APPENDIX C

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

Form Approved
OMB No. 0990-0308
Exp. Date XX/XX/20XX

Referral Number

Participant Name:_____

Address: _____

Phone Number: _____

Independent Living and Mobility Program In-Person Interview

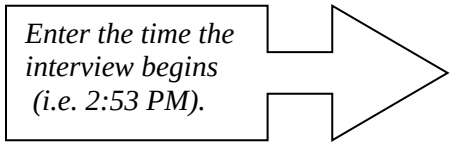
Assessor – *Print your name with credentials and the date that the interview was completed.*

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

. 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.

. 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

. Hospital/Emergency Visits and Surgery

D. 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/ Surgery	Date (month/ year)	Type of Surgery &/or Treatment received	Current Status

. Primary Care Physician

A. Do you have a primary care physician?..... ☐
No ☐ Yes

Physician's name:_____Phone number:_____

City:_____State_____Street address:_____

Specialty:_____

. Falls History

A. **Since your recent phone interview have you had one or more episodes of fainting, falling or dropping to the ground, passing out or have you lost your balance, slipped or tripped over something that 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 Visit ☐ Hospital Admission ☐ 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.....	☐ No ☐ Yes	
Object in	☐ No	☐

walkway/path.....Yes

Behaviors	For each Yes, answer additional question	Additional Question
Wearing shoes that did not fit properly	☐No ☐Yes	☐ Have you changed this behavior?.....☐No ☐Yes
Wearing clothes that did not fit properly	☐No ☐Yes	☐ Have you changed this behavior?.....☐No ☐Yes
Not using necessary visual aid/glasses	☐No ☐Yes	☐ Have you changed this behavior?.....☐No ☐Yes
Not using necessary equipment	☐No ☐Yes	☐ Have you changed this behavior?.....☐No ☐Yes
(cane, walker, shower seat, grab bars)	☐No ☐Yes	☐

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 you are afraid of falling?**.....☐ No ☐Yes

If Yes, Which activities and why?_____

_____

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

. Medications

A. **Please tell me the names and dosages of all the medications you currently take including non-prescription 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						☐ Yes ☐ No	
2						☐ Yes ☐ No	
3						☐ Yes ☐ No	
4						☐ Yes ☐ No	
5						☐ Yes ☐ No	
6						☐ Yes ☐ No	
7						☐ Yes ☐ No	
8						☐ Yes ☐ No	
9						☐ Yes ☐ No	
10						☐ Yes ☐ No	
11						☐ Yes ☐ No	
12						☐ Yes ☐ No	
13						☐ Yes ☐ No	
14						☐ Yes ☐ No	
15						☐ Yes ☐ No	
16						☐ Yes ☐ No	

17						☐ Yes ☐ No	
18						☐ Yes ☐ No	
19						☐ Yes ☐ No	
20						☐ Yes ☐ No	

. Medical Conditions and Symptoms

B. **Do you have a history of any of the following conditions?** *(if any answer is "Yes," explain below)*

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 Diagnosis/ 1st Sympto	Date of most recent Sympto	Is Condition treated	Is Condition Controll	Treatment

		m	m	by a doctor?	ed/ Stable?	
1				☐No ☐Yes	☐No ☐Yes	
2				☐No ☐Yes	☐No ☐Yes	
3				☐No ☐Yes	☐No ☐Yes	
4				☐No ☐Yes	☐No ☐Yes	
5				☐No ☐Yes	☐No ☐Yes	
6				☐No ☐Yes	☐No ☐Yes	
7				☐No ☐Yes	☐No ☐Yes	
8				☐No ☐Yes	☐No ☐Yes	
9				☐No ☐Yes	☐No ☐Yes	

. Physical Measurements

Some falls occur when people stand up from a lying position because their blood pressure drops. Therefore, I would like to take your blood pressure from two positions – one when you are lying down, then one after you stand up from a lying position. Please lie down on a couch for the first blood pressure and pulse.

A. Supine BP: _____ / _____.....Exact Time: ____: _____ (*wait no more than 1 minute before taking standing BP*)

& Heart rate:_____ What does your blood pressure usually run? _____ / _____ or ☐Unknown

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

B. Standing BP: _____ / _____.....Exact Time: ____: _____

& Heart rate:_____

C. Height: ____ft._____ in. .....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 current ability to perform daily activities. I will first ask if you have any difficulty doing the activity, then if you receive any assistance or use any equipment and then I will ask you to demonstrate the motions that are required to complete the activities. I will also be asking to do a safety evaluation in your kitchen, bedroom, the bathroom that you use most often and the rooms in which you spend 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 ½ inch high, furniture is sturdy and note any nightlights that are used regularly.*

C. Transferring:

1. Do have difficulty when transferring in or out of a bed or chair without assistance from another person?.....☐ 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:* ☐*hoyer 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 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*

D. Mobility Outside:

1. Do have difficulty when walking outside your home (within walking distance) including negotiating uneven surfaces (curbs, 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 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*

E. Chair stands

1. Baseline Chair Stand

These next exercises measure the strength in your legs. Please sit in a chair that is at a comfortable height.

Do you think it would be safe for you to try to stand up from a chair without using your arms? ☐No ☐Yes

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 try to stand up, 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 arms)*

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 folded across your chest and stand up straight as many times as you can until I tell you to stop. After standing up each time, sit down and then stand up again. Keep your arms folded across your chest. I will be timing you for 30 seconds. OK, are you ready? Stand. *Assessor:* ***Start timing*** *and* ***Count out loud how many times*** *the 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 from chair during 30 seconds: _____chair stands

☐Time stopped due to safety concern at:_____seconds.
Number of chair stands during that time:_____chair stands

☐Time stopped due to participant's inability to complete any chair stands with arms folded on chest.

F. Mobility Inside & timed get up and go:

1. Do you have difficulty when walking from one room to another inside your home without assistance from another 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* ☐w*heelchair* ☐*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 sit back down?.....☐No ☐Yes

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 *(8 feet from where participant is seated*), turn around, walk back and sit down on that seat again. Are you ready?

OK, Go. *(START TIMING and Describe below)*

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

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 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*

G. Four-test balance scale

E. ***DO NOT DO this test if participant cannot stand without the assistance of a 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:* *(1) the person moves their feet from the proper position,*

G. *(2) you provide contact to prevent a fall or*

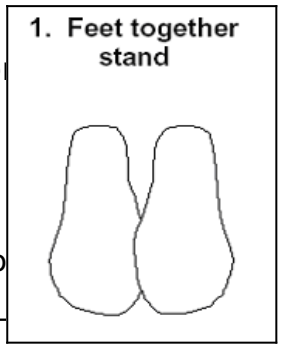
H. *(3) the person touches the wall or other support with their hand.*

I.

Many falls are caused by imbalance, so next I will check your balance. For this exercise, please 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, for about 10 seconds *(show picture)*. You may use your arms, bend your knees or move your body to maintain your balance, but try not to move your feet. Try to hold this positio until I tell you to stop.



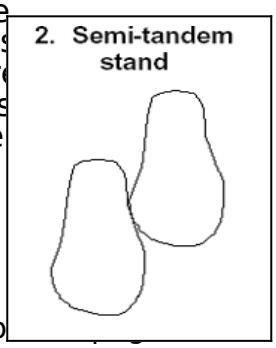
OK, Start. *(Time for 10 seconds)* Ok, Stop. *(Record result below)*

- ☐ 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

☐ Fear of falling ☐ Physically unable ☐ Other: _____

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 *(show picture)*. You may put either foot in front, whichever is more comfortable for you. You may use your arms, bend your knees move your body to maintain your balance, but try not to move your feet. Try to hold this position until I tell you to stop.



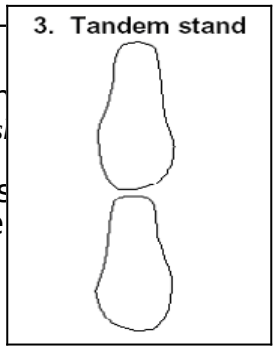
OK, Start. *(Time for 10 seconds)* Ok, Stop. *(Record result below)*

- ☐ 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

☐ Fear of falling ☐ Physically unable ☐ Other: _____

3. **Tandem stand**

Now, I want you to try to stand with the heel of one foot in fron and touching the toes of the other foot for about 10 seconds *(s picture)*. You may put either foot in front, whichever is more comfortable for you. You may use your arms, bend your knees move your body to maintain your balance, but try not to move your feet. Try to hold this position until I tell you to stop.



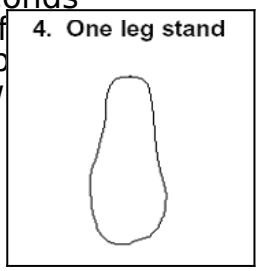
OK, Start. *(Time for 10 seconds)* Ok, Stop. *(Record result below)*

- ☐ 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 page)

☐ Fear of falling ☐ Physically unable ☐ Other: _____

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 of the ground for about 10 seconds *(show picture)*. You may use whichever foot is more comfortable f you. You may use your arms, bend your knees or move your b to maintain your balance, but try not to put the other foot dow Try to hold this position until I tell you to stop.



OK, Start. *(Time 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 page)
  - ☐ Fear of falling ☐ Physically unable ☐ Other: _____

H. 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?.....☐
   No ☐Yes
   22. *If Yes,* Describe why completion of this activity is difficult for you:
   23. _____
   24. _____
   25. _____
2. Does anyone help you eat?.....☐
   No ☐Yes
3. Do you require equipment when eating?.....☐
   No ☐Yes
   26. *If Yes identify type:* ☐*Feeding tube* ☐*TPN* ☐*other:*_____
4. Please demonstrate how you grasp a cup and then a fork or spoon.
   (Use pen if fork/spoon not available)
   Assessor: Did the participant have any difficulty completing this task?.....☐
   No.....☐
   Yes
   27. *If Yes, choose one and explain:* ☐Difficulty noted ☐Not completed, safety issue
   28. _____
   29. _____
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*

I. 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?*.....☐No
   ☐Yes
   *If No: Explain:*_____
   _____
6. *Are counters and shelves at an appropriate height such that items can be easily reached?* ..☐No
   ☐Yes
   *If No: Explain:*_____
   Is a sturdy, non-skid step stool used to reach items outside participant's reach?.....☐No ☐Yes

J. 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?*.....☐None ☐
   No ☐Yes
   *If No: Explain:*_____
2. *Are the stairs inside the home well lit with sturdy railings on both sides?*.....☐None ☐
   No ☐Yes
   *If No: Explain:*_____

K. Bedroom safety evaluation

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

1. *Is the mattress firm and sag resistant and at a height that enables easy transfers?*..... ☐ No ☐ Yes

*If No: Explain:*_____

_____

7. *Is there a clear path from where participant sleeps to the bathroom for easy navigation in the dark?*

☐ No..... ☐ Yes

*If No: Explain:*_____

_____

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

*If No: Explain:*_____

_____

L. Dressing:

1. Do you have difficulty when dressing/undressing including getting your clothes from closets/drawers, putting them on and 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. _____

9. Does anyone help you dress or undress?.....☐No ☐Yes

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

34. If Yes identify type: _____

2. 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. _____

11. 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*

M. Bathroom safety evaluation:

Next I will ask you about bathing and toileting, let's go into the bathroom and I will evaluate the lighting 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 areas?*.....☐No ☐Yes

*If No: Explain:*_____
_____

12. *Are grab bars securely fastened for use while bathing in the bathing area?*.....☐None ☐ No ☐Yes

*If No: Explain:*_____
_____

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

*If No: Explain:*_____

_____

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

*If No: Explain:*_____

_____

15. *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 and off the toilet and getting in and out of the shower or tub. Since these two actions are the most common cause of fall, I am going to ask you to demonstrate how you do these activities for me.

N. Bathing:

A. How do you usually bathe? ☐ Sponge Bath ☐ Whirlpool/Tub ☐ Shower in 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 bathing area, washing 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. _____

16. Does anyone help you bathe?.....☐ No ☐ Yes

17. Do you require equipment when bathing?.....☐ No ☐ Yes

43. *If Yes identify type:* ☐ *bath bench/seat* ☐ *hand held shower* ☐ *grab bars* ☐ *other*_____

18. Please show me how you get in and out of your bathing area and show me how you can wash your head, back and feet.

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. _____

19. 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*

O. TOILETING:

1. Do you have difficulty when toileting including getting to and from and on and off the toilet, cleaning yourself after 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. _____

20. 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. BLADDER CONTINENCE:

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

21. Do you use a urostomy or a catheter?.....☐No ☐Yes

56. *If No to <u>both questions</u>, skip to Bowel Continence question.*

57. *If Yes to either question:*

- Do have difficulty when washing yourself, disposing of soiled items, changing or adjusting your 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*

Q. BOWEL CONTINENCE:

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

22. Do you use a colostomy or ileostomy?.....☐No ☐Yes

63. *If No to <u>both questions</u>, skip to next page.*

64. *If "Yes" to either question* Do have difficulty when washing yourself, disposing of soiled items, changing or 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*

0. Current Care

R. 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 and Hours per Day (e.g., 2-3 hrs / day 7 days / wk)	Projected Duration (e.g., Long term, 3 weeks, 3-6 weeks)	Start Date of Service	Hourly Rate/ monthly fee

K.

S. Do you receive personal care or assistance from any unpaid caregivers (including family members/friends)?..... ☐ 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 and Hours per Day (e.g., 2-3 hrs/day 7 days/wk)	Projected Duration (e.g., Long term, 3 weeks, 3-6 weeks)	Start Date of assistance
Does this person live with the participant? ☐ No ☐ Yes	☐ Bathing ☐ Dressing ☐ Transfers ☐ Eating ☐ Toileting ☐ Continence ☐ IADLs ☐ Companionship ☐ Supervision ☐ Med Administration ☐ Other_____			
Does this	☐ Bathing ☐ Dressing ☐ Transfers ☐ Eating ☐ Toileting ☐ Continence ☐ IADLs ☐ Companionship ☐ Supervision ☐ Med Administration ☐ Other_____			

person live with the participant? ☐ No ☐ Yes				
Does this person live with the participant? ☐ No ☐ Yes	☐ Bathing ☐ Dressing ☐ Transfers ☐ Eating ☐ Toileting ☐ Continence ☐ IADLs ☐ Companionship ☐ Supervision ☐ Med Administration ☐ Other_____			

1. 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 rooms: ☐ *Bathroom* ☐ *Bedroom* ☐ *Kitchen* ☐ *Other:*_____

*Explain:*_____

_____

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

If No: in which rooms: ☐ *Bathroom* ☐ *Bedroom* ☐ *Kitchen* ☐ *Other:*_____

*Explain:*_____

_____

24. *Are **thresholds** at a height no greater than ½ inch?*..... ☐ No ☐ Yes

If No: in which rooms: ☐ *Bathroom* ☐ *Bedroom* ☐ *Kitchen* ☐ *Other:*_____

*Explain:*_____

_____

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

If No: in which rooms: ☐ *Bathroom* ☐ *Bedroom* ☐ *Kitchen* ☐ *Other:*_____

*Explain:*_____

_____

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

If No: in which rooms: ☐ *Bathroom* ☐ *Bedroom* ☐ *Kitchen* ☐ *Other:*_____

*Explain:*_____

_____

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

If No: in which rooms: ☐ *Bathroom* ☐ *Bedroom* ☐ *Kitchen* ☐ *Other:*_____

*Explain:*_____

_____

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

If No: in which rooms: ☐ *Bathroom* ☐ *Bedroom* ☐ *Kitchen* ☐ *Other:*_____

*Explain:*_____

_____

29. *Other than was noted in the previous few pages, did the participant's home appear to be hazard-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

2. 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 summary of this interview will be sent to you along with recommendations of how to maintain your independence over time and keep your home safer. Also we will be sending the Health Promotion and Fall Prevention Tool kit mentioned at the beginning of the interview. Additionally, a clinician will be calling you every 3 months or so to gather information from your Exercise Progress Chart and Falls Journal which are part of the Tool kit. As part of the program, you will be asked to document in your Exercise Progress Chart an on a weekly basis and in the Falls Journal every time you ever experience a fall or a near 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 the 2 year study, we really appreciate the time you have invested in this important national program.

3. 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_____

_____

_____

T. Was there any indication that the participant is not taking reasonable care of his/her home environment in terms of cleanliness, neatness and minimizing clutter? .....☐
No ☐**Yes**

If Yes, explain_____

_____

_____

U. Was there any indication that the participant is not taking reasonable care of themselves in terms of appearance, hygiene, and grooming? .....☐
No ☐Yes

If Yes, explain_____

_____

_____

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

Who:_____

Relationship to participant:_____

W. Did anyone other than the participant answer any of the interview questions?.....☐
No ☐**Yes**

If Yes, explain_____

_____

_____

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

If Yes, explain_____

_____

_____

Y. Did you observe any non-reported safety issues (including skin breakdown, bruises, malnourishment etc…)?.....☐
No ☐**Yes**

If Yes, explain_____

_____

_____

Z. Are there any other concerns or comments that you feel should be documented or explained?.....☐
No ☐**Yes**

If Yes, explain_____

_____

_____

4. 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:*

☐Straight Cane	☐Hospital Bed	☐Commode
☐Multi-pronged Cane	☐Tub rail (tub)	☐Raised Toilet Seat
☐Walker	☐Bath/shower Stool	☐Toilet Safety Frame[1]
☐Wheelchair	☐Shower bench with back	☐Medical Alert System
☐Electric Scooter	☐Hand Held Shower[2]	☐Stair Lift
☐Electric Recliner	☐Grab Bars in shower/tub	☐Other:_____

Type of Equipment	Reason recommended

30. 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
☐	Home Health Aide/Personal Care Attendant	____hrs/day ____d/wk	
☐	Homemaker/Companion	____hrs/day ____d/wk	
☐	Physical/Occupational/ Speech Therapy	____hrs/day ____d/wk	
☐	Skilled Nurse	____hrs/day ____d/wk	
☐	Medical Social Worker	____hrs/day	

[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

		____d/wk	
☐	Meals on Wheels/Nutritional Services	____meals/wk	
☐	Pharmaceutical Care		
☐	Transportation		
☐	Other_____		
☐	Other_____		

Why are these services being recommended?

_____
_____
_____
_____

Assessor signature:_____ Date of interview:_____

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