

HEALTH PROBLEMS

Do you have any health problems, and how do they affect you? **(Ask):** For instance, has a doctor told you that you have any of the following health problems or symptoms of health problems? **(Read Health Conditions to Client)**

<u>Health Conditions</u>	<u>Present</u>	<u>Interferes With Living</u>	<u>Condition Not Under Treatment</u>	<u>Notes:</u>
Allergies (Type) (Drug/skin/etc): _____	___	___	___	
*Amputation (Site): _____	___	___	___	
*Anemia (Type): _____	___	___	___	
Arthritis (Type): _____	___	___	___	
Asthma (Type): _____	___	___	___	
*Bed Sore(s) (Decubitus Stage) : _____	___	___	___	
Bladder/Kidney Problems (UTI, etc.)	___	___	___	
Broken Bones (Type; Site): _____	___	___	___	
*Cancer Type): _____	___	___	___	
*Dehydration	___	___	___	
Dementia (Type); (Alz, OBS, etc): _____	___	___	___	
*Dialysis (Type): _____	___	___	___	
*Diabetes (Type): _____	___	___	___	
Dizziness	___	___	___	
*Emphysema (COPD, etc.)	___	___	___	
Falls (Past Year)	___	___	___	
Gallbladder Problems (Gallstones, etc.)	___	___	___	
Hearing Problems	___	___	___	
Heart Problems (CHF, MI, etc.)	___	___	___	
*High Blood Pressure (Type) _____	___	___	___	
*HIV/ARC/AIDS	___	___	___	
*Liver Problems (Cirrhosis, Hepatitis, etc.)	___	___	___	
*Osteoporosis	___	___	___	
Paralysis (Site): _____	___	___	___	
Parkinson's Disease	___	___	___	
Pneumonia	___	___	___	
*Potassium/Sodium Imbalance (Electrolytes)	___	___	___	
Seizure Disorders (epilepsy, etc.)	___	___	___	
Shingles (Herpes Zoster)	___	___	___	
Sleep Problems	___	___	___	
Stroke (CVA, etc.)	___	___	___	
Thyroid Problems (Graves, Myxedema, etc.)	___	___	___	
Tuberculosis	___	___	___	
*Ulcers (Type, Site): _____	___	___	___	
*Ulcerative Colitis/Crohn's	___	___	___	
Vision Problems (Cataracts, Glaucoma, etc.)	___	___	___	
Other (Specify) _____	___	___	___	

*Asterisked items refer to question on page 5 (nutrition section)

I-OASIS

CLIENT SUPPORT: Complete for Services/Help received and needed.

a. SERVICES/HELP			b. NAME OF HELPER Person or agency name	c. HELPER CODE 1 = Spouse 2 = Children 3 = Friend 4 = Other relative 5 = Agency 6 = Church	d. FREQUENCY Hours, visits, meals in a typical week.	e. ADDITIONAL HELP NEEDED
Do you receive help with...	Yes	No				
Personal Care Assistance (bathing, dressing, getting out of bed, toileting and eating)			1.			
			2.			
			3.			
			4.			
Housekeeping (laundry, cleaning, meals, etc.)			1.			
			2.			
			3.			
Transportation			1			
			2.			
Shopping/Errands			1.			
			2.			
Personal Finance (money management)			1.			
			2.			
Services from a health professional (such as a RN or therapist)			1.			
			2.			
Adult Day Care			1.			
			2.			
Home Delivered Meals (formal only)			1.			
			2.			
Congregate Meals (specify the site)			1.			
			2.			
Emergency Response Syst.			1.			
In Home Health Care Provider Program - DHS			1.			
Any other kind of help? (specify)			1.			
			2.			
Social Contacts: Phone calls from others						
Visits (from those not living with you)						
What activities/interests do you enjoy?						
Attend religious services as often as you like? (specify denomination)						

I-OASIS

CAREGIVER ASSESSMENT - Address questions to caregiver (not to include home care agency or assisted living staff)

Name of Primary Caregiver: _____

Consider the care you provide for _____, I would like to ask you if various aspects of your life have become better, the same, or worse since you began providing care.

	<u>Better</u>	<u>Same</u>	<u>Worse</u>	<u>Don't Know</u>
Relationship with the client	_____	_____	_____	_____
Relationship with other family members	_____	_____	_____	_____
Relationship with friends	_____	_____	_____	_____
Your health	_____	_____	_____	_____
Your work (if applicable)	_____	_____	_____	_____
Your emotional well-being	_____	_____	_____	_____

No Yes **If you were suddenly unable to provide care, would there be someone who could take your place?**
If yes, specify _____

No Yes **Is there anything else we need to know that makes it difficult for you to manage care?**
If yes, please describe _____

No Yes **Do you need training or services?**
If yes, please describe _____

NUTRITION *(Circle the score of the items that apply.)*

		Yes
I have an illness or condition that made me change the kind and/or amount of food I eat. <i>[Assessor: Review diagnoses asterisked on page 2, If any are checked 'Interferes with Living', circle 4. If none are checked 'Interferes', but 1 or more are checked 'Present', circle 2.]</i>	2 4	4
I eat fewer than 2 meals per day.		3
I eat few fruits or vegetables or milk products.		2
I have 3 or more drinks of beer, liquor or wine almost every day.		2
I have problems that make it hard for me to eat...		
Tooth or mouth?	1	
Swallowing?	1	
Nausea/Vomiting/Diarrhea?	1	
Taste Problems?	1	
Problems eating certain foods?	1	
Food allergies?	1	
Heartburn?	1	
Poor Appetite?	1	
Enter 'Problem' Subtotal at Right		
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
Height _____ Weight _____		
Without wanting to, I have lost or gained 10 pounds in the last 6 months.		2
I am not always physically able to shop, cook and/or feed myself.		2
Total		

Are you on any special diets for medical reasons? (Check those that apply)

_____ Low Sodium (salt)?	_____ Calorie Supplement?
_____ Low fat/cholesterol?	_____ Other special diet?
_____ Low sugar?	(Describe) _____

If TOTAL nutritional score is:

- 0 - 3 **Low Risk.** No referral for dietician consultation is needed.
- 4 - 7 **Moderate Risk.** Assessor judgment required regarding client's overall status and ability to meet nutritional deficits with current resources to determine need for referral for dietician consultation.
- 8+ **High Risk.** Refer client to dietician for further nutritional assessment and consultation.

I-OASIS

Do you drink any alcoholic beverages including beer and wine?

Yes How much/How often _____
 No

Do you smoke or use tobacco?

Yes How much/How often _____ Type _____
 No

Do you use other drugs not prescribed by your doctor? Yes No If yes, what are they? _____

SPECIAL EQUIPMENT/ASSISTIVE DEVICES

Do you have or need any of the following special equipment or aids?

U=Uses, H=Has, doesn't use, N=Needs

- ___ Prosthesis (Type) _____
- ___ Cane
- ___ Walker
- ___ Wheelchair
- ___ Brace (leg/back)
- ___ Hearing Aid
- ___ Glasses
- ___ Contact lenses
- ___ Dentures
- ___ Emergency Alert Response (i.e., Lifeline)
- ___ Hospital Bed
- ___ Bedside commode
- ___ Bathing equipment
- ___ Transfer equipment
- ___ Adaptive eating equipment
- ___ Disposable medical supplies
- ___ Other (**Specify**) _____
- ___ Other (**Specify**) _____

Should client be referred for mental health assessment/services? (Based on interview data). Yes No

Are you referring this client for case management staffing? Yes No

If "No" – please provide reason:

I-OASIS NOTIFICATION SHEET for
CMPFE/HCBS-ELDERLY WAIVER

SEND TO: Iowa Foundation for Medical Care
6000 Westown Parkway – Ste. 350E
West Des Moines, IA 50266

PHONE: 515-223-2117

1-800-383-1173

FAX: 515-222-2432

IFMC ROUTING - for AAA COORDINATOR USE ONLY

Area Agency on Aging Name: _____

Date Assessment Completed: _____ Date Entered CMPFE: _____

- Original Assessment Annual Update Reimbursement Requested
 Suspected change in level of care Not admitted to CM
 New application for HCBS-EW; most recent assessment more than 60 days old
 OASIS electronically submitted Date _____

Person Completing Assessment: _____

Assessor's Agency: _____ Agency Type _____

Assessor's Agency Medicare-certified? Yes No

Case Manager's Agency: _____ Agency Type _____

- Agency Type: 1 Homemaker/Chore 6 Private Home Health Agency
2 Hospice 7 DHS
3 Alzheimer's Chapter 8 Mental Health
4 AAA/other aging services agency (e.g., CASI, ESA) 9 Adult Day Services Center
5 Public Health Agency 10 Other

Client's SS# _____ County _____

Client's Name _____

Client's Address _____

Physician's Name _____ Phone _____
FIRST/LAST

Physician's Address _____
MAILING ADDRESS CITY ZIP

Client's Primary Language: English Spanish Other (SPECIFY) _____

Can the client speak English? Yes No

Can the client understand English? Yes No

U.S. Citizen or Legal Resident? Yes No

Country of Origin? _____

How many persons live in the household (including client)? _____

