APPENDIX 6
REPORT FORMS

NON-UNIT COST INVOICE

Contractor Name and Address:

_____

_____

_____

Prepared by:

_____

Invoice No. _____

Month/Year: _____

Service Type: _____

Project Income Collected: $ _____

Telephone Number: _____

Reimbursable Expenses

	A BUDGET	B PRIOR MONTHS	C CURRENT MONTH	D CUMULATIVE	E BALANCE
Personnel/Fringe					
Travel					
Utilities, Rent, Phone					
Equipment					
Supplies					
Other:					
TOTALS					

Less Prior YTD Costs	$
Subtotal	$
Advance Request	$
Invoice Total for Current Month	$

Contributed Expenses

F BUDGET	G PRIOR MONTHS	H CURRENT MONTH	I CUMULATIVE	J BALANCE

Units _____

New Unduplicated Clients _____

Narrative Justification of Contributed Expenses on Back of Form ---->>

CERTIFICATION:

I, the undersigned, do hereby certify the following:

- Services have been rendered as itemized in this invoice and in conformance to the contract Scope of Service.
- Accurate cost accounting records are being maintained.
- All project income has been reported and remitted to MARC.
- I am authorized to authenticate and certify this claim.

_____

Typed Name **Authorized Signature** **Date**

NARRATIVE JUSTIFICATION OF CONTRIBUTED SERVICES

UNIT COST INVOICE

Contractor Name and Address:

_____

_____

_____

Invoice No. _____

Month/Year: _____

Service Type: _____

Project Income Collected: $ _____

Telephone Number: _____

Prepared by:

_____

A	B	C	D	E	F	G	H	I
New Unduplicated Clients	Service Area/ Senior Center	Prior Months Units Used	Current Month Units Used	Total (YTD) Units Used	Contract Unit Rate	Total YTD Costs	Total Contract Dollars (if applicable)	Percent of Contract Used (YTD)
					$	$	$	%
					$	$	$	%
					$	$	$	%
					$	$	$	%
					$	$	$	%
					$	$	$	%
					$	$	$	%
					$	$	$	%
					$	$	$	%
					$	$	$	%
					$	$	$	%
					$	$	$	%
					$	$	$	%
					$	$	$	%
					$	$	$	%
	Totals				$	$	$	%

Less Prior YTD Costs	$
Subtotal	$
Advance Request	$
Invoice Total for Current Month	$

CERTIFICATION:

I, the undersigned, do hereby certify the following:

- Services have been rendered as itemized in this invoice and in conformance to the contract Scope of Service.
- Accurate cost accounting records are being maintained.
- All project income has been reported and remitted to MARC.
- I am authorized to authenticate and certify this claim.

_____

Typed Name **Authorized Signature** **Date**

MID-AMERICA REGIONAL COUNCIL CLIENT SUMMARY SHEET
CLIENT SUMMARY REPORT

Month/Year: _____ Nutrition Center/Contractor _____ Service: _____

Name:																															Social Security Number:
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL

Name:																															Social Security Number:
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL

Name:																															Social Security Number:
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL

Name:																															Social Security Number:
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL

Name:																															Social Security Number:
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL

Name:																															Social Security Number:
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL

Name:																															Social Security Number:
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL

Name:																															Social Security Number:
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL

Name:																															Social Security Number:
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL

Name:																															Social Security Number:
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL

Subtotal/Grand Total																															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL

PLEASE PRINT

MARC CLIENT INTAKE FORM - TRANSPORTATION SERVICES

(A) Name (Last, First, Middle Initial)	**(B) Social Security Number**
(C) Ethnicity: Hispanic/Latino _____ Not Hispanic/Latino _____	**(D) Race (may choose more than one):** White _____ American Indian or Alaskan Native _____ Asian _____ Black or African American _____ Native Hawaiian or Other Pacific Islander _____ Other _____
(E) Street Address	**(F) City, State, Zip Code**
(G) County: Cass _____ Clay _____ Jackson _____ Platte _____ Ray _____ Other _____	
(H) Telephone Number: ( )	**(I) Date of Birth (mm/dd/yy):**
(J) Income Status: Supplementary Security Income _____ Low-Income Housing _____ Subsidized Housing _____ Medicaid Recipient _____ Other _____	
(K) Service:	**(L) Provider:**
(M) Gender: M ____ F ____	**(N) Living Alone:** Y ___ N ___
(O) Veteran: Y ___ N ___	**(P) Spouse of Veteran:** Y ___ N ___
(Q) MARC Service Area:	**(R) 18-59 Disabled:** Y ____ N ____
(S) Amended: Y ___ N ___	**(T) Corrected:** Y ____ N ____
Client Signature:	**Date:**

Person to Notify in Case of Emergency:

Name _____

Address _____

Phone _____

Relationship _____

Special Information _____

_____

MARC CLIENT INTAKE FORM - HOME DELIVERED MEALS

____ **New Client** ____ **Reassessment** **Information Provided by:** ___ **Client** ____ **Other**

Provider _____ **Date of Assessment** _____ **Start Date** _____

Last Name:_____ First Name:_____ MI:_____

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

Address:_____ City:_____ Zip:_____

Phone Number:_____ Living Alone: Y N

Marital Status: ____ Single ____ Married ____ Divorced ____ Partnered ____Separated
____Widowed (date of spouse's death): _____

Eligibility: ____ Age ____ 18-59 Disabled ____Eligible Spouse ____ Family Caregiver (for:_____)

Legal Status: ____ Responsible for Self ____ Power of Attorney ____ Guardian

Name:_____ Phone Number:_____

Veteran: ____ Yes ____ No Branch: _____ Discharge Date: _____

Spouse/Widow of Veteran? ____ Yes ____ No

Ethnicity: ____ Hispanic/Latino ____ Not Hispanic/Latino

Primary Language: ____ English ____Spanish Other:_____

Citizenship Status:
___ US Citizen
___ Permanent Res.

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

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

Notes (Condition which necessitates meals) :

Client Signature Date

Intake Worker Signature Date

Referral Source Phone Number

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

Specialist: _____ Hospital Preference: _____

In-Home Provider: _____ Phone: (_____) _____-_____

Client Name: _____

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: _____

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:

MODIFIED DIET

Has your doctor recommended any special diet(s) ____**Yes** ____**No**

If yes, check recommended diet:

	Recommended	**Followed**	**Comments (Include recommending doctor & phone number)**
Low sodium (salt)			
Diabetic			
Low fat/cholesterol			
Renal/kidney			
Nutrition supplements			
6 small meals daily			
Vegetarian			
Pureed			
Weight reduction			
Other:			

MEAL PREPARATION **Does anyone help prepare or bring food to you?** o **Yes** o **No** **If yes, then ask the following:**

Who helps prepare your meals (be specific): _____

What meal(s)? ____ Breakfast ____ Lunch ____ Dinner What day(s)? M T W TH F SAT SUN

Check any item(s) that effect your ability to eat: ____ Choking ____ Choking on liquids ____ Swallowing ____ Taste

____ Nausea/Vomiting ____ Cutting up food ____ Opening containers ____ Vision ____ Dentures (Lack of / ill fitting

Client: _____

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

1. For each activity check the box indicating the assistance needed.
2. If assistance is needed, indicate the source of help (**be specific: spouse, family, friend, paid help, volunteer, professional)**
3. 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)				

Client Name:_____

TRANSPORTATION NEEDS

1. Do you Drive? o Yes o No
2. Do you have a car? o Yes o No
   If so, is the car insured? o Yes o No
   If client has a car but does not drive, does someone else drive him/her places? o Yes o No
   If yes, specify who drives the client. _____

Read to the client or caregiver: "After each statement, indicate how often you need transportation to the following destinations."

	2 or more times/ week	Once a week	1-2 times a month	Less than once a month	Never
Grocery Store					
Other Shopping					
Senior Center					
Entertainment					
Essential Business					
Doctor					
Medical Appts					
Prescription Pickup					
Dialysis					
Therapy (PT, Chemo, OT)					

After each statement, indicate how often you use the following modes of transportation

	Every Day	Once a week	2 or more times/week	1-2 times a month	Less than once a month	Never
Public Transportation						
Taxi Cab						
Senior Transportation Services						
Call-A-Ride						
Sr. Center Van/Vehicle						
Neighbor						
Relative						
Friend						
Hospital						
Doctor's Office						
Church						
Volunteer						

Can you walk from inside your home to the curb? o **Yes** o **No**

Can you carry 10 pounds without assistance? o **Yes** o **No**

Do you need a vehicle with a wheelchair lift? o **Yes** o **No**

Notes:

Client Name:_____

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

1. How many times have you fallen in the past year?_____
2. Are you worried you might have a fall? Not at all A little Somewhat Very
3. 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.

4. Where have you fallen?

Getting in & out of bed Bathroom Outside the home Between the bed & the bathroom Kitchen

5. Can you say what makes you more likely to fall?

HEALTH CARE UTILIZATION

1. Overall, how would you rate your health at the present time?
   o Excellent o Good o Fair o Poor o 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?
   o Yes o 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 o 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 o None (skip to question 6) o 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 only)?
   o Medical Condition was Serious o No Other Source of Medical Care Was Available When Needed
   o Referred by Health Professional/Caregiver o Do not know/Refused
   o 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 o None o 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 o None o Do not know/Refused

8. During the past 12 months, did you receive a flu shot?
   o Yes o No o Do not know/Refused

9. How long ago was your last doctor visit?
   o During the past 60 days o During the past 3 to 12 months o Between 1 and 2 years ago
   o 2 to 4 years ago o More than 4 years ago o Never seen a doctor o Do not know/Refused

10. During the past year, were you ever **unable** to see a doctor when you needed to?
    o Yes o No (skip to question 12) o 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):
    o Cost too much o Lack of transportation o Could not get appointment
    o Doctor would not accept Medicaid o Limited hours of service o Other reason o Do not know/Refused

12. During the past 12 months, were you admitted to a nursing home? (all levels of care)
    o Yes o No

    If yes, indicate number of admissions _____ and indicate # of nights_____ o Do not know/Refused

13. Overall, how satisfied are you with the quality of the medical care you received during the past year?
    o Very satisfied o Somewhat satisfied o Somewhat dissatisfied
    o Very dissatisfied o Do not know/Refused

14. Are finances a factor in obtaining adequate health/medical care? o Yes o No

15. Is transportation a factor in obtaining adequate health/medical care? o Yes o No

Referral Information (circle any referrals your will make for the client)

Abuse/Neglect	Adult Day Care	Advocacy	Animal Services	Case Mgmt
Caregiver Services	Property Tax Credit	Dental	Disabilities	Food
Funeral	Health Centers	Hearing	Home Health	Homemaker
Home Repairs	Home Del. Meals	Housing Options	Legal Services	Mental Hlth Srvs.
Ombudsman	Personal Care	Senior Center	Transportation	Veterans

Client Name:_____

MEDICAL CONDITIONS

What are your medical problems? (use the following codes to answer)
1 - had previously
2 - under control
3 - has currently/being treated
4 - has currently/ not being treated

Height: _____

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 disability		Amyotrophic lateral sclerosis	
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		**PAIN LEVEL:** _____	
				No problem			

Client Name:_____

MEDICATIONS

List medications client is taking:

PRESCRIPTION DRUGS:	OVER THE COUNTER MEDICATIONS

Notes:

Medication Management

How do you remember to take your medications?

____ Calendar

____ Egg Carton

____ Envelope

____ Bag

____ Pill Box/Dispenser

____ Personal Reminders

____ Another person gives them/Sets them up
Who?

How often

____ Follow label directions

____ Other:

MARC CLIENT INTAKE FORM - CONGREGATE MEALS

Client Information

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:

Eligibility: ___ Age ____ Eligible Spouse ___ 18-59 Disabled ____ Volunteer

Citizenship Status
___ US Citizen
___ Permanent Res.

Ethinicity:
___ Hispanic/Latino
___ Not Hispanic/Latino

Veteran: _____Yes _____No Branch: _____ Discharge Date: _____

Spouse/Widow of Veteran? _____Yes _____ No

Race (mark more than one if necessary): _____African-American _____American Indian/Native Alaskan _____Asian _____Native Hawaiian/Pacific Islander _____White Other:

Income: ____Subsidized/Low-Income Housing _____Medicaid _____SSI _____Food Stamps ____Low Income Other:_____ _____ NA

Nutritional Status

	7/1/13-6/30/14 Yes	7/1/14-6/30/15 Yes	Comment
I have an illness or condition that made me change the kind/amount of food I eat.	2	2	
I eat fewer than 2 meals per day.	3	3	
I eat few fruits, vegetables, or milk products.	2	2	
I have 3 or more drinks of beer, liquor, or wine almost everyday.	2	2	
I have tooth or mouth problems that make it hard for me to eat.	2	2	
I don't always have enough money to buy the food I need.	4	4	
I eat alone most of the time.	1	1	
I take 3 or more different prescribed or over-the-counter drugs a day.	1	1	
Without wanting to, I have gained or lost 10 pounds in the past 6 months	2	2	Change:
I am not always physically able to shop, cook or feed myself.	2	2	Which:
Total score for each Yes response			Risk level: ____ Low (0-2) ____ Moderate (3-5) ____ High (6 or more)

Primary Emergency Contact:

Name:_____ Aware they are emergency contact? Y N

Home Number:_____ Work Phone:_____ Relationship:_____

Cell Number:_____ Email:_____

Address:_____ City:_____ Zip:_____

Service Provider: Service Area: **Services:** Congregate meals Transportation

Client Signature **Date**

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

Ethinicity: ___ Hispanic/Latino ___ Not Hispanic/Latino

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

Citizenship Status

___ 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:_____

Client Name: _____

Referral Information

____ Abuse/Neglect	____ Adult Day Care	____ Advocacy	____ Animal Services	____ Case Mgmt
____ Caregiver Services	____ Property Tax Credit	____ Dental	____ Disabilities	____ Food
____ Funeral	____ Health Centers	____ Hearing	____ Home Health	____ Homemaker
____ Home Repairs	____ Home Del. Meals	____ Housing Options	____ Legal Services	____ Mental Hlth Srvs.
____ Ombudsman	____ Personal Care	____ Senior Center	____ Transportation	____ Veterans
____ Vision	____ 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 _____

Intake Worker Signature _____ Date _____

Referral Source: _____ Telephone Number: _____

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

1. For each activity check the box indicating the assistance needed.
2. If assistance is needed, indicate the source of help (**be specific: spouse, family, friend, paid help, volunteer, professional)**
3. 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)				

Client Name:_____

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)

1. How many times have you fallen in the past year?_____
2. Are you worried you might have a fall? Not at all A little Somewhat Very
3. 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.

4. Where have you fallen?
   - Getting in & out of bed
   - Between the bed & the bathroom
   - Bathroom
   - Kitchen
   - Outside the home
   - Other:

5. Can you say what makes you more likely to fall?
   - Feeling dizzy/lightheaded
   - Certain Shoes
   - Stairs
   - Getting up too quickly
   - Turns
   - Dim Lighting
   - Walking in darkness
   - Walking on certain surfaces
   - Other:

Client Name:_____

MEDICAL CONDITIONS

What are your medical problems? (use the following codes to answer)
1 - had previously
2 - under control
3 - has currently/being treated
4 - has currently/ not being treated

Height: _____

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 disability		Amyotrophic lateral sclerosis	
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: (___) ___ - _____ o Short-term o Long-term

HEALTH CARE UTILIZATION

1. Overall, how would you rate your health at the present time?
   o Excellent o Good o Fair o Poor o 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?
   o Yes o 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 o 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 o None (skip to question 6) o 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)?
   o Medical Condition was Serious o No Other Source of Medical Care Was Available When Needed
   o Referred by Health Professional/Caregiver o Do not know/Refused
   o 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 o None o 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 o None o Do not know/Refused

8. During the past 12 months, did you receive a flu shot?
   o Yes o No o Do not know/Refused

9. How long ago was your last doctor visit?
   o During the past 60 days o During the past 3 to 12 months o Between 1 and 2 years ago
   o 2 to 4 years ago o More than 4 years ago o Never seen a doctor o Do not know/Refused

10. During the past year, were you ever **unable** to see a doctor when you needed to?
    o Yes o No (skip to question 12) o 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):
    o Cost too much o Lack of transportation o Could not get appointment
    o Doctor would not accept Medicaid o Limited hours of service o Other reason o Do not know/Refused

12. During the past 12 months, were you admitted to a nursing home? (all levels of care)
    o Yes o No

    If yes, indicate number of admissions _____ and indicate # of nights_____ o Do not know/Refused

13. Overall, how satisfied are you with the quality of the medical care you received during the past year?
    o Very satisfied o Somewhat satisfied o Somewhat dissatisfied
    o Very dissatisfied o Do not know/Refused

14. Are finances a factor in obtaining adequate health/medical care? o Yes o No

15. Is transportation a factor in obtaining adequate health/medical care? o Yes o No

MARC CLIENT INTAKE FORM - NATIONAL FAMILY CAREGIVER SUPPORT

Client Information

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:

___ Family Caregiver 60+ ___Family Caregiver Under 60

Relationship: ___Husband ___ Wife ___Son/Son-in-Law ___Daughter/Daughter-in-Law ___Other Relative ___Non-Relative ___Relationship Missing

Veteran: ___Yes ___ No Branch: Discharge Date:

Spouse/Widow of Veteran? ___Yes ___No

Ethinicity: ___Hispanic/Latino ___Not Hispanic/Latino

Race (mark more than one if necessary): ___African-American ___American Indian/Native Alaskan ___Asian ___Native Hawaiian/Pacific Islander ___White ___Other:

Citizenship Status

___ 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:_____

Caregiver Name: _____

Referral Information

___ Abuse/Neglect	___ Adult Day Care	___ Advocacy	___ Animal Services	___ Case Mgmt
___ Caregiver Services	___ Property Tax Credit	___ Disabilities	___ Funeral	___ Health Centers
___ Hearing	___ Home Health	___ Homemaker	___ Home Repairs	___ Home Del. Meals
___ Housing Options	___ Legal Services	___ Mental Hlth Srvs.	___ Ombudsman	___ Personal Care
___ Senior Center	___ Transportation	___ Veterans	___ Vision	
___ 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 _____

Intake Worker Signature _____ Date _____

Referral Source: _____ Telephone Number: _____

Provider:	Service:	Service Area:

Notes:

Caregiver Name:_____

Additional Caregiver Information

Caregiver is: ____ Employed Full-Time ____ Employed Part-Time ____ Student

____ Unemployed ____ Retired ____ Other:

1. Does the caregiver have any informal supports? o Yes o No
2. Check limitations or constraints of primary caregiver.

____ No particular constraint
____ Poor health, disabled, frail
____ Employed
____ Lacks knowledge, skills
____ Providing care to others
____ Not reliable due to other commitments
____ Poor relationship with care recipient
____ Lives at a distance
____ Alcohol, drug abuse
____ Financial strain
____ Dependent on care recipient for housing, money or other

3. Have your job or social life been affected by your caregiver duties? o Yes o No If yes, how? _____

4. How many hours a day do you have available to provide care to this care recipient? _____

5. How many hours a day do you usually spend providing care to this care recipient? _____

6. Overall, how stressed do you feel in caring for the care recipient? (If caregiver is somewhat stressed or very stressed then complete Caregiver Stress Interview.) Check one:

o Not Stressed o Somewhat Stressed o Very Stressed

Notes:

Care Recipient Information

Last Name:_____ First Name:_____ MI:_____

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

Address:_____ City:_____ Zip:_____

Phone Number:_____ Permanent Address: Y N 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:_____

Care Recipient Lives: ____ With Caregiver ____ Near Caregiver ____ Long Distance

MARC CLIENT INTAKE FORM - GRANDPARENT AS PARENTS

Client Information

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 Number of Children under the age of 18:_____

Veteran: ___Yes ___ No Branch: Discharge Date:

Spouse/Widow of Veteran? ___Yes ___No

Ethinicity: ___Hispanic/Latino ___Not Hispanic/Latino

Race (mark more than one if necessary): ___African-American ___American Indian/Native Alaskan ___Asian ___Native Hawaiian/Pacific Islander ___White ___Other:

Citizenship Status

___ 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:_____

Grandparent Name: _____

Referral Information

____ Abuse/Neglect	____ Adult Day Care	____ Advocacy	____ Animal Services	____ Case Mgmt
____ Caregiver Services	____ Property Tax Credit	____ Disabilities	____ Funeral	____ Health Centers
____ Hearing	____ Home Health	____ Homemaker	____ Home Repairs	____ Home Del. Meals
____ Housing Options	____ Legal Services	____ Mental Hlth Srvs.	____ Ombudsman	____ Personal Care
____ Senior Center	____ Transportation	____ Veterans	____ Vision	
____ 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 _____

Intake Worker Signature _____ Date _____

Referral Source: _____ Telephone Number: _____

Notes:

Grandparent Name:_____

GRANDPARENT AS PARENT - Grandchildren at residence

Grandchild's Name	Grandchild's Date of Birth	Relationship

GRANDPARENT AS PARENT - Individuals 18-59 at residence, with a disability

Individual's Name	Individual's Date of Birth	Relationship

Notes:

QUARTERLY COST REPORT

Contractor Name and Address:

_____

_____

_____

Months Reported: _____

Service Area(s): _____

Contract Service Unit Rate: _____

Prepared by: _____ Phone Number: _____

	Reimbursable Expenses					Contributed Expenses					TOTALS
	A BUDGET	B PRIOR QUARTER(S)	C CURRENT QUARTER	D CUMULATIVE	E BALANCE	F BUDGET	G PRIOR QUARTER(S)	H CURRENT QUARTER	I CUMULATIVE	J BALANCE	K TOTAL YTD PROGRAM COSTS (col. D plus col. I)
(1) Personnel/Fringe											
(2) Travel											
(3) Utilities, Rent, Phone											
(4) 'Equipment											
(5) Supplies											
Other:											
(6)											
(7)											
(8)											
(9)											
(10)											
(11)											
TOTALS											

Current Quarter Information

(12) MARC Funds Invoiced (column C)	$
(13) Contractor In-Kind (column H)	$

YTD Information

(14) MARC Funds Invoiced YTD (column D)	$
(15) Contractor In-Kind YTD (column I)	$
(16) % of Contractor Contribution YTD (col.I divided by col. I	%

CERTIFICATION:

Narrative Justification of Contributed Expenses on Back of Form ---->>

I, the undersigned, do hereby certify this report is accurate and complete to the best of my knowledge and that this compilation of data is supported by accounting records and adequate source documentation.

_____

Typed Name **Authorized Signature** **Date**

NARRATIVE JUSTIFICATION OF CONTRIBUTED SERVICES

MID-AMERICA REGIONAL COUNCIL
Department of Aging Services

Quarterly Service Narrative

SFY:_____ **Quarter:**_____ **Date Submitted:**_____

Agency:_____

Contact Person:_____ **Phone number:**_____

Person completing Report:_____

A. Provide responses to monitoring issues and areas of non-compliance:

B. Describe special activities or events participated in or conducted by your agency:

C. Discuss administrative issues which have impacted your service:

D. Provide comments or concerns about service issues:

E. Discuss activities your agency is undertaing to target information about services, specifically to low-income elderly?

F. Are low-income minority elderly in your service area(s), receiving a proportional amount of service?

   Why/Why not?

G. Other:

CATERER'S INVOICE

Caterer Name and Address:

_____

_____

_____

Invoice No. _____

Month/Year: _____

Telephone Number: _____

Prepared by:

_____

	CURRENT MONTH				MARC USE ONLY			
Senior Center	A Type of Meal (C or H)	B Meal Rate	C Total Meals	D Total Amount	E congregate meals	F congregate amount	G home delivered meals	H home delivered amount
Belton								
Booth								
Booth - week meals								
CTK								
Hillcrest								
Mohart								
Palmer								
Westport								
Whatsoever								
TOTAL AMOUNT OF INVOICE ---------->				$0.00		$0.00		$0.00

CERTIFICATION:

I, the undersigned, do hereby certify the following:

- Services have been rendered as itemized in this invoice and in conformance to the contract Scope of Service.
- Accurate cost accounting records are being maintained.
- All project income has been reported and remitted to MARC.
- I am authorized to authenticate and certify this claim.

_____

Typed Name **Authorized Signature** **Date**

SENIOR CENTER INVOICE

Contractor Name and Address:

_____

_____

_____

Invoice No. _____

Month/Year: _____

Telephone Number: _____

SENIOR CENTER NAME(S):

Contract Amount	Reimbursements to Date	Amount of Invoice	Balance

INVOICE CERTIFICATION:

During the report period, the center served as a focal point for activities in the followng services:

____ Nutrition Education (approved by MARC dietitian)

____ Outreach

____ Information and Referral

____ Health Promotion Activities

____ Legal Assistance

____ Consumer Education and Service

____ Recreation

I, the undersigned, do hereby certify the following:

- Services have been rendered as itemized in this invoice and in conformance to the contract Scope of Service.
- Accurate cost accounting records are being maintained.
- All project income has been reported and remitted to MARC.
- I am authorized to authenticate and certify this claim.

_____

Typed Name **Authorized Signature** **Date**

MARC Client Closure Summary

Provider:_____ **Month:**_____

Client's Name	Reason for Closing From MARC Service