interior Lighting
Stove, hotplate, oven, toaster oven			Room Temperature
Can opener (electric or manual)			Accessibility of Phone(s)
Microwave			Food Storage
Blender			Accessibility of fire exits and smoke detectors
Radio, television			Bugs or rodents inside home
Refrigerator			Accessibility of emergency phone numbers
Telephone			
Washer			Unsafe Pathways
Dryer			Pets
Comments:			No Problems

PLACE OF RESIDENCE

What floor does the client live on? _____ Is the bathroom on the same floor? Yes No

If the client lives on other than the main floor: Is there an elevator, lift or stair lift? Yes No

Number of steps to enter the home? _____ Are steps a problem within the home? Yes No

Ask the Client the following: Do you have difficulty getting into your home? Yes No
Do you have difficulty getting into any room in your home? Yes No

Comments:

FALL RISK SCREENING (ask the client the following questions)

- How many times have you fallen in the past year? _____
- Are you worried you might have a fall? Not at all A little Somewhat Very
- Do you limit activities now because of fall-related concerns? Never Occasionally Sometimes Often

If client has NOT fallen in the past year, skip questions 4 & 5 below.

- Where have you fallen?
Getting in & out of bed Bathroom Outside the home
Between the bed & the bathroom Kitchen Other:
- Can you say what makes you more likely to fall?
Feeling dizzy/lightheaded Getting up too quickly Walking in darkness
Certain Shoes Turns Walking on certain surfaces
Stairs Dim Lighting Other:

MEDICAL CONDITIONS

What are your medical problems? (use the following codes to answer)

Height: _____

1 - had previously

2 - under control

3 - has currently/being treated

4 - has currently/ not being treated

Weight: _____

Category	Code	Category	Code	Category	Code	Category	Code
Cardiovascular		Hearing/Vision		Respiratory		Skin	
Ankle edema		Deaf		Asthma		Pressure/other ulcer	
By-pass surgery/ Angioplasty		Hearing deficit		COPD		Rashes	
Chest pain		Hearing aid		Cough (dry/productive)		Shingles	
Circulation problems		Hearing Other		Difficulty breathing		Stasis dermatitis	
Congestive heart failure		Hearing No Problem		Emphysema		Other	
Heart attack		Blind		Oxygen		No problem	
Hypertension		Blurred Vision		Bronchitis		Genitourinary	
Hypotension		Cataracts		Pneumonia		Dialysis	
Pacemaker		Glaucoma		Other		Difficulty/frequent urination	
Shortness of breath		Macular Degeneration		No Problem		Dribbling / incontinence	
Other		Vision Other				Frequent bladder infections	
No problem		Vision No Problem				Nighttime urination/ Nocturia	
Endocrine		Infectious Disease				Other	
Diabetes		AIDS				No Problem	
Thyroid		HIV positive					
Other		Hepatitis				Neurological	
No problem		Tuberculosis				Alzheimer's disease	
		Other				Cerebral Palsy	
Gastrointestinal		No Problem		Other		CVA/Stroke	
Abdominal pain				Reduced Physical Stamina		Dementia	
Colitis		Musculoskeletal		Dehydration		Dizziness	
Constipation		Amputation of:		Allergies - food/ medicine		Paralysis of:	
Diarrhea		Arthritis - rheumatoid or osteo		Anemia		Parkinson's Disease	
Difficulty swallowing		Back pain		Autism		Seizures/epilepsy	
Diverticular disease		Contractures		Cancer		Multiple Sclerosis (MS)	
Frequent use of laxatives		Fracture of:		Developmental disabili- ty		Amyotrophic lateral sclero- sis	
Gall bladder problems		Joint replacement of:		Depression		Other	
Indigestion		Polio/Post Polio		Drug use/abuse		No Problem	
Irritable bowel syndrome		Other		Mental retardation		PAIN	
Ulcers		No problem		Tobacco use		Are you in pain now?	
Other				Obesity		If yes, rate your level of pain on a scale of 1 - 10 (1 indicates no pain, 10 indicates the most intense level of pain)	
No problem				Chronic pain			
				Other			
				No problem		PAIN LEVEL: _____	

MEDICAL PERSONNEL

Primary Doctor: _____ Phone Number (____) ____ - _____

Other In-home provider name: _____ Phone: (____) ____ - _____ Short-term Long-term**HEALTH CARE UTILIZATION**

1. Overall, how would you rate your health at the present time?
 Excellent Good Fair Poor Do not know/Refused
2. During the past 12 months, were you admitted to the hospital for a stay that included at least one night?
 Yes No
 If yes, indicate number of times admitted _____ **and** ask the following question.
3. During the past 12 months, how many nights did you spend in the hospital?
 _____ Indicate # of nights Do not know/Refused
4. During the past 12 months, how many trips did you make to the emergency room? (respondent as patient)
 _____ Indicate number of trips None (skip to question 6) Do not know/Refused (skip to question 6)
5. What was the main reason you went to the Emergency Room (if more than one visit, ask about most recent visit, one response only)?
 Medical Condition was Serious No Other Source of Medical Care Was Available When Needed
 Referred by Health Professional/Caregiver Do not know/Refused
 Other (Record Reason:) _____
6. How many **primary care doctor** visits (your main doctor, not including specialists) did you have during the past 12 months?
 _____ # of visits None Do not know/Refused
7. During the past 12 months, how many doctor visits did you have with **specialist(s)** (doctors other than your primary care doctor)?
 _____ Indicate number of visits None Do not know/Refused
8. During the past 12 months, did you receive a flu shot?
 Yes No Do not know/Refused
9. How long ago was your last doctor visit?
 During the past 60 days During the past 3 to 12 months Between 1 and 2 years ago
 2 to 4 years ago More than 4 years ago Never seen a doctor Do not know/Refused
10. During the past year, were you ever **unable** to see a doctor when you needed to?
 Yes No (skip to question 12) Do not know/Refused (skip to question 12)
11. If you were unable to see a doctor when you needed to, was it because of (check all yes responses):
 Cost too much Lack of transportation Could not get appointment
 Doctor would not accept Medicaid Limited hours of service Other reason Do not know/Refused
12. During the past 12 months, were you admitted to a nursing home? (all levels of care)
 Yes No
 If yes, indicate number of admissions _____ and indicate # of nights _____ Do not know/Refused
13. Overall, how satisfied are you with the quality of the medical care you received during the past year?
 Very satisfied Somewhat satisfied Somewhat dissatisfied
 Very dissatisfied Do not know/Refused
14. Are finances a factor in obtaining adequate health/medical care? Yes No
15. Is transportation a factor in obtaining adequate health/medical care? Yes No