

Testing Experience and Functional Tools (TEFT) Functional Assessment Standardized Items (FASI)

Please Complete All Items on Each Page

Section A	
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PRA Disclosure Statement: This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) with standardizing functional assessment items for home and community based services (HCBS) and develop performance measures. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The control number for this project is 0938-1037 (Expires: TBD). The SORN is 09-70-0569.

Section B **Functional Abilities and Goals**

Self-Care

Form Instructions:

Code the person's **usual** performance during the **past 3 days** using the 6-point scale in **Column A**. If the person's performance **changed** during the **past month**, also code their **most dependent** performance in **Column B**. If the person's self-care performance was **unchanged** during the **past month**, column B should be coded the same as column A. *If the activity was not attempted, code the reason.*

Please complete the Self-Care Priorities section at the bottom of this page.

CODING:	Performance Level Enter Codes in Boxes		
	A Usual	B Most Dependent	
Safety and Quality of Performance - If helper assistance is required because person's performance is unsafe or of poor quality score according to amount of assistance provided. <i>Activities may be completed with or without assistive devices.</i> 06. Independent - Person completes the activity by him/herself with no assistance from a helper. 05. Setup or cleanup assistance - Helper SETS UP or CLEANS UP; person completes activity. Helper assists only prior to or following the activity. 04. Supervision or touching assistance - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as person completes activity. Assistance may be provided throughout the activity or intermittently. 03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort. 02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. Dependent - Helper does ALL of the effort. Person does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the person to complete the activity. If activity was not attempted, code reason: 07. Person refused. 09. Not applicable - Person does not usually do this activity. 88. Not attempted due to short-term medical condition or safety concerns.	<input type="text"/>	<input type="text"/>	6a. Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency. 6b. Oral hygiene: The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.] 6c. Toileting hygiene: The ability to maintain perineal/feminine hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment. 6d. Wash upper body: The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed. 6e. Shower/bathe self: The ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower. 6f. Upper body dressing: The ability to put on and remove shirt or pajama top; includes buttoning, if applicable. 6g. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear. 6h. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility.

Self-Care Priorities: Please ask the person to describe at least one or two personal priorities in the area of self-care for the next six months. If the person does not express any personal priorities in this area, please note this below.

1.

2.

Section B	Functional Abilities and Goals																			
Mobility (Bed mobility and transfers)																				
<p>Form Instructions: Code the person's usual performance during the past 3 days using the 6-point scale in Column A. If the person's performance changed during the past month, also code their most dependent performance in Column B. If the person's transfer/bed mobility performance was unchanged during the past month, column B should be coded the same as column A. <i>If the activity was not attempted, code the reason.</i></p>																				
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Performance Level Enter Codes in Boxes																				
A Usual	B Most Dependent																			
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Section B **Functional Abilities and Goals**

Mobility (Wheelchair)

Form Instructions:

Code the person's **usual** performance during the **past 3 days** using the 6-point scale in **Column A**. If the person's performance **changed** during the **past month**, also code their **most dependent** performance in **Column B**. If the person's wheelchair mobility performance was **unchanged** during the **past month**, column B should be coded the same as column A. *If the activity was not attempted, code the reason.*

Please complete the Mobility Priorities section at the bottom of this page.

<p>CODING:</p> <p>Safety and Quality of Performance - If helper assistance is required because person's performance is unsafe or of poor quality score according to amount of assistance provided.</p> <p><i>Activities may be completed with or without assistive devices.</i></p> <p>06. Independent - Person completes the activity by him/herself with no assistance from a helper.</p> <p>05. Setup or cleanup assistance - Helper SETS UP or CLEANS UP; person completes activity. Helper assists only prior to or following the activity.</p> <p>04. Supervision or touching assistance - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as person completes activity. Assistance may be provided throughout the activity or intermittently.</p> <p>03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.</p> <p>02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>01. Dependent - Helper does ALL of the effort. Person does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the person to complete the activity.</p> <p>If activity was not attempted, code reason:</p> <p>07. Person refused.</p> <p>09. Not applicable - Person does not usually do this activity.</p> <p>88. Not attempted due to short-term medical condition or safety concerns.</p>	<input type="checkbox"/>	<p>9. Does the person use a manual wheelchair?</p> <p>0. No - Skip to question 10.</p> <p>1. Yes - Continue to question 9a.</p>		
	Manual Wheelchair			
	Performance Level Enter Codes in Boxes			
	A Usual	B Most Dependent		
	<input type="checkbox"/>	<input type="checkbox"/>	9a. Wheels 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.	
	<input type="checkbox"/>	<input type="checkbox"/>	9b. Wheels 150 feet: Once seated in wheelchair/ scooter, the ability to wheel at least 150 feet in a corridor or similar space.	
	<input type="checkbox"/>	<input type="checkbox"/>	9c. Wheels for 15 minutes: without stopping or resting (e.g., department store, supermarket.)	
	<input type="checkbox"/>	<input type="checkbox"/>	9d. Wheels across a street: crosses street before light turns red.	
	<input type="checkbox"/>	<p>10. Does the person use a motorized wheelchair/scooter?</p> <p>0. No - Skip to question 11a.</p> <p>1. Yes - Continue to question 10a.</p>		
	Motorized Wheelchair/Scooter			
	Performance Level Enter Codes in Boxes			
	A Usual	B Most Dependent		
	<input type="checkbox"/>	<input type="checkbox"/>	10a. Wheels 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.	
	<input type="checkbox"/>	<input type="checkbox"/>	10b. Wheels 150 feet: Once seated in wheelchair/ scooter, the ability to wheel at least 150 feet in a corridor or similar space.	
	<input type="checkbox"/>	<input type="checkbox"/>	10c. Wheels for 15 minutes: without stopping or resting (e.g., department store, supermarket.)	
<input type="checkbox"/>	<input type="checkbox"/>	10d. Wheels across a street: crosses street before light turns red.		

Mobility Priorities: Please ask the person to describe at least one or two personal priorities in the area of mobility for the next six months. If the person does not express any personal priorities in this area, please note this below.

1.	
2.	

Section B		Functional Abilities and Goals																					
Instrumental Activities of Daily Living																							
<p>Form Instructions:</p> <p>Code the person's usual performance during the past 3 days using the 6-point scale in Column A. If the person's performance changed during the past month, also code their most dependent performance in Column B. If the person's IADL performance was unchanged during the past month, column B should be coded the same as column A. <i>If the activity was not attempted</i>, code the reason.</p>																							
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	A Usual	B Most Dependent																					
	<input type="text"/>	<input type="text"/>																					
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<input type="text"/>	<input type="text"/>																						

Section B	Functional Abilities and Goals
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Instrumental Activities of Daily Living (continued)

Form Instructions:

Code the person's **usual** performance during the **past 3 days** using the 6-point scale in **Column A**. If the person's performance **changed** during the **past month**, also code their **most dependent** performance in **Column B**. If the person's IADL performance was **unchanged** during the **past month**, column B should be coded the same as column A. *If the activity was not attempted*, code the reason.

Please complete the IADL Priorities section at the bottom of the page.

CODING:	Performance Level Enter Codes in Boxes		
	A Usual	B Most Dependent	
<p>Safety and Quality of Performance - If helper assistance is required because person's performance is unsafe or of poor quality score according to amount of assistance provided.</p> <p><i>Activities may be completed with or without assistive devices.</i></p> <p>06. Independent - Person completes the activity by him/ herself with no assistance from a helper.</p> <p>05. Setup or cleanup assistance - Helper SETS UP or CLEANS UP; person completes activity. Helper assists only prior to or following the activity.</p> <p>04. Supervision or touching assistance - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as person completes activity. Assistance may be provided throughout the activity or intermittently.</p> <p>03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.</p> <p>02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>01. Dependent - Helper does ALL of the effort. Person does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the person to complete the activity.</p> <p>If activity was not attempted, code reason:</p> <p>07. Person refused.</p> <p>09. Not applicable - Person does not usually do this activity.</p> <p>88. Not attempted due to short-term medical condition or safety concerns.</p>	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<p>11h. Medication management-oral medications: The ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.</p>
	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<p>11i. Medication management-inhalant/mist medications: The ability to prepare and take all prescribed inhalant/mist medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.</p>
	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<p>11j. Medication management-injectable medications: The ability to prepare and take all prescribed injectable medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.</p>
	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<p>11k. Simple financial management: The ability to complete financial transactions such as counting coins, verifying change for a single item transaction, writing a check, online/mobile bill pay, banking, or shopping.</p>
	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<p>11l. Complex financial management: The ability to complete financial decision-making such as budget and remembering to pay bills.</p>

IADL Priorities: Please ask the person to describe at least one or two personal priorities in the area of instrumental activities of daily living for the next six months. If the person does not express any personal priorities in this area, please note this below.

1. 2.

Section C **Assistive Devices**

Assistive Devices for Everyday Activities

Form Instructions:

Identify the person's need for and availability of each assistive device. *If no assistive device is needed to complete self-care, mobility, and instrumental activities of daily living, check "Not Applicable" box. If device is not used, code reason.*

CODING:	Enter Codes in Boxes		
Code the person's usual need for, and availability of, assistive devices to complete self-care, mobility, or instrumental activities of daily living.	<input type="checkbox"/>	12a. Manual wheelchair	
	<input type="checkbox"/>	12b. Motorized wheelchair or scooter	
	02. Assistive device needed and available - Person needs this device to complete daily activities and has the device in the home.	<input type="checkbox"/>	12c. Specialized seating pad (e.g. air-filled, gel, shaped foam)
		<input type="checkbox"/>	12d. Mechanical lift
	01. Assistive device needed but current device unsuitable - Device is in home but no longer meets person's needs.	<input type="checkbox"/>	12e. Walker
		<input type="checkbox"/>	12f. Walker with seat
	00. Assistive device needed but not available - Person needs the device but it is not available in the home.	<input type="checkbox"/>	12g. Cane
		<input type="checkbox"/>	12h. Reacher/Grabber
	If device is not used, code reason:	<input type="checkbox"/>	12i. Sock aid
		<input type="checkbox"/>	12j. Orthotics/Brace
	07. Person refused - Person chooses not to use needed device.	<input type="checkbox"/>	12k. Bed rail
		<input type="checkbox"/>	12l. Electronic bed
	09. Not applicable - Person does not need this device.	<input type="checkbox"/>	12m. Grab bars
		<input type="checkbox"/>	12n. Transfer board
		<input type="checkbox"/>	12o. Shower/commode chair
		<input type="checkbox"/>	12p. Walk/wheel-in shower
		<input type="checkbox"/>	12q. Glasses or contact lenses
		<input type="checkbox"/>	12r. Hearing aid
		<input type="checkbox"/>	12s. Communication device
		<input type="checkbox"/>	12t. Stair rails
		<input type="checkbox"/>	12u. Lift chair
		<input type="checkbox"/>	12v. Ramps
	<input type="checkbox"/>	12w. Raised toilet seat	
	<input type="checkbox"/>	12x. Glucometer	
	<input type="checkbox"/>	12y. CPAP	
	<input type="checkbox"/>	12z. Oxygen concentrator	
	<input type="checkbox"/>	Other:	
	<input type="checkbox"/>	I have indicated all the devices needed.	
	<input type="checkbox"/>	Not Applicable - No assistive device needed in past month	

Section D Living Arrangements, Caregiver Assistance and Availability

Living Arrangements

13. Identify the person's usual living arrangement during the past 3 days and the past month. CODING: 05. Person lives alone - no other residents in the home. 04. Person lives with others in the home - for example, family, friends, or paid caregiver. 03. Person lives in congregate home - for example, assisted living, or residential care home. 02. Person does not have a permanent home or is homeless. 01. Person was in a medical facility.	A Past 3 Days	B Past Month
	<input type="text"/>	<input type="text"/>

Living Arrangement Priorities: Please ask the person to describe at least one or two personal priorities in the area of living arrangements for the next six months. If the person does not express any personal priorities in this area, please note this below.

1.	<input type="text"/>
2.	<input type="text"/>

Availability of Assistance

14. Does the person have assistance in their home? 0. No - Do not code availability of assistance - skip to question 15a. 1. Yes - Continue to question 14a.	<input type="text"/>	
14a. Code the level of assistance in the person's home (both paid and unpaid) during the past month. CODING: 05. No assistance received 04. Occasional/short term assistance 03. Regular night time 02. Regular daytime 01. Around the clock	A Paid	B Unpaid
	<input type="text"/>	<input type="text"/>

Section D	Living Arrangements, Caregiver Assistance and Availability
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Availability of Paid and Unpaid Assistance

Form Instructions:

Code the **Paid** caregiver's usual ability and willingness to provide assistance with each activity during the past 3 days in **Column A** and the **Unpaid** caregiver's usual ability and willingness to provide assistance with each activity during the past 3 days in **Column B**. *If the activity was not attempted, code as not applicable (09).*

Please complete the Living Arrangement and Caregiving Priorities section at the bottom of this page.

CODING: Code safety and quality of BOTH paid and unpaid caregiver assistance and their willingness to provide assistance with each of the following activities.	Enter Codes in Boxes		
	A Paid	B Unpaid	
05. Assistance not needed - No assistance needed.	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	15a. Self-care assistance (for example, bathing, dressing, toileting, or eating/feeding).
04. Caregiver(s) currently provide assistance - Person's usual caregiver(s) willing and able to provide needed assistance.	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	15b. Mobility assistance (for example, bed mobility, transfers, ambulating, or wheeling).
03. Caregiver(s) need training/supportive services to provide assistance - Caregiver(s) available and need assistance to provide support.	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	15c. IADL assistance (for example, making meals, housekeeping, telephone, shopping, or finances).
02. Unclear if caregiver(s) will provide assistance - Caregiver(s) available in the home but it is not clear if caregiver(s) will provide needed assistance.	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	15d. Medication administration (for example, oral, inhaled, or injectable medications).
01. Assistance needed but no caregiver(s) available - Person needs assistance but no caregiver(s) available in the home.	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	15e. Medical procedures/treatments (for example, changing wound dressing, or home exercise program).
00. Assistance needed but person declines assistance - Person needs caregiving but declines this assistance.	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	15f. Management of equipment (for example, oxygen, IV/infusion equipment, enteral/parenteral nutrition, or ventilator therapy equipment and supplies).
09. Not applicable - Person does not do this activity.	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	15g. Supervision (for example, due to safety concerns).
	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	15h. Advocacy or facilitation of person's participation in appropriate medical care (for example, transportation to or from appointments).

Caregiving Priorities: Please ask the person to describe at least one or two personal priorities in the area of caregiving for the next six months. If the person does not express any personal priorities in this area, please note this below.

1.

2.