HUD's Integrated Wellness in Supportive Housing (IWISH) Resident and Wellness Assessment – Paper Version **- DRAFT**

PAPERWORK REDUCTION ACT STATEMENT OF PUBLIC BURDEN:

The public reporting burden for this information collection is estimated to be 80 minutes. This burden estimate includes time for reviewing instructions, researching existing data sources, gathering and maintaining the needed data, and completing and submitting the information. Send comments regarding the accuracy of this burden estimate and any suggestions for reducing the burden to: U.S. Office of Personnel Management, Federal Investigative Services, Attn: OMB Number (3206-0246), 1900 E Street NW, Washington, DC 20415-7900.

The information requested under this collection is protected and held confidential in accordance with 42 U.S.C. 1306, 20 CFR 401 and 402, 5 U.S.C.552 (Freedom of Information Act), 5 U.S.C. 552a (Privacy Act of 1974) and OMB Circular No. A-130.

Please use this paper version of the health and wellness assessment for times when you cannot enter information directly into the demonstration's online platform, hosted by Population Health Logistics (PHL). After completing the paper assessment, please follow the IWISH PHL User Guide for instructions on how to enter the data into PHL.

Participant Information	
1. First Name	
2. Middle Name	
3. Last Name	
4. Date of Birth	
5. Gender (select one)	☐ Male ☐ Female ☐ Transgender ☐ Does Not Declare ☐ Other
6. Preferred Language (select one)	☐ English ☐ Spanish ☐ Albanian ☐ Arabic ☐ Cambodian ☐ Chinese-Cantonese ☐ Chinese –Mandarin ☐ Farsi ☐ French Creole ☐ German ☐ Greek ☐ Hindi ☐ Italian ☐ Korean ☐ Persian ☐ Portuguese ☐ Russian ☐ Tagalog ☐ Twi ☐ Ukrainian ☐ Vietnamese ☐ Other _____
7. Date(s) of Assessment	

8. Marital Status (select one)	☐ Married ☐ Never Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated ☐ Other _____
9. Race/Ethnicity (select all that apply)	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other _____
10. Social Security Number	_____ - _____- _____
11. Veteran	☐ Yes ☐ No
12. Was the Participant Information section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions

Participant Contact Information			
Add Address			
1. Address Type	☐ Home ☐ Mailing ☐ Other		
2. Address 1			
3. Address 2			
4. City, State, Zip			
5. Primary Address	☐ Yes ☐ No		
Add Phone			
6. Phone Number Type	☐ Home ☐ Mobile ☐ Work ☐ Other		
7. Phone Number	_____-_____-_____	8. Primary Phone	☐ Yes ☐ No
Add Email			
9. Email Type (select one)	☐ Personal ☐ Family Member Email Address ☐ Other		
10. Email Address		11. Primary Email	☐ Yes ☐ No
12. Was the Participant Contact Information section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions		

Insurance *Ability to add multiple insurance policies. Space for two is included below.	
1. Insurance Number	
2. Insurance Type (select one)	☐ Medicare Part A (Hospital Coverage) ☐ Medicare Part B ☐ Medicare Part C (Medicare Advantage) ☐ Medicare Part D (Prescription Coverage) ☐ Medicare Supplemental (Medigap) ☐ Medicaid ☐ PACE ☐ Tricare ☐ Veteran's Affairs ☐ Commercial Insurance ☐ Uninsured ☐ Other
3. Insurance Number	
4. Insurance Type (select one)	☐ Medicare Part A (Hospital Coverage) ☐ Medicare Part B ☐ Medicare Part C (Medicare Advantage) ☐ Medicare Part D (Prescription Coverage) ☐ Medicare Supplemental (Medigap) ☐ Medicaid ☐ PACE ☐ Tricare ☐ Veteran's Affairs ☐ Commercial Insurance ☐ Uninsured ☐ Other

5. Insurance Number	
6. Insurance Type (select one)	☐ Medicare Part A (Hospital Coverage) ☐ Medicare Part B ☐ Medicare Part C (Medicare Advantage) ☐ Medicare Part D (Prescription Coverage) ☐ Medicare Supplemental (Medigap) ☐ Medicaid ☐ PACE ☐ Tricare ☐ Veteran's Affairs ☐ Commercial Insurance ☐ Uninsured ☐ Other
7. Was the Insurance section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions

Contacts *Ability to add multiple contacts. Space for three contacts is included below.			
Contact Details – Contact #1			
1. Full Name (of contact)			
2. Relationship to Participant (select one)	☐ Spouse ☐ Son ☐ Daughter ☐ Daughter-in-law ☐ Son-in-law ☐ Sister ☐ Brother ☐ Spouse Equivalent ☐ Friend ☐ Neighbor ☐ Granddaughter ☐ Grandson ☐ Nephew ☐ Niece ☐ Other		
3. Power of Attorney (POA) (select one)	☐ Health Care ☐ Financial ☐ Health Care and Financial ☐ Not Applicable		
4. Guardian (select one)	☐ Yes ☐ No ☐ Pending	5. Contact Method Preference (select one)	☐ Phone ☐ Email ☐ Phone or Email ☐ Fax ☐ Mail ☐ Other

6. Frequency of participant meeting with this contact (select one)	☐ Daily ☐ 2-3 times/month ☐ Other	☐ 2-3 times weekly ☐ Several times/year	☐ Weekly ☐ As-needed		
7. Primary Contact	☐ Yes	☐ No	8. Emergency Contact	☐ Yes	☐ No
9. Caregiver	☐ Yes	☐ No	10. Household (i.e., does this contact live in participant's home?)	☐ Yes	☐ No
11. Address Type	☐ Home ☐ Other		12. Primary Address	☐ Yes	☐ No
13. Address					
14. City, State, Zip					
15. Phone Number Type	☐ Home ☐ Work	☐ Mobile ☐ Other	16. Phone Number	_____-_____-_____ Ext: (_____)	
17. Primary Phone	☐ Yes	☐ No			
18. Email Type (select one)	☐ Personal ☐ Family Member ☐ Office	☐ Other	19. Primary Email	☐ Yes ☐ No	

20. Email Address	
Contact Details – Contact #2 (if applicable)	
1. Full Name (of contact)	
2. Relationship to Participant (select one)	☐ Spouse ☐ Son ☐ Daughter ☐ Daughter-in-law ☐ Son-in-law ☐ Sister ☐ Brother ☐ Spouse Equivalent ☐ Friend ☐ Neighbor ☐ Granddaughter ☐ Grandson ☐ Nephew ☐ Niece ☐ Other
3. Power of Attorney (POA) (select one)	☐ Health Care ☐ Financial ☐ Health Care and Financial ☐ Not Applicable
4. Guardian (select one)	☐ Yes ☐ No ☐ Pending
5. Contact Method Preference (select one)	☐ Phone ☐ Email ☐ Phone or Email ☐ Fax ☐ Mail ☐ Other
6. Frequency of participant meeting with this contact (select one)	☐ Daily ☐ 2-3 times weekly ☐ Weekly ☐ 2-3 times/month ☐ Several times/year ☐ As-needed ☐ Other

7. Primary (i.e., primary contact)	☐ Yes ☐ No	8. Emergency Contact	☐ Yes ☐ No
9. Caregiver	☐ Yes ☐ No	10. Household (i.e., does this contact live in participant's home?)	☐ Yes ☐ No
11. Address Type	☐ Home ☐ Other	12. Primary Address	☐ Yes ☐ No
13. Address			
14. City, State, Zip			
15. Phone Number Type	☐ Home ☐ Mobile ☐ Work ☐ Other	16. Phone Number	_____-_____-_____ Ext: (_____)
17. Primary Phone	☐ Yes ☐ No		
18. Email Type (select one)	☐ Personal ☐ Family Member ☐ Office ☐ Other	19. Primary Email	☐ Yes ☐ No

20. Email Address			
Contact Details – Contact #3 (if applicable)			
1. Full Name (of contact)			
2. Relationship to Participant (select one)	☐ Spouse ☐ Son ☐ Daughter ☐ Daughter-in-law ☐ Son-in-law ☐ Sister ☐ Brother ☐ Spouse Equivalent ☐ Friend ☐ Neighbor ☐ Granddaughter ☐ Grandson ☐ Nephew ☐ Niece ☐ Other		
3. Power of Attorney (POA) (select one)	☐ Health Care ☐ Financial ☐ Health Care and Financial ☐ Not Applicable		
4. Guardian (select one)	☐ Yes ☐ No ☐ Pending	5. Contact Method Preference (select one)	☐ Phone ☐ Email ☐ Phone or Email ☐ Fax ☐ Mail ☐ Other
6. Frequency of participant meeting with this contact (select one)	☐ Daily ☐ 2-3 times weekly ☐ Weekly ☐ 2-3 times/month ☐ Several times/year ☐ As-needed ☐ Other		

7. Primary (i.e., primary contact)	☐ Yes	☐ No	8. Emergency Contact	☐ Yes	☐ No
9. Caregiver	☐ Yes	☐ No	10. Household (i.e., does this contact live in participant's home?)	☐ Yes	☐ No
11. Address Type	☐ Home	☐ Other	12. Primary Address	☐ Yes	☐ No
13. Address					
14. City, State, Zip					
15. Phone Number Type	☐ Home ☐ Work	☐ Mobile ☐ Other	16. Phone Number	_____-_____-_____ Ext: (_____)	
17. Primary Phone	☐ Yes	☐ No			
18. Email Type (select one)	☐ Personal ☐ Family Member ☐ Office	☐ Other	19. Primary Email	☐ Yes	☐ No
20. Email Address					

21. Was the Contacts section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions

Participant Resources

Specify which resources/services the participant currently receives in this section.

Please use one row for each service and specify the Agency Type, the Category of Service Provided, the Type of Service, Date Service Began, and Current Service Status.

A table listing the different types of services for each category is available following this section.

Service Number	Agency Type	Service Category	Service Type	Date Service Began	Service Status
	Indicate one: • Your own IWISH site • Adult Day Care • Area Agency on Aging • Home Health Agency • Mental Health Agency • Primary Care • Specialty Care • Transportation Agency • Other	*Indicate one:* • Case Management Services • Food • Housing • Home Modification • Utility Assistance • Transportation • Medical • Financial • Legal • Employment • Education • Other	*See choices following this table*	*If known*	*Indicate one:* • Currently Received • Denied • Pending • Waitlisted • Other
1.					
2.					
3.					
4.					

Service Number	Agency Type	Service Category	Service Type	Date Service Began	Service Status
	Indicate one: • Your own IWISH site • Adult Day Care • Area Agency on Aging • Home Health Agency • Mental Health Agency • Primary Care • Specialty Care • Transportation Agency • Other	*Indicate one:* • Case Management Services • Food • Housing • Home Modification • Utility Assistance • Transportation • Medical • Financial • Legal • Employment • Education • Other	*See choices following this table*	*If known*	*Indicate one:* • Currently Received • Denied • Pending • Waitlisted • Other
5.					
6.					
7.					
8.					
9.					
10.					

11. Was the Resources section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions

Participant Resources: Category of Services and Associated Type of Service

Please use this table as a reference when completing the *Participant Resource* portion that precedes this section. This table defines the types of services within each service category.

Category of Service	Type of Service
Case Management Services	☐ Case management ☐ Homemaker services ☐ Level of care assessment ☐ Options/benefits counseling ☐ Personal care services ☐ Other case management services
Food	☐ Home delivered meals ☐ Congregate meals ☐ SNAP (food stamps) ☐ Pantry/food bank ☐ Nutrition education ☐ Other food/nutrition
Housing	☐ Hoarding ☐ Lease compliance ☐ Other housing services
Home Modification	☐ Home safety assessment ☐ Accessibility modifications ☐ Other home modification
Utility Assistance	☐ Low Income Home Energy Assistance Program (LIHEAP) ☐ Other utility assistance
Transportation	☐ Transportation voucher/ride program ☐ Medical transportation ☐ Driver Safety ☐ Other transportation
Medical	☐ Alcohol use ☐ Chronic condition management ☐ Cognitive health ☐ Dental ☐ Emergency room use ☐ Exercise/ physical activity ☐ Falls ☐ Financial assistance ☐ Hearing ☐ Hospice/ palliative care

Participant Resources: Category of Services and Associated Type of Service

Please use this table as a reference when completing the *Participant Resource* portion that precedes this section. This table defines the types of services within each service category.

Category of Service	Type of Service
	☐ Immunizations/ screenings ☐ Medications ☐ Medical supplies/ equipment ☐ Mental health ☐ Pain Management ☐ Provider/ pharmacy access and relationships ☐ Therapy (occupational, physical, speech) ☐ Tobacco cessation support ☐ Visual ☐ Weight management ☐ Other medical
Financial	☐ Budgeting/ financial planning ☐ Income/benefits ☐ Insurance ☐ Other financial
Legal	☐ Adult protective services ☐ End of life planning (will, advance directive, DNR, etc.) ☐ Guardian ☐ Power of attorney (financial, medical) ☐ Other legal
Employment	☐ Full/part-time employment ☐ Senior employment program ☐ Other employment services
Education	☐ Language ☐ Literacy ☐ Lifelong learning ☐ Other education
Other	☐ Caregiver support ☐ Interpersonal relationships (family, friends) ☐ Pets (care, support/needs) ☐ Recreation/ social activities ☐ Spirituality/ religious participation ☐ Support groups ☐ Volunteering/ community service ☐ Other social support or engagement

Immunizations			
Immunization	**Status (select one)**	**Approximate Immunization Date**	**Notes**
1. Influenza	☐ Yes ☐ No ☐ Unknown ☐ No - Medical Reason		
2. Pneumovax	☐ Yes ☐ No ☐ Unknown ☐ No - Medical Reason		
3. Prevnar	☐ Yes ☐ No ☐ Unknown ☐ No - Medical Reason		
4. Shingles	☐ Yes ☐ No ☐ Unknown ☐ No - Medical Reason		
5. Other:_____ _	☐ Yes ☐ No ☐ Unknown ☐ No - Medical Reason		
6. Other:_____ _	☐ Yes ☐ No ☐ Unknown ☐ No - Medical Reason		
7. Other:_____ _	☐ Yes ☐ No ☐ Unknown ☐ No - Medical Reason		
8. Other:_____ _	☐ Yes ☐ No ☐ Unknown ☐ No – Medical Reason		
9. Was the Immunization section completed in full?		☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions	

General Information	
Advance Directive, DNR, and POAs	
1. Does participant have a documented Advance Directive?	☐ Yes ☐ No ☐ Unknown
2. If no, would the participant like assistance creating an Advance Directive?	☐ Yes ☐ No ☐ Not Now ☐ N/A
3. Advance Directive Agent's Name and Contact Information	
4. Where is Advance Directive stored? (select all that apply)	☐ Family Member ☐ Home ☐ MD Office ☐ Preferred Hospital ☐ Other ☐ N/A
5. Does the participant have a Do Not Resuscitate (DNR) order?	☐ Yes ☐ No ☐ Unknown
6. Who, if anyone, has a copy of the participant's DNR?	☐ Family Member ☐ MD Office ☐ Healthcare Power of Attorney ☐ Preferred Hospital ☐ Other ☐ N/A
7. Does the participant have a Health Care Power of Attorney?	☐ Yes ☐ No ☐ Unknown

8. Contact information for who, if anyone, has a copy of the participant's Health Care Power of Attorney?	
9. Does the participant have a Financial Power of Attorney?	☐ Yes ☐ No ☐ Unknown
10. Contact information for who, if anyone, has a copy of the participant's Financial Power of Attorney?	
Household, Assistive Devices, and Transportation	
11. Does the participant have a Personal Emergency Response System (PERS) such as Lifeline or Link to Life?	☐ Yes ☐ No
12. Mode(s) of Transportation (select all that apply)	☐ Own Car ☐ Bus ☐ Support Person ☐ Transportation Agency ☐ Other

13. Notes for the General Information Section:	
14. Was the General Information section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions

Clinicians **Please include the participant's Primary Care Provider and key specialists the participant regularly visits.**	
Primary Care Provider	
1. Primary Care Provider's full name	
2. Phone	_____-_____-_____
3. Fax	_____-_____-_____
4. Email	
5. Practice Name and Address	
Specialist #1	
1. Specialist Full Name	
2. Specialty **(select one)**	☐ Oncologist ☐ Neurologist ☐ Psychologist ☐ Psychiatrist ☐ Cardiologist ☐ Ophthalmologist/Optometrist ☐ OBGYN ☐ Other _____
3. Phone	_____-_____-_____
4. Fax	_____-_____-_____
5. Email	

6. Practice Name and Address	
Specialist #2	
1. Specialist Full Name	
2. Specialty **(select one)**	☐ Oncologist ☐ Neurologist ☐ Psychologist ☐ Psychiatrist ☐ Cardiologist ☐ Ophthalmologist/Optometrist ☐ OBGYN ☐ Other _____
3. Phone	_____-_____-_____
4. Fax	_____-_____-_____
5. Email	
6. Address	

Specialist #3	
1. Specialist Full Name	
2. Specialty **(select one)**	☐ Oncologist ☐ Neurologist ☐ Psychologist ☐ Psychiatrist ☐ Cardiologist ☐ Ophthalmologist/Optometrist ☐ OBGYN ☐ Other _____
3. Phone	_____-_____-_____
4. Fax	_____-_____-_____
5. Email	
6. Practice Name and Address	
7. Clinician and Specialist Notes:	
8. Was the Clinician section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions

General Health Assessment			
Annual Exams, Hospitals, and Surgery			
1. How do you rate your health?	☐ Excellent ☐ Fair	☐ Very Good ☐ Poor	☐ Good ☐ Unknown
2. Do you have routine annual exams?	☐ Yes	☐ No	☐ Unknown
3. When was your last annual exam, if known?			
4. Have you had surgery in the past 10 years?	☐ Yes	☐ No	☐ Unknown
5. List all surgical procedures in the past 10 years			
Specific Health Questions			
6. Do you use an assistive device to help you move?	☐ Yes	☐ No	
7. Select all assistive device(s) that apply	☐ Cane ☐ Walker	☐ Motorized Scooter ☐ Wheelchair	
8. Do you need assistance obtaining any of the following (select all that apply)?	☐ Eyeglasses ☐ Dentures ☐ Other	☐ Hearing aids ☐ None	
9. Does you take care of your own feet/toenails?	☐ Yes	☐ No	

10. If you do not take care of your own feet/toenails, who does?	
11. Do you have any foot conditions (select all that apply)	☐ Calluses ☐ Corns ☐ Cuts ☐ Bruises ☐ Fungus ☐ Overgrown Toenails ☐ Ingrown Toenails ☐ Dry Skin ☐ N/A ☐ Other
12. How many days a week do you get a total of 30 minutes or more of physical activity? (enough to raise breathing rate) (select one)	☐ Zero ☐ One ☐ Two ☐ Three ☐ Four ☐ Five ☐ Six ☐ Seven
13. Was the General Health Assessment section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions

Diagnosis		
Diagnosis (select all that apply)		**Notes**
1. Heart/ Circulation	☐ Cancer ☐ Anemia ☐ Atrial Fibrillation or other Dysrhythmias (bradycardias and tachycardia) ☐ Coronary Artery Disease (angina, myocardial infarction, atherosclerotic heart disease) ☐ Deep Vein Thrombosis ☐ Pulmonary Embolus ☐ Pulmonary Edema ☐ Peripheral Vascular Disease ☐ Heart Disease ☐ Pre-Hypertension ☐ Hypertension ☐ Pacemaker/ Implantable Cardiac Defibrillator	

2. Gastrointestinal	☐ Cirrhosis ☐ Ulcer (esophageal, gastric, and peptic ulcers) ☐ GERD or Acid Reflux ☐ Diverticulitis ☐ Liver Disease ☐ Crohn's Disease ☐ Irritable Bowel Syndrome	
3. Genitourinary	☐ Benign Prostatic Hyperplasia ☐ Renal Insufficiency ☐ Renal Failure ☐ End Stage Renal Disease ☐ Neurological Bladder ☐ Obstructive Uropathy	

4. Infections	☐ Multi-drug resistant organisms ☐ Pneumonia ☐ Septicemia ☐ Tuberculosis ☐ Urinary Tract Infection ☐ Viral Hepatitis ☐ Wound Infection (other than foot)	
5. Metabolic and Endocrine	☐ Diabetes Mellitus ☐ Pre-Diabetes ☐ Hyponatremia ☐ Hyperkalemia ☐ Hyperlipidemia ☐ Thyroid Disease	
6. Musculoskeletal	☐ Arthritis ☐ Osteoporosis ☐ Hip Fracture ☐ Other Fracture	

7. Neurological	☐ Alzheimer's Disease ☐ Aphasia ☐ Cerebral Palsy ☐ Cerebrovascular Accident ☐ Transient Ischemic Attack ☐ Stroke ☐ Non-Alzheimer's Dementia ☐ Hemiplegia ☐ Hemiparesis ☐ Paraplegia ☐ Quadriplegia ☐ Multiple Sclerosis ☐ Huntington's Disease ☐ Parkinson's Disease ☐ Tourette's Syndrome ☐ Seizure Disorder ☐ Epilepsy ☐ Traumatic Brain Injury	

8. Nutritional	☐ Malnutrition ☐ Risk for Malnutrition	
9. Psychiatric Mood Disorders	☐ Anxiety Disorder ☐ Depression ☐ Manic Depression (bipolar) ☐ Psychotic Disorder ☐ Schizophrenia ☐ Post-Traumatic Stress Disorder	
10. Addiction	☐ Nicotine ☐ Alcohol Abuse	
11. Sleep Disorder	☐ Insomnia ☐ Sleep Apnea	
12. Pulmonary	☐ Asthma ☐ Chronic Obstructive Pulmonary Disorder ☐ Chronic Lung Disease (chronic bronchitis and restrictive lung diseases such as asbestosis) ☐ Respiratory Failure	

13. Hearing	☐ Hearing Impairment	
14. Vision	☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ General Visual Decline	
15. Other	☐ Chronic Pain ☐ Obesity ☐ Other	
16. Was the Diagnosis section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions	

Medication						
Medication Name	Strength (i.e. dosage)	Units	Dosage Frequency	Dosage Number	Dosage Method	Special Instructions

1. Was the Medication section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions

Medication Review	
Medication #1 (enter name of medication): _____	
1. Medication Review Prescription Status (select all that apply)	☐ New taken < 1 week ☐ Ongoing ☐ Review requested ☐ Discontinued ☐ Prescription not filled ☐ Refill overdue ☐ Other
2. Why are you taking this medication?	
3. Does the participant seem to understand why they are taking this medication?	☐ Yes ☐ No ☐ N/A
4. Are you able to read the prescription label?	☐ Yes ☐ No ☐ N/A
5. How do you take this medication? (select all that apply)	☐ Self (i.e., the participant) ☐ Caregiver ☐ RN ☐ Unknown ☐ Other

6. Where do you store this medication? (select one)	☐ Bag ☐ Bathroom cabinet ☐ Refrigerator ☐ Bathroom counter ☐ Box ☐ Kitchen cabinet ☐ Kitchen counter ☐ Mixed containers ☐ Multiple locations ☐ Night stand ☐ Other
7. Would you like to consider an alternative medication, if available? (select one)	☐ Yes ☐ No ☐ N/A
8. Would you like to speak with your doctor or pharmacist about this medication? (select one)	☐ Yes ☐ No ☐ N/A
9. Does this participant share their medication with anyone? (select one)	☐ Yes ☐ No ☐ N/A
10. After reviewing all of this participant's medications, is an additional medication review or medication reconciliation recommended? (select one)	☐ Yes ☐ No ☐ N/A
Medication #2 (enter name of medication): _____	

1. Medication Review Prescription Status (select all that apply)	☐ New taken < 1 week ☐ Ongoing ☐ Review requested ☐ Discontinued ☐ Prescription not filled ☐ Refill overdue ☐ Other
2. Why are you taking this medication?	
3. Does this participant seem to understand why they are taking this medication?	☐ Yes ☐ No ☐ N/A
4. Are you able to read the prescription label?	☐ Yes ☐ No ☐ N/A
5. How do you take this medication? (select all that apply)	☐ Self (i.e., the participant) ☐ Caregiver ☐ RN ☐ Unknown ☐ Other

6. Where do you store this medication? (select one)	☐ Bag ☐ Bathroom cabinet ☐ Refrigerator ☐ Bathroom counter ☐ Box ☐ Kitchen cabinet ☐ Kitchen counter ☐ Mixed containers ☐ Multiple locations ☐ Night stand ☐ Other
7. Would this participant like to consider an alternative medication if available? (select one)	☐ Yes ☐ No ☐ N/A
8. Would this participant like to speak with the prescribing clinician or pharmacist about this medication? (select one)	☐ Yes ☐ No ☐ N/A
9. Does this participant share their medication with anyone? (select one)	☐ Yes ☐ No ☐ N/A
10. After reviewing all of this participant's medications, is an additional medication review or medication reconciliation recommended? (select one)	☐ Yes ☐ No ☐ N/A

1. Was the Medication Review section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions

Supplemental Mediation Review sheets are available at the end of this Assessment for printing when necessary.

Morisky 8-Item Medication Adherence Questionnaire	
Question	Patient Answer
1. Do you sometimes forget to take your medicine?	☐ Yes ☐ No
2. People sometimes miss taking their medicines for reasons other than forgetting. Thinking over the past two weeks, were there any days when you did not take your medicine?	☐ Yes ☐ No
3. Have you ever cut back or stopped taking your medicine without telling your doctor because you felt worse when you took it?	☐ Yes ☐ No

4. When you travel or leave home, do you sometimes forget to bring along your medicine?	☐ Yes ☐ No
5. Did you take all your medicines yesterday?	☐ Yes ☐ No
6. When you feel like your symptoms are under control, do you sometimes stop taking your medicine?	☐ Yes ☐ No
7. Taking medicine every day is a real inconvenience for some people. Do you ever feel hassled about sticking to your treatment plan?	☐ Yes ☐ No
8. How often do you have difficulty remembering to take all your medicine?	☐ Never/rarely ☐ Once in a while ☐ Sometimes ☐ Usually ☐ All the time
9. Was the Morisky Medication Adherence section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions

Allergies

1. Allergy Name(s) (specify all allergies):

2. Allergy Notes (specify for all allergies):	
3. Intolerance Name (specify for all allergies):	
4. Intolerance Notes (specify for all allergies):	
5. Was the Allergies section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions

Vitals	
1. Blood Pressure Sitting (systolic/diastolic)	
2. Heart Rate	
3. Weight (lbs.)	
4. Height (inches)	
5. BMI (calculated automatically)	
6. Temperature	
7. Pain (indicate zero to 10, with zero being no pain and 10 being the most intense pain)	
8. A1C Number	
9. Oxygen Saturation %	
10. Home Blood Glucose	
11. Edema (select one)	☐ Absent ☐ +1 ☐ +2 ☐ +3 ☐ +4
12. Respiratory rate	
13. Vitals Notes:	
14. Was the Vitals section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions

Physical Self-Maintenance Scale (PSMS): Activities of Daily Living (ADLs)		
1. Toileting Hygiene	☐ Independent	☐ Needs Assistance
2. Feeding or Eating	☐ Independent	☐ Needs Assistance
3. Dressing Upper Body	☐ Independent	☐ Needs Assistance
4. Dressing Lower Body	☐ Independent	☐ Needs Assistance
5. Grooming	☐ Independent	☐ Needs Assistance
6. Bathing	☐ Independent	☐ Needs Assistance
7. Toilet Transferring	☐ Independent	☐ Needs Assistance
8. Transferring	☐ Independent	☐ Needs Assistance
9. Ambulation/Locomotion	☐ Independent	☐ Needs Assistance
10. Was the PSMS/ADLs section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions	

Instrumental Activities of Daily Living (IADLs)		
1. Telephone	☐ Independent	☐ Needs Assistance
2. Traveling	☐ Independent	☐ Needs Assistance
3. Shopping	☐ Independent	☐ Needs Assistance
4. Preparing Meals	☐ Independent	☐ Needs Assistance
5. Housework	☐ Independent	☐ Needs Assistance
6. Medications	☐ Independent	☐ Needs Assistance
7. Money	☐ Independent	☐ Needs Assistance
8. Was the IADLs section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions	

Nutrition Screen (DETERMINE)

These questions identify older persons at risk for low nutrient intake and subsequent health problems. Communicate to participant: "*What you eat does affect your health. These questions help us determine any if you are at nutritional risk.*"

Summing the scores associated with each Yes answer indicates:

- Low nutritional risk = score 0-2
- Moderate nutritional risk = score 3-5
- High nutritional risk = score 6 or more

1. Have you made any changes in lifelong eating habits because of health problems?	☐ Yes (2) ☐ No (0)
2. Do you eat fewer than two meals a day?	☐ Yes (3) ☐ No (0)
3. Do you eat fewer than five servings (1/2 cup each) of fruits and vegetables every day?	☐ Yes (1) ☐ No (0)
4. Do you eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day?	☐ Yes (1) ☐ No (0)
5. Do you sometimes not have enough money to buy food?	☐ Yes (4) ☐ No (0)
6. Do you have trouble eating due to problems with biting, chewing, or swallowing?	☐ Yes (2) ☐ No (0)
7. Do you eat alone most of the time?	☐ Yes (1) ☐ No (0)
8. Without wanting to, have you lost or gained ten pounds in the last six months?	☐ Yes (2) ☐ No (0)
9. Are you not always physically able to shop, cook, and/or feed yourself (or get someone to do it for you?)	☐ Yes (2) ☐ No (0)

10. Do you have three or more drinks of beer, liquor, or wine almost every day?	☐ Yes (2) ☐ No (0)
11. Do you take three or more prescriptions or over-the-counter drugs per day?	☐ Yes (1) ☐ No (0)
Total Score:	
12. Was the Nutrition Assessment section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions

Falls Risk Assessment (STEADI)

These questions identify persons at risk for falling.

Sum the scores associated with each "Yes" answer. Scores of 4 points or more indicate the participant may be at risk for falling.

Question	Why it matters	Answer
1. I have fallen in the past year.	People who have fallen once are likely to fall again.	☐ Yes (2) ☐ No (0)
2. I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.	☐ Yes (2) ☐ No (0)
3. Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.	☐ Yes (1) ☐ No (0)
4. I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.	☐ Yes (1) ☐ No (0)
5. I am worried about falling.	People who are worried about falling are more likely to fall.	☐ Yes (1) ☐ No (0)
6. I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.	☐ Yes (1) ☐ No (0)
7. I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.	☐ Yes (1) ☐ No (0)
8. I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.	☐ Yes (1) ☐ No (0)

9. I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.	☐ Yes (1) ☐ No (0)
10. I take medicine that sometimes make some feel lightheaded or more tired than usual.	Side effects from medicines can sometimes increase you a chance of falling.	☐ Yes (1) ☐ No (0)
11. I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.	☐ Yes (1) ☐ No (0)
Total Score:		
12. Was the Falls Risk Assessment section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions	

Mini Cog

Begin the cognitive assessment with word recall.

Have the participant repeat the following three words right after you say them: **Telephone, umbrella, flowers**.

This is to make sure they heard and understood the words correctly.

Next, provide a blank piece of paper to the participant and ask them to do the following steps:

- First, draw the face of a clock and put all of the numbers on it. Make it large.
- Now, draw the hands, point at 20 minutes before 4 O'clock, Good.

Keep the clock drawing.

Ask the participant, "**Please tell me the three words I asked you to remember earlier**." Note how many words the participant was able to recall.

Next, is the category fluency, please make sure you have a timing device available. Say, "When I tell you to start, please name as many kinds of animals as you can think of in one minute. Ok?" When the person is ready. Say, "begin" and start the timer. At the end of 60 seconds stop the timer and say, "Ok, that's good. Thank you." Keep track of how many animals they named here (which animal is not important).

1. Clock Drawing	5-7 points = passing score 4 points = borderline 0-3 points = failing score
2. Three Word Recall (1 point for each word correctly recalled)	3 points = passing score 2 points = borderline 1-0 points = failing score
3. Category Fluency	>15 animals named within the one minute = passing score 15 animals = borderline <15 animals = failing score
4. Total Cognitive Ability Score: Pass/Fail (Fail if: fail 2 or more components OR scores "borderline" on 2 of 3 components)	☐ Pass ☐ Fail
5. Participant is unable to perform the cognitive screen	☐ Yes ☐ No

6. Additional information about cognitive assessment:	
7. Was the Mini Cog section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions

Use this page for the Mini Cog:

Use this page for the Mini Cog:

Loneliness Scale	
The scores of each individual question can be added together to give range of scores from 3 to 9. Researchers have grouped people who score 3-5 as “not lonely” and people with a score of 6-9 as “lonely.”	
1. How often do you feel that you lack companionship?	☐ Hardly ever (1) ☐ Some of the time (2) ☐ Often (3) ☐ Not performed
2. How often do you feel left out?	☐ Hardly ever (1) ☐ Some of the time (2) ☐ Often (3) ☐ Not performed
3. How often do you feel isolated from others?	☐ Hardly ever (1) ☐ Some of the time (2) ☐ Often (3) ☐ Not performed
4. Was the Social Connectedness section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions

Behavioral Health	
1. How many times in the past year have you had four or more alcoholic drinks in a day? (select one)	☐ Zero ☐ One ☐ Two ☐ Three or more times
If answer above is "Two" or "Three or more," complete the S-MAST-G below.	
2. What is your current relationship with tobacco (select one)?	☐ Never ☐ Former ☐ Current tobacco user ☐ Currently exposed to second hand smoke ☐ No for medical reasons
3. Would you like assistance with tobacco cessation?	☐ Yes ☐ No ☐ Not now ☐ N/A
4. Notes:	
5. Was the Behavioral Health section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions

S-MAST-G	
Two or more "Yes" answers below indicate the need for a brief intervention and possibly a referral for assessment and treatment.	
1. When talking to others, do you ever understate how much you actually drink?	☐ Yes ☐ No
2. When drinking, have you sometimes skipped a meal because you did not feel hungry?	☐ Yes ☐ No
3. Does having a few drinks help reduce shakiness or tremors?	☐ Yes ☐ No
4. Does alcohol sometimes make it hard for you to remember parts of a day or night?	☐ Yes ☐ No
5. Do you usually take a drink to relax or calm your nerves?	☐ Yes ☐ No
6. Do you drink to take your mind off problems like feeling alone or being in physical or emotional pain?	☐ Yes ☐ No
7. Have you increased your drinking after experiencing a loss in your life?	☐ Yes ☐ No
8. Has a doctor, nurse, or other health care provider ever said that they were concerned about your drinking?	☐ Yes ☐ No
9. Have you tried to reduce your drinking from your own concern or to try and manage the amount of your drinking?	☐ Yes ☐ No
10. When you feel lonely does having a drink help you feel better?	☐ Yes ☐ No

11. Do you drink alcohol and at the same time use mood or mind altering drugs, including prescription, tranquilizers, prescription sleeping pills, prescription pain pills, or illicit drugs?	☐ Yes ☐ No
12. Notes:	
13. Was the S-MAST-G section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions ☐ Not applicable

General Anxiety Disorder Scale (GAD-2)	
1. Over the past two weeks, how often have you been bothered by feeling nervous, anxious, or on edge (circle one)?	0 – Not at all 1 – Several days 2 – more than half the days 3 – Nearly every day
2. Over the past two weeks how often have you been bothered not being able to stop or control worrying (circle one)?	0 – Not at all 1 – Several days 2 – more than half the days 3 – Nearly every day
Total Score:	
If the total score from two GAD-2 questions above is 3 or higher, complete GAD-7 below.	

General Anxiety Disorder Scale (GAD-7)	
Scoring: Sum points from all GAD-7 answers: 5-9 Mild Anxiety, 10-14 Moderate Anxiety, 15 + Severe Anxiety	
1. Over the last two weeks, how often have you been bothered by feeling nervous, anxious, or on edge?	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
2. Over the last two weeks, how often have you been bothered by not being able to stop or control worrying	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
3. Over the last two weeks, how often have you been worrying too much about different things	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
4. Over the last two weeks, how often have you had trouble relaxing	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
5. Being so restless that it is hard to sit still	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day

6. Becoming easily annoyed or irritable	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
7. Feeling afraid as if something awful might happen	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
8. If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?	☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult
Total Score:	
9. Was the GAD-7 section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions ☐ Not applicable

Patient Health Question-2 (PHQ-2): Depression Screener	
1. Over the past two weeks, how often have you been had little interest or pleasure in doing things	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
2. Over the past two weeks, how often have you felt down, depressed, or hopeless	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
Total Score:	
If the total PHQ-2 score is 3 or greater complete the PHQ-9	
3. Was the PHQ-2 section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions

Patient Health Question-9 (PHQ-9) For participants who scored 3 or greater total points on the PHQ-2 complete this section. .	
Ask the participant: "*Over the past two weeks, how often have you been bothered by any of the following problems?*"	
1. Over the past two weeks, how often have you had trouble falling asleep, staying asleep, or sleeping too much	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day

2. Over the past two weeks, how often have you felt tired or had little energy	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
3. Over the past two weeks, how often have you been bothered by poor appetite or overeating	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
4. Over the past two weeks, how often have you been bothered by feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
5. Over the past two weeks, how often have you been bothered by trouble concentrating on things such as reading the newspaper or watching television	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
6. Over the past two weeks, how often have you been bothered by moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual.	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day

7. Over the past two weeks, how often have you been bothered by thinking that you would be better off dead or that you want to hurt yourself in some way	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
Total Score:	

Take the total score from PHQ-2 and add to the sum of the additional questions.

0-4 = minimal depression, 5-9 = mild, 10-14 = moderate, 15-19 = moderately severe, 20-27 = severe.

8. Was the PHQ-9 section completed in full?	☐ Yes – section completed in full ☐ No – not yet completed ☐ No – participant refused to answer one or more questions ☐ Not applicable

Assessment Status

1. If the IWISH health and wellness assessment was not completed in full, please indicate the reason(s) why. (select all that apply)	☐ Participant declined to complete one or more sections ☐ Participant did not respond to at least three attempts to contact ☐ Participant already has completed an assessment with another program ☐ Other reason

Supplemental Medication Review	
Medication (enter name of medication): _____	
11. Medication Review Prescription Status (select all that apply)	☐ New taken < 1 week ☐ Ongoing ☐ Review requested ☐ Discontinued ☐ Prescription not filled ☐ Refill overdue ☐ Other
12. Why are you taking this medication?	
13. Does the participant seem to understand why they are taking this medication?	☐ Yes ☐ No ☐ N/A
14. Are you able to read the prescription label?	☐ Yes ☐ No ☐ N/A
15. How do you take this medication? (select all that apply)	☐ Self (i.e., the participant) ☐ Caregiver ☐ RN ☐ Unknown ☐ Other

16. Where do you store this medication? (select one)	☐ Bag ☐ Bathroom cabinet ☐ Refrigerator ☐ Bathroom counter ☐ Box ☐ Kitchen cabinet ☐ Kitchen counter ☐ Mixed containers ☐ Multiple locations ☐ Night stand ☐ Other
17. Would you like to consider an alternative medication, if available? (select one)	☐ Yes ☐ No ☐ N/A
18. Would you like to speak with your doctor or pharmacist about this medication? (select one)	☐ Yes ☐ No ☐ N/A
19. Does this participant share their medication with anyone? (select one)	☐ Yes ☐ No ☐ N/A
20. After reviewing all of this participant's medications, is an additional medication review or medication reconciliation recommended? (select one)	☐ Yes ☐ No ☐ N/A