

APPENDIX C

IN-PERSON ASSESSMENT INSTRUMENT
(FOR USE AS BOTH INITIAL AND FINAL ASSESSMENT)

Referral Number

Participant Name: _____

Address: _____

Phone Number: _____

Independent Living
and
Mobility Program
In-Person Interview

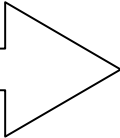
Assessor *Print your name with credentials and the date that the interview was completed.*

Name and credentials: _____

Date of interview: _____

Was more than one person in this household interviewed?..... No Yes.....

Enter the time the interview begins (i.e. 2:53 PM).



Exact time:
____:____ am/pm

1. Instructions

Please read this paragraph to the participant before beginning the interview.

My name is _____, and I will be interviewing you and taking your height, weight and blood pressure readings as part of the Independent Living and Mobility Program.

The interview takes approximately one hour. I will be asking questions about your health and daily activities and will perform a brief home safety evaluation.

I will be asking you questions on a number of different topics. Some of these questions may or may not be applicable to you; but it is important that we ask all participants the same questions.

If this is the initial in-person assessment add:

The information from this interview will be sent to the home office where a report will be created that highlights things you can do to improve your safety and reduce the chance of falling in your home. This report will then be sent to you. Along with the summary, a Health Promotion and Independent Living and Mobility Tool kit **will be** sent to you that contains

- 1) Health and Home Safety Handout,
- 2) Wipe-Off Medication Management Planner,
- 3) Exercise video,
- 4) Exercise Progress Chart,
- 5) Falls **Journal in which you can record any falls or near falls that may occur and**
- 6) **Pedometer.**

Additionally, you will be receiving a quarterly follow-up phone call shortly after this interview. In the interim, if you have any questions regarding the Independent Living and Mobility Program, please contact XXXXXXXX at XXX-XXX-XXXX.

If this is the final in-person assessment add:

This is the final interview that we will be conducting, thank you for participating in this important national program over the past 2 years.

For all assessments finish the introduction with:

Do you have any questions regarding the interview before we begin?

Please document any questions the participant has.

2. General Questions

- A Do you have any visual deficits? (If "Yes," explain below) No Yes.....
- B Do you have any hearing deficits? (If "Yes," explain below)..... No Yes.....

Condition	Date of Diagnosis (month/year)	Dr. Name	Treatment	Current Status

- C Are you having any difficulty understanding me? (If "Yes," explain below) No Yes.....
- Reason for difficulty: _____
- What can be done to compensate for this problem? _____
- A. _____ Assessor: _____
- compensate as best you can and then ask:*
- Now can you understand me? (If "No," terminate interview) No Yes.....

3. Hospital/Emergency Visits and Surgery

- A. Since your recent phone interview have you had any Hospital Admissions, Emergency Room Visits, or Surgery? No Yes
- If Yes, indicate number of times: _____

Reason for Hospital Admission/ Emergency Room visit (month/year)	Type of Surgery &/or Treatment received	Current Status

4. Primary Care Physician

- A. Do you have a primary care physician? No Yes.....
- Physician's name: _____ Phone number: _____
- City: _____ State _____ Street address: _____
- Specialty: _____

5. Falls History

A Since your recent phone interview have you had one or more episodes of fainting to the ground, passing out or have you lost your balance, slipped or tripped over resulted in falling or dropping to the ground?..... No Yes.....

If Yes, How many times did this happen? _____

Regarding your most recent fall, what time of day did it happen? Day Eve.....

Morn/Day 5:01AM-9:00AM 9:01AM-12:00PM 12:01PM-4:00PM

Eve/Noc 5:01PM-7:00PM 7:01PM-10:00AM 10:01AM-5:00AM

Did you get hurt or injure yourself?..... No Yes.....

Did you require Medical Attention? No Yes.....

Emergency Room Hospital Adm Doctor Visit

What were you doing when you fell? _____

Were you at home when you fell? No Yes.....

If Yes, Where? Bathroom Kitchen Entryway

Stairs Other: _____

If No, Where? Store/Business Parking Lot/Street Relative/Friend House

Dr. Office Walkway/Pathway Other _____

What was the cause of your fall? Tripped Slipped Dizziness Seizure

Loss of Balance Fainted/Blacked out Other: _____

Were any of the following conditions present when you fell? (read all)

Ground conditions

Wet Ground No Yes.....

Icy/snowy Ground No Yes.....

Uneven Ground..... No Yes.....

Stepping up onto/down from a curb No Yes.....

Climbing up/going down stairs Yes..... No Yes.....

Object in walkway/path No Yes.....

Behaviors For each Yes, answer additional question

Wearing shoes that did not fit properly. you changed this behavior? No Yes.....

Wearing clothes that did not fit properly. you changed this behavior? No Yes.....

Not using necessary visual aids/glasses. you changed this behavior? No Yes.....

Not using necessary equipment. Have you changed this behavior? No Yes.....

(cane, walker, shower seat, grab bars)

B Have you been anxious or worried or afraid you might fall?..... No Yes.....

C Do you ever limit your activities, for example, what you do or where you go because of falling?..... No Yes.....

If Yes, Which activities and why? _____

How often? All of the time Some of the time Rarely Doesn't know

6. Medications

Please tell me the names and dosages of all the medications you currently take including over-the-counter medications, eye drops and inhalers. (Assessor - Please obtain details for all medications)

	Medication Name	Dosage	Frequency	If PRN, indicate how often used	Reason for taking	Do you take this as prescribed by your doctor?	If NO, Why Not? Too Expensive, Side Effects; "I don't need them", They don't work", Ran out of Rx, Forgets, Other:
1						<input type="checkbox"/> Yes <input type="checkbox"/> No	
2						<input type="checkbox"/> Yes <input type="checkbox"/> No	
3						<input type="checkbox"/> Yes <input type="checkbox"/> No	
4						<input type="checkbox"/> Yes <input type="checkbox"/> No	
5						<input type="checkbox"/> Yes <input type="checkbox"/> No	
6						<input type="checkbox"/> Yes <input type="checkbox"/> No	
7						<input type="checkbox"/> Yes <input type="checkbox"/> No	
8						<input type="checkbox"/> Yes <input type="checkbox"/> No	
9						<input type="checkbox"/> Yes <input type="checkbox"/> No	
10						<input type="checkbox"/> Yes <input type="checkbox"/> No	
11						<input type="checkbox"/> Yes <input type="checkbox"/> No	
12						<input type="checkbox"/> Yes <input type="checkbox"/> No	
13						<input type="checkbox"/> Yes <input type="checkbox"/> No	
14						<input type="checkbox"/> Yes <input type="checkbox"/> No	
15						<input type="checkbox"/> Yes <input type="checkbox"/> No	
16						<input type="checkbox"/> Yes <input type="checkbox"/> No	
17						<input type="checkbox"/> Yes <input type="checkbox"/> No	
18						<input type="checkbox"/> Yes <input type="checkbox"/> No	
19						<input type="checkbox"/> Yes <input type="checkbox"/> No	
20						<input type="checkbox"/> Yes <input type="checkbox"/> No	

7. Medical Conditions and Symptoms

A Do you have a history of any of the following conditions? (if any answer is "Yes," ex

Irregular Heart Beat/A-fib/Arrhythmia No Yes Sciatica, Back pain or swelling No Yes

High Blood Pressure No Yes Foot Disorders..... No Yes

Low Blood Pressure No Yes Ankle, Knee or Hip replacement No Yes

Congestive Heart Failure No Yes Ankle, Knee or Hip pain, swelling or redness. No Yes

Heart Attack No Yes Amputation of Leg, Foot or Toe No Yes

Any other heart problem(s)..... No Yes Cancer, Leukemia, Lymphoma No Yes

Vitamin B12 Deficiency or Anemia No Yes Diabetes..... No Yes

Other blood disorder?..... No Yes Numbness (**where?**)..... No Yes

Circulatory Problems No Yes Weakness (**where?**) No Yes

Stroke, TIA or "Mini-Stroke" No Yes Fatigue No Yes

Paralysis (**where?**) No Yes Tremors (**where?**) No Yes

Peripheral Neuropathy No Yes Seizures, convulsions (**date of last**)..... No Yes

Multiple Sclerosis..... No Yes Neurological Problems No Yes

Parkinson's Disease No Yes Unsteadiness/Imbalance No Yes

Alzheimer's Disease/Dementia No Yes Psychiatric Disorders No Yes

Shortness of breath/Difficulty Breathing No Yes Depression No Yes

Asthma, Emphysema, COPD, Chronic Cough No Yes Anxiety No Yes

Arthritis (**Type? Location?**) No Yes Alcoholism/Drug Addiction No Yes

Osteoporosis No Yes Dizziness/Vertigo No Yes

Bone Fractures (**where? why?**) No Yes Insomnia/difficulty sleeping No Yes

B.

If any condition

is answered "Yes," gather details in the grid below

	Condition	Date of Date of missCondition Condition Diagnosis/recent treated to Condition 1 st Symptom Symptom doctor? Controlled/ Stable?				Treatment
				<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
1				<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
2				<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
3				<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
4				<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
5				<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
6				<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
7				<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
8				<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

9			<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
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8. Physical Measurements

Some falls occur when people stand up from a lying position because their blood pressure would like to take your blood pressure from two positions - one when you are lying and one when you stand up from a lying position. Please lie down on a couch for the first blood pressure measurement.

- A. Supine BP: ____ / ____ Exact Time: ____: ____ (wait no more than 1 minute before taking second reading) & Heart rate: ____ What does your blood pressure usually run? Unknown ____ or

Now please stand up and I will take your blood pressure and pulse again.

- B. Standing BP: ____ Exact Time: ____: ____
& Heart rate: ____

- C. Height: ____ ft. ____ Have you had any loss of height? No. Yes.....
How much? _____ Reason: _____

- D. Weight: _____ lbs.

9. Activities of Daily Living & Physical Performance Measurements

The next questions concern your ability to perform daily activities. I will first ask if you have difficulty doing the activity, then if you receive any assistance or use any equipment to demonstrate the motions that are required to complete the activities. I will also be conducting an evaluation in your kitchen, bedroom, the bathroom that you use most often and the most of your time. Assessor: As you view each room, look to see that flooring is securely attached (including area rugs), walkways are well lit and clear of obstructions, thresholds are only 1/2 inch high, furniture is sturdy and note any nightlights that are used regularly.

B. Transferring:

- 1 Do you have difficulty when transferring in or out of a bed or chair without assistance? No Yes.....
1. _____ If Yes, Describe

why completion of this activity is difficult for you: _____

2. _____

3. _____

4. _____

- 2 Does anyone help you transfer in and out of a bed or chair?..... No Yes.....

- 3 Do you use equipment when transferring from a bed or chair? No Yes.....

5. _____ If Yes identify
type: hooyer lift chair lift walker cane other _____

- 4 Please stand up then sit back down for me.

Assessor: Did the participant have any difficulty completing this task?..... No Yes.....

6. _____ If Yes, choose one and explain difficulty noted Not completed
safety issue

7. _____

8. _____

9. _____

10. _____

5. Based on the information above and using your clinical judgment, choose the level of assistance another person most often required for the insured to complete this activity: (Choose only one)

- No physical assistance** from another person required
- Stand-by assistance** from another person required - *within arm's reach for safety*
- Hands-on assistance** from another person required - *physical assist*

C. Mobility Outside:

1. Do you have difficulty when walking outside your home (within walking distance) including ramps, sidewalks, uneven ground etc...) without assistance from another person? No Yes.....

11. _____ If Yes, Describe

why completion of this activity is difficult for you: _____

12. _____

13. _____

14. _____

2. Does anyone help you when you walk outside your home?..... No Yes.....

3. Do you require equipment when walking outside your home? No Yes.....

If yes, identify type: scooter wheelchair walker cane other _____

4. Based on the information above and using your clinical judgment, choose the level of assistance another person most often required for the insured to complete this activity: (Choose only one)

- No physical assistance** from another person required
- Stand-by assistance** from another person required - within arm's reach for safety
- Hands-on assistance** from another person required - physical assist

D. Chair stands

1. Baseline Chair Stand

These next exercises measure the strength in your legs. Please sit in a chair that is at _____ Do you think it would be safe for you to try to stand up from a chair with _____

If Yes: Demonstrate chair stand for participant as you explain and record results below

First fold your arms across your chest and sit so that your feet are on the floor, then keeping your arms folded across your chest.

- Gets up easily on first try.....(continue with #2 below).
- Gets up on first try but has difficulty.....(continue with #2 below).
- Requires more than one attempt ... (continue with #2 below)..
- Can rise but not without using arms.....(skip to next page).....
- Cannot rise without assistance from another person.....(skip to next page)
- Refused to participate(indicate reason and skip to next page)
- Fear of falling Physically unable Other: _____

If No: Record reason and skip to next page

- Cannot rise without assistance from another person.....(skip to next page)
- Refused to participate(indicate reason and skip to next page)
- Fear of falling Physically unable Other: _____

2. Timed Chair Stands (do not complete if participant indicates it is unsafe to stand without using a _____)

C. Assessor: use a STOP

WATCH or WATCH WITH A SECOND HAND for this section.

OK, now I am going to ask you to stand up a few more times. Please keep your arms _____ and stand up straight as many times as you can until I tell you to stop. After standing _____ and then stand up again. Keep your arms folded across your chest. I will be timing _____

are you ready? **Start timing** **Count out loud how many times**

participant rises from the chair during the 30 seconds. Record results below. Stop timing if there is a safety concern.

- Timed for 30 seconds - Indicate the number of times participant stood first chair d
- Time stopped due to safety concerns at: Number of chair stands during that time
- Time stopped due to participant's inability to complete any chair stands with arms

E. Mobility Inside & timed get up and go:

1 Do you have difficulty when walking from one room to another inside your home without person?..... No Yes.....

15. _____ If Yes, Describe

why completion of this activity is difficult for you: _____

16. _____

17. _____

2 Does anyone help you walk from one room to another inside your home? No Yes.....

3 Do you require equipment when performing this activity? No Yes.....

If yes, identify type stair lift wheelchair walker cane other _____

4 Do you think it would be safe for you to stand up from a chair walk 8 feet and back then

D.

If Yes Use

Measuring Tape to measure out 8 feet. Stand 8 feet from participant and say:

OK, I am going to time how long it takes you to stand up, walk to here is

seated, turn around, walk back and sit down on that seat again. Are you ready?

OK, (START TIMING and Describe below)

Time taken for participant to rise from chair, walk 8 feet, turn, walk back and sit

Posture (e.g. : erect, kyphotic) _____

Balance (e.g. : steady, imbalanced) _____

Pace (e.g. : fast, medium, slow) _____

Stride length (e.g. : short, medium, long) _____

Step height (e.g. : shuffle, exaggerated, natural) _____

Gait (e.g. : smooth, choppy, stiff) _____

Arm movement (e.g. pendulum swing, stiff, bent elbows) _____

Ability to turn (e.g. natural, small steps, unbalanced) _____

Physical Abnormalities/Deformities/Equipment: _____

If No, Why would it not be safe? _____

Assessor: Did the participant have any difficulty completing this task?..... No Yes.....

18. _____ If Yes, choose one and explain difficulty noted Not completed

safety issue

19. _____

20. _____

21. _____

5. Based on the information above and using your clinical judgment, choose the level of assistance another person most often required for the insured to complete this activity: (Choose only one)

No physical assistance from another person required

Stand-by assistance from another person required - within arm's reach for safety

Hands-on assistance from another person required - physical assist

F. Four-test balance scale

E. DO NOT DO this test if participant cannot stand without the assistance of person/assistive device or if s/he feels it is unsafe. Use a STOP WATCH or a WATCH WITH A SECOND HAND for this section. No practices are allowed for these exercises and they should be carried out in bare feet or stocking feet. You may help the person in to each position, but the person must hold the position unaided. **Each position must be held for 10 seconds before progressing to the next position.**

F. Stop timing if:
their feet from the proper position,

(1) the person moves

G. to prevent a fall or

(2) you provide contact

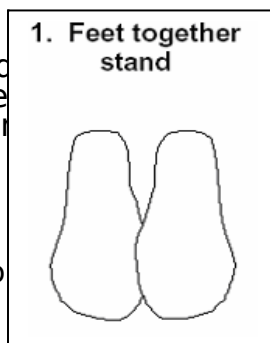
H. the wall or other support with their hand.

(3) the person touches

Many falls are caused by imbalance, so next I will check your balance. For this exercise, take off your shoes. I will ask you to stand in 4 different positions for about 10 seconds each.

1 Feet Together Stand

First I would like you to try to stand with your feet together, side by side (show picture). You may use your arms, bend your knees or move your feet to maintain your balance, but try not to move your feet. Try to hold this position for 10 seconds.

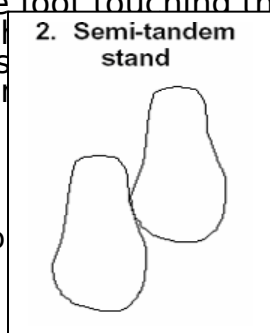


OK, Start timing for 10 seconds. OK, Stop. Record result below)

- Held position successfully for 10 seconds
- Held position successfully, but not for 10 seconds
- Unable to hold position/did not do (indicate reason and skip to next position)
- Fear of falling/physically unable: _____

2 Semi-tandem stand

Next, I want you to try to stand with the side of the heel of one foot touching the big toe of the other foot for about 10 seconds. You may put either foot in front, whichever is comfortable for you. You may use your arms, bend your knees or move your feet to maintain your balance, but try not to move your feet. Try to hold this position for 10 seconds.

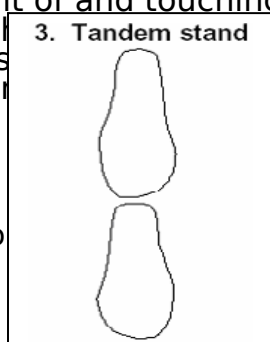


OK, Start timing for 10 seconds. OK, Stop. Record result below)

- Held position successfully for 10 seconds
- Held position successfully, but not for 10 seconds
- Unable to hold position/did not do (indicate reason and skip to next position)
- Fear of falling/physically unable: _____

3 Tandem stand

Now, I want you to try to stand with the heel of one foot in front of and touching the toe of the other foot for about 10 seconds. You may put either foot in front, whichever is comfortable for you. You may use your arms, bend your knees or move your feet to maintain your balance, but try not to move your feet. Try to hold this position for 10 seconds.

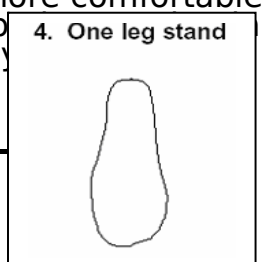


OK, Start timing for 10 seconds. OK, Stop. Record result below)

- Held position successfully for 10 seconds
- Held position successfully, but not for 10 seconds
- Unable to hold position/did not do (indicate reason and skip to next position)
- Fear of falling/physically unable: _____

4 One leg stand

Now, I want you to try to stand on one foot (only if you feel it is safe!), raising the other foot off the ground for about 10 seconds. You may use whichever foot is more comfortable for you. You may use your arms, bend your knees or move your body to maintain your balance, but try not to put the other foot down. Try to hold this position until I tell you to stop.



OK, Start *Time for 10 seconds*, Stop *OK, Stop* (record result below)

- Held position successfully for 10 seconds
- Held position successfully, but not for 10 seconds
- Unable to hold position/did not do (indicate reason and skip to next page)
- Fear of falling Physically unable Other: _____

G. Eating (Note: Eating does not include meal preparation, cooking, cutting food, pouring liquids or buttering bread):

1 Do you have difficulty eating without assistance from another person?.....NoYes.....
22. _____ If Yes, Describe

why completion of this activity is difficult for you: _____

23. _____

24. _____

25. _____

2 Does anyone help you eat?.....NoYes.....

3 Do you require equipment when eating?NoYes.....

26. _____ If Yes identify

type:Feeding tubeTPN other: _____

4 Please demonstrate how you grasp a cup and the fork or spoon (as applicable)

Assessor: Did the participant have any difficulty completing this task?.....NoYes.....

27. _____ If Yes, choose

one and explain Difficulty not completed, safety issue _____

28. _____

29. _____

5. Based on the information above and using your clinical judgment, choose the level of assistance another person most often required for the insured to complete this activity: (Choose only one)

No physical assistance from another person required

Stand-by assistance from another person required - within arm's reach for safety

Hands-on assistance from another person required - physical assist

H. Kitchen safety evaluation

Let's go into the kitchen and I will evaluate the lighting, counter height and flooring.

1 Is lighting adequate (light bulbs greater than 60 watts) in this room?.....NoYes.....

If No: Explain: _____

2 Are counters and shelves at an appropriate height such that items can be easily reached? NoYes

If No: Explain: _____

Is a sturdy, non-skid step stool used to reach items outside participant's reach? NoYes

I. Stairway Safety Evaluation

Next I would like to see any stairs that you use.

1 Are the stairs used to enter/exit well lit with sturdy railings on both sides? NoneNoYes

If No: Explain: _____

2 Are the stairs inside the home well lit with sturdy railings on both sides? NoneNoYes

If No: Explain: _____

J. Bedroom safety evaluation

Next I will ask you about dressing, let's go into the bedroom and I will evaluate the lighting safety, flooring and pathway to the bathroom.

1 Is the mattress firm and sag resistant and at a height that enables easy transfers? NoYes

If No: Explain: _____

2 Is there a clear path from where participant sleeps to the bathroom for easy navigation in dark? NoYes

If No: Explain: _____

3 Are nightlights used so that the pathway to the bathroom is visible at night?..... No Yes....

If No: Explain: _____

K. Dressing:

1 Do you have difficulty when dressing/undressing including getting your clothes from closet, taking them off and doing buttons, hooks and zippers without assistance from another person? No Yes

30. _____ If Yes, Describe

why completion of this activity is difficult for the participant: _____

31. _____

32. _____

33. _____

2 Does anyone help you dress or undress? No Yes.....

3 Do you require equipment when dressing or undressing? No Yes.....

34. _____ If Yes identify

type: _____

4 Please show me the movements you use to get your clothes, put on a shirt, pants/skirt and shoes

Assessor: Did the participant have any difficulty completing this task?..... No Yes.....

35. _____ If Yes, choose one and explain Difficulty noted Not completed

safety issue

36. _____

37. _____

38. _____

5 Based on the information above and using your clinical judgment, choose the level of assistance from another person most often required for the insured to complete this activity: (Choose only one)

No physical assistance from another person required

Stand-by assistance from another person required - within arm's reach for safety

Hands-on assistance from another person required - physical assist

L. Bathroom safety evaluation:

Next I will ask you about bathing and toileting, let's go into the bathroom and I will evaluate the bathroom and the flooring in the bathing area and toilet are as well as check if there are any grab bars

1 Is lighting adequate (light bulbs greater than 60 watts) in the tub, toilet and shower area? No Yes

If No: Explain: _____

2 Are grab bars securely fastened for use while bathing in the bathing area? None No Yes

If No: Explain: _____

3 Are grab bars/toilet safety frame securely fastened for use with getting on and off toilet? None No Yes

If No: Explain: _____

4 Is there a bath mat or non-skid flooring in tub/shower?..... No Yes.....

If No: Explain: _____

5 Are nightlights used so the bathroom is visible at night?..... No Yes.....
If No: Explain: _____

Many falls that occur in the home occur in the bathroom while people are transferring on a toilet and getting in and out of the shower or tub. Since these two actions are the most of fall, I am going to ask you to demonstrate how you do these activities for me.

M. Bathing:

A. How do you usually bathe? Sponge bath Whirlpool/Tub Shower/Tub Shower in Stall/Walk-in Shower

1. Do you have difficulty when bathing including getting to and from and in and out of the tub/shower and drying all parts of your body without assistance from another person?..... No Yes.....
 39. _____ If Yes, Describe

why completion of this activity is difficult for you: _____

40. _____

41. _____

42. _____

2. Does anyone help you bathe?..... No Yes.....

3. Do you require equipment when bathing? No Yes.....
 43. _____ If Yes identify

type: bath bench/seal hand held shower grab bars other _____

4. Please show me how you get in and out of your bathing area and show me how you can bathe. Assessor: Did the participant have any difficulty completing this task?..... No Yes.....

44. _____ If Yes, choose

one and explain: Difficulty noted Not completed, safety issue _____

45. _____

46. _____

5. Based on the information above and using your clinical judgment, choose the level of assistance from another person most often required for the insured to complete this activity: (Choose only one)

- No physical assistance** from another person required
- Stand-by assistance** from another person required - within arm's reach for safety
- Hands-on assistance** from another person required - physical assist

N. TOILETING:

1. Do you have difficulty when toileting including getting to and from and on and off the toilet, elimination and adjusting your clothing without assistance from another person?..... No Yes.....
 47. _____ If Yes, Describe

why completion of this activity is difficult for the participant: _____

48. _____

49. _____

50. _____

2. Does anyone help you toilet at all?..... No Yes.....

3. Do you require equipment when performing this activity? No Yes.....
 51. _____ If Yes identify

type: bedpan urinal commode raised toilet seat

52. _____

walker cane wheelchair toilet safety frame other _____

4. Please show me how you get on and off of your toilet.

Assessor: Did the participant have any difficulty completing this task?..... No Yes.....

53. _____ If Yes, choose
one and explain. Difficulty noted Not completed, safety issue _____

54. _____

55. _____

5. Based on the information above and using your clinical judgment, choose the level of assistance another person most often required for the insured to complete this activity: (Choose only one)

- No physical assistance** from another person required
- Stand-by assistance** from another person required - *within arm's reach for safety*
- Hands-on assistance** from another person required - *physical assist*

O. BLADDER CONTINENCE:

1 Do you ever experience any loss of bladder control? No Yes.....

2 Do you use a urostomy or a catheter? No Yes.....

56...../.

f No to both questions, skip to Bowel Continence question.

57...../.

f Yes to either question:

- Do have difficulty when washing yourself, disposing of soiled items, changing or adjusting clothing or caring for the medical device without assistance from another person? No Yes

58. _____ If Yes, Describe why completion

of this activity is difficult you: _____

59. _____

60. _____

61. _____

- Does anyone help you when you are incontinent? No Yes.....

- Do you require equipment when because of your bladder incontinence? No Yes.....

62. _____ If Yes identify

type: pads briefs urostomy catheter other _____

- Based on the information above and using your clinical judgment, choose the level of assistance from another person most often required for the insured to complete this activity: (Choose only one)

No physical assistance from another person required

Stand-by assistance from another person required – within arm’s reach for safety

Hands-on assistance from another person required – physical assist

P. BOWEL CONTINENCE:

1 Do you ever experience any loss of bowel control? No Yes.....

2 Do you use a colostomy or ileostomy? No Yes.....

63...../.

f No to both questions, skip to next page.

64...../.

- Do have difficulty when washing yourself, disposing of soiled items, adjusting your clothing or caring for the medical device without assistance from another person? No Yes

65. _____ If Yes, Describe

why completion of this activity is difficult you: _____

66. _____

67. _____

68. _____

- Does anyone help you when you are incontinent? No Yes.....

- Do you require equipment when because of your bladder incontinence? No Yes.....

69. _____ If Yes identify

type: pads briefs colostomy ileostomy other _____

- Based on the information above and using your clinical judgment, choose the level of assistance from another person most often required for the insured to complete this activity: (Choose only one)

- No physical assistance** from another person required
- Stand-by assistance** from another person required – *within arm’s reach for safety*
- Hands-on assistance** from another person required – *physical assist*

10. Current Care

Q Do you receive personal care or assistance from any paid caregivers (including Medicare services)? No Yes
 J. Assessor: Below

please document any and all paid services provided to the participant.

Service Provider (e.g. RN, CNA)	Service Provided (e.g. skilled care, ADLs, supervision, etc.)	Frequency per Week (e.g., 2-3 hrs / day 7 days/wk)	Projected Duration (e.g., Long term, 3 weeks)	Start Date of Service	Hourly Rate/ monthly fee

K.

R Do you receive personal care or assistance from any unpaid caregivers (including family members)? No Yes
 L. Assessor: Below

please document any and all services provided to the participant.

Unpaid Caregiver Name and relationship	Service Provided (check all that apply)	Frequency per Week (e.g., 2-3 hrs/day 7 days/wk)	Projected Duration (e.g., Long term, 3 weeks)	Start Date of assistance
Does this person live with the participant? <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Bathing <input type="checkbox"/> Dressing <input type="checkbox"/> Transfers <input type="checkbox"/> Eating <input type="checkbox"/> Toileting <input type="checkbox"/> Continence <input type="checkbox"/> IADLs <input type="checkbox"/> Companionship <input type="checkbox"/> Supervision <input type="checkbox"/> Med Administration <input type="checkbox"/> Other _____			
Does this person live with the participant? <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Bathing <input type="checkbox"/> Dressing <input type="checkbox"/> Transfers <input type="checkbox"/> Eating <input type="checkbox"/> Toileting <input type="checkbox"/> Continence <input type="checkbox"/> IADLs <input type="checkbox"/> Companionship <input type="checkbox"/> Supervision <input type="checkbox"/> Med Administration <input type="checkbox"/> Other _____			

<p>Does this person live with the participant?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p><input type="checkbox"/> Bathing</p> <p><input type="checkbox"/> Dressing</p> <p><input type="checkbox"/> Transfers</p> <p><input type="checkbox"/> Eating</p> <p><input type="checkbox"/> Toileting</p> <p><input type="checkbox"/> Continence</p> <p><input type="checkbox"/> IADLs</p> <p><input type="checkbox"/> Companionship</p> <p><input type="checkbox"/> Supervision</p> <p><input type="checkbox"/> Med Administration</p> <p><input type="checkbox"/> Other _____</p>			
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11. Summary of Home Safety Evaluation

M.

Assessor: Take one last walk

through any rooms that you viewed and answer the following questions about the areas where the participant spends most of his/her time. Please supply details for each "No" answer.

1 Is **flooring** non-skid and firmly attached to floor?..... No Yes.....

If No: in which room Bathroom Bedroom Kitchen Other: _____

Explain: _____

2 Are **walkways** well lit, visible and free of obstruction and clutter?..... No Yes.....

If No: in which room Bathroom Bedroom Kitchen Other: _____

Explain: _____

3 Are **thresholds** at a height no greater than 1/2 inch?..... No Yes.....

If No: in which room Bathroom Bedroom Kitchen Other: _____

Explain: _____

4 Are **scatter rugs** (throw rugs) securely fastened to the floor?..... None No Yes

If No: in which room Bathroom Bedroom Kitchen Other: _____

Explain: _____

5 Are the **electrical cords** cleared from pathways?..... No Yes.....

If No: in which room Bathroom Bedroom Kitchen Other: _____

Explain: _____

6 Are **seats and chairs** safe for transfers with sturdy footing and secure armrests? No Yes.

If No: in which room Bathroom Bedroom Kitchen Other: _____

Explain: _____

7 Are **counters/furniture** secure enough to provide support if leaned upon for mobility assistance? No Yes

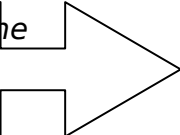
If No: in which room Bathroom Bedroom Kitchen Other: _____

Explain: _____

8 Other than was noted in the previous few pages, did the participant's home appear to be fall-free? No Yes

If No: Explain other safety hazards noted: _____

Enter the time the interview ends (i.e. 2:53 PM).



Exact time:
_____:____ am/pm

12. Wrap up

If this is the initial in-person assessment end with:

Thank you for your participation in the Independent Living and Mobility Prevention Program. A letter of appreciation will be sent to you along with recommendations of how to maintain your independence over time and stay safer. Also we will be sending the Health Promotion and Fall Prevention Tool kit mentioned in the interview. Additionally, a clinician will be calling you every 3 months or so to gather information for your Progress Chart and Falls Journal which are part of the Tool kit. As part of the program, you will be completing your Exercise Progress Chart on a weekly basis and in the Falls Journal every time you fall of some kind. Thank you again for your participation!

If this is the Final in-person assessment end with:
Thank you for your participation in the Independent Living and Mobility Program. This ends
we really appreciate the time you have invested in this important national program.

13. Clinical Summary

N.

Assessor: Complete

the Clinical Summary after you have left the Participant's home. Please be sure to provide an answer for each question

A. Was there any indication that the participant is unsafe to be left alone?... No Yes.....

If Yes, explain _____

B. Was there any indication that the participant is not taking reasonable care of his/her home cleanliness, neatness and minimizing clutter? No Yes.....

If Yes, explain _____

C. Was there any indication that the participant is not taking reasonable care of themselves hygiene, and grooming? No Yes.....

If Yes, explain _____

D. Was anyone other than the participant present during any part of the interview? No Yes.....

Who: _____
Relationship to participant: _____

E. Did anyone other than the participant answer any of the interview questions? No Yes.....

If Yes, explain _____

F. Does the participant appear to be in immediate danger due to an unsafe home environment? No Yes.....

If Yes, explain _____

G. Did you observe any non-reported safety issues (including skin breakdown, incontinence, or falls)? No Yes.....

If Yes, explain _____

H. Are there any other concerns or comments that you feel should be documented? No Yes.....

If Yes, explain _____



14. Field Based Observations

O. *Please use the information you gathered during the interview to identify unmet needs that should be addressed in the summary that will be sent to the participant.*

1. Do you feel the insured has the appropriate equipment in his/her home? Yes No.....

P. *Check all equipment/safety devices that the insured **does not have**, but would benefit from, to remain safely in his/ her present location: For each piece of equipment noted, indicate why it is needed below:*

- | | | |
|---|--|---|
| <input type="checkbox"/> Straight Cane | <input type="checkbox"/> Hospital Bed | <input type="checkbox"/> Commode |
| <input type="checkbox"/> Multi-pronged Cane | <input type="checkbox"/> Tub rail (tub) | <input type="checkbox"/> Raised Toilet Seat |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Bath/shower Stool | <input type="checkbox"/> Toilet Safety Frame |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Shower bench with back | <input type="checkbox"/> Medical Alert System |
| <input type="checkbox"/> Electric Scooter | <input type="checkbox"/> Hand Held Shower | <input type="checkbox"/> Stair Lift |
| <input type="checkbox"/> Electric Recliner | <input type="checkbox"/> Grab Bars in shower/tub | Other: _____ |

Type of Equipment	Reason recommended

2. Do you feel the insured has the appropriate level, intensity and duration of services? Yes No?

Q. *If No, complete the table below. In the table below, check the type of care you would recommend for this insured and provide information on frequency and duration.*

Recommended Service	Recommended Frequency	Recommended Duration
<input type="checkbox"/> Home Health Aide/Personal Care Attendant	_____ d/wk	_____ d/wk
<input type="checkbox"/> Homemaker/Companion	_____ hrs/day	_____ d/wk
<input type="checkbox"/> Physical/Occupational/Speech Therapy	_____ hrs/day	_____ d/wk
<input type="checkbox"/> Skilled Nurse	_____ hrs/day	_____ d/wk
<input type="checkbox"/> Medical Social Worker	_____ hrs/day	_____ d/wk
<input type="checkbox"/> Meals on Wheels/Nutritional Services	_____ meals/wk	
<input type="checkbox"/> Pharmaceutical Care		
<input type="checkbox"/> Transportation		
<input type="checkbox"/> Other _____		
<input type="checkbox"/> Other _____		

Why are these services being recommended?

¹ Minimum requirement: 3 inches between toilet and sink/tub and no shelves above toilet with legs going to floor

² Due to liability, typically Hand Held Showers will not be installed by the Medical Equipment Vendors

Assessor signature: _____ Date of interview: _____

~ PLEASE FAX IMMEDIATELY TO ----- WHEN COMPLETED! THANK YOU ~