

LOUISIANA INDEPENDENT LIVING ASSESSMENT

3.1 COVER SHEET

<input type="checkbox"/> Assessment	<input type="checkbox"/> Re-Assessment	<input type="checkbox"/> Annual	Clients Initials _____
Date: _____	Date: _____	<input type="checkbox"/> Change	Nutrition Score _____
			ADL _____ IADLS _____

A. Client Identification

1. Name: _____
(First) (MI) (Last)

Maiden Name: _____

Also Known as: _____

2. ID Number _____

3. Ethnic Race

- a. Non-Minority (White, non-Hispanic)
- b. Black/African-American
- c. American Indian / Native Alaskan
- d. Asian
- e. White Hispanic
- f. Native Hawaiian/Other Pacific Islander
- g. Other _____

4. Phone Number _____

5. Social Security Number# _____

6. DOB _____
Month / Day / Year

7. Age _____

8. Gender Male Female

9. Mailing Address

- a. Street _____
- b. Town _____
- c. State LA d. Zip _____

10. Residence

- a. Street or PO Box _____
- b. Town _____
- c. State LA d. Zip _____

11. Marital Status

- a. Single b. Married c. Separated
- d. Widowed e. Divorced f. Not Available

12. Are you a Veteran? Yes No

13. Are you a Veteran dependent?
 Yes No

B. Emergency Contact

Primary Physician

Name _____

Address _____

Phone Number _____

Relative/Friend

Name _____

Address _____

Phone Number _____

C. Directions to Home

D. Does Client live?

- 1. Alone
- 2. With spouse/partner
- 3. With spouse and child
- 4. With child/children (including adult child)
- 5. Information unavailable
- 6. With others _____
Name of spouse/Partner (Optional)

E. Health Insurance: Do you have?

Yes	No	Type
<input type="checkbox"/>	<input type="checkbox"/>	1. Medicare A
<input type="checkbox"/>	<input type="checkbox"/>	2. Medicare B
<input type="checkbox"/>	<input type="checkbox"/>	3. Medicare D
<input type="checkbox"/>	<input type="checkbox"/>	4. Medigap
<input type="checkbox"/>	<input type="checkbox"/>	5. Medicaid
<input type="checkbox"/>	<input type="checkbox"/>	6. LTC
<input type="checkbox"/>	<input type="checkbox"/>	7. Other

F. Do you have prescription drug insurance?

Yes No

If no, do you want information on the Senior Rx program?

Yes No

G. Client Characteristics

	Yes	No
a. Abused/Neglected/Exploited	<input type="checkbox"/>	<input type="checkbox"/>
If yes, Referred to _____	Date	_____
b. Disabled	<input type="checkbox"/>	<input type="checkbox"/>
c. Duplicate Mail	<input type="checkbox"/>	<input type="checkbox"/>
d. Female head of household	<input type="checkbox"/>	<input type="checkbox"/>
e. Frail	<input type="checkbox"/>	<input type="checkbox"/>
f. Homebound	<input type="checkbox"/>	<input type="checkbox"/>
g. Medicare Eligible	<input type="checkbox"/>	<input type="checkbox"/>
h. Receiving Social Security	<input type="checkbox"/>	<input type="checkbox"/>
i. State Resident	<input type="checkbox"/>	<input type="checkbox"/>
j. Tribal	<input type="checkbox"/>	<input type="checkbox"/>

H. Household Size (entire household)

a.	1 person	<input type="checkbox"/>
b.	2 people	<input type="checkbox"/>
c.	3 people	<input type="checkbox"/>
d.	4 or more people	<input type="checkbox"/>

I. Monthly Income: (entire household)

SSI	\$ 565	or less	<input type="checkbox"/>
1	\$ 775	or less	<input type="checkbox"/>
2	\$1,040	or less	<input type="checkbox"/>
3	\$1,305	or less	<input type="checkbox"/>
4	\$1,576	or less	<input type="checkbox"/>
5	\$1,836	or less	<input type="checkbox"/>

J. Donations

Individual has been advised that s/he has an opportunity to make voluntary and anonymous donations for any service s/he may receive. Yes No

K. Permission

The client has formally authorized a release of information. Yes No
 Attach copy of signed and dated authorization.

L. Services

	Yes	No	Want to Apply
Adult Day Care/Adult Day Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assisted Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chore	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congregate Meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I&A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outreach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wellness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NFCSP ¹	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

¹ National Family Caregiver Support Program requires a different assessment form.

M. Services

Client is placed on waiting list? Yes No

If yes, list services(s) _____

N. Interview Questions

Where interviewed: Home Hospital
 Nursing Home Other
 _____ (Specify)

Did someone help client or answer questions for client? Yes No

Helper's Name _____
 Relationship _____

Communication/Language Assistance needed for assessment? Yes No

Language _____
 Type of assistance _____

Assessor: _____

Agency: _____

Client signature: _____

O. Determine Your Nutritional Health.

(Circle your answers and add up your score)	Yes	No
Client has made changes in lifelong eating habits because of health problems.		
Client eats fewer than two (2) meals per day.		
Client eats fewer than 5 servings of fruits and vegetables		
Client eats fewer than two (2) servings of dairy products (such as milk, yogurt, or cheese) every day.		
Client has biting, chewing, or swallowing problems that makes it difficult to eat.		
Client does not have enough money to buy food most of the time.		
Client eats alone most of the time.		
Client takes three (3) or more different prescriptions or over-the-counter drugs per day.		
Without wanting to, Client has lost or gained ten (10) pounds in the past six (6) months.		
Client is not physically able to shop, cook, and/or feed themselves (or to get someone to do it for them) most of the time.		
Client has three (3) or more drinks of beer, liquor, or wine almost every day.		
TOTALS		0

(Add YES and NO columns) for your total nutrition score.

COMBINED TOTAL

Record the combined total on the Cover Sheet and the GOEA Score Sheet.

If it is:

- 0 - 2 **GOOD!** Recheck the Nutritional Score at annual review.
- 3-5 You are at a moderate nutritional risk. Ask your area agency on aging, senior nutrition program, senior citizens center or health department what can be done to improve your eating habits and lifestyles.
- 6 or more You are at high nutritional risk. Bring a copy of this checklist the next time you see your doctor, dietician, or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

NOTE: High-risk clients should receive a copy of the scoring sheet and instructed to give to their physician, caregiver, or family member for follow-up. High-risk clients should be closely monitored - a six-month review.

SECTION 3.2 INTAKE ASSESSMENT

A. Legal Representative

1. Do you have a:

	Yes	No
a. Power of Attorney	<input checked="" type="checkbox"/>	<input type="checkbox"/>
b. DPOA for Health Care	<input type="checkbox"/>	<input type="checkbox"/>
c. DPOA for Finances	<input checked="" type="checkbox"/>	<input type="checkbox"/>
d. Representative Payee	<input checked="" type="checkbox"/>	<input type="checkbox"/>
e. Guardian	<input type="checkbox"/>	<input type="checkbox"/>

2. Do you have advanced directives?

Yes No

If no, do you need information provided about advance directives?

Yes No

B. Assessment Information

1. Reason for Referral _____

2. Referred by?

- | | |
|--|---|
| a. <input type="checkbox"/> Self
b. <input type="checkbox"/> Family
c. <input type="checkbox"/> Hospital | d. <input type="checkbox"/> Agency _____ (Name)
e. <input type="checkbox"/> Other _____
f. <input type="checkbox"/> Information unavailable |
|--|---|

3. Do you live in (Read all choices before recording the answer)

- a. House/mobile home
- b. Private Apartment
- c. Private Apartment in senior housing
- d. Residential care home
- e. Nursing home
- f. Information unavailable
- g. Other _____

4. How long have you lived at this current residence?

- a. Less than 12 months
- b. 1 - 3 years
- c. 3 years or more

5. If you moved in the past 3 years, did you live in?

- | | |
|---|--|
| a. <input type="checkbox"/> Own home for _____ months
b. <input type="checkbox"/> Residential care home for _____ months
c. <input type="checkbox"/> Other _____ for _____ months | d. <input type="checkbox"/> Nursing home for _____ months
e. <input type="checkbox"/> Hospital for _____ months
f. <input type="checkbox"/> Not applicable |
|---|--|

6. Are you currently employed?

- a. Yes b. No

7. Are you receiving any of the following services? (Refers to services that may not be funded with GOEA dollars)

Services	Yes	No	Want to Apply	Services	Yes	No	Want to Apply
a. Attendant services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	r. Energy Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Medicaid Waiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	s. Telephone Reassurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Homemaker Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	t. Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Home Health Aide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	u. SSI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Private Nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	v. Prescription Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	w. OMB/SLMB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	x. Medical Alert	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	y. Community Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Private Sitter Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	z. Respite Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Emergency Lifeline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Hospice Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Senior Companion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Rehabilitation Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Weatherization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Transportation Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Home Repair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Support Group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Adult Day Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Commodity Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Food Stamps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Read all choices before recording the answer)

(Arrows and Italics indicate that the question is to be answered by the client only)

8. Do you have any children or other relatives who live nearby (within one hour's drive)?

- a. Yes b. No

*9. Do you have contact with:

- | | | |
|-------------------------|--------------------------|--------------------------|
| | Yes | No |
| a. Family often enough | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Friends often enough | <input type="checkbox"/> | <input type="checkbox"/> |

10. Is there a friend or relative who could take care of you for a few days?

- a. Yes b. No

*11. When you make a decision about something, in general, how do you do it?

- a. By yourself
- b. By yourself after talking to family/friends
- c. Follow advice of family/friends
- d. Let other people make decisions for you
- e. Information unavailable

*12. In rating your health, would you say that it is excellent, good, fair or poor?

- a. Excellent b. Good c. Fair d. Poor e. Information Unavailable

13. In the past, how many times have you stayed overnight in a hospital?

- a. Not at all b. One time c. 2 or 3 times d. More than 3 times

14. Have you ever stayed in a nursing home, residential care home or other institution?

- a. Yes b. No

15. Do you have the following conditions?

- | | | | | | |
|---------------------------------|----------------------------|----------------------------|----------------------------------|----------------------------|----------------------------|
| a. Heart problems | Y <input type="checkbox"/> | N <input type="checkbox"/> | g. Breathing disorders | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| b. Arthritis | Y <input type="checkbox"/> | N <input type="checkbox"/> | h. Cataracts | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| c. Diabetes | Y <input type="checkbox"/> | N <input type="checkbox"/> | i. Urinary problems | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| d. Cancer | Y <input type="checkbox"/> | N <input type="checkbox"/> | j. Ankle/leg swelling | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| e. Stroke/neurological problems | Y <input type="checkbox"/> | N <input type="checkbox"/> | k. Cognitive impairment/dementia | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| f. Mental/emotional condition | Y <input type="checkbox"/> | N <input type="checkbox"/> | l. Other | Y <input type="checkbox"/> | N <input type="checkbox"/> |

*16. If stroke/neurological condition, are you limited in what you can do? Yes No

17. How much of the time does bad health, sickness, pain, or disability stop you from doing things you would like to do?

- a. Never b. Sometimes c. Often d. Always

18. Have you fallen in the last 3 months? a. Yes b. No

19. How often do you go out of the house/building where you live?

- a. Two or more days a week b. One day a week or less

20. Do you use a walker or four-pronged cane to get around?

- a. Yes b. No c. Sometimes

21. Do you use a wheelchair to get around?

- a. Yes b. No c. Sometimes

*22. Could you please tell me what year it is? a. Correct answer b. Incorrect answer

*23. What month is it? a. Correct answer b. Incorrect answer

*24. Where are we now? a. Correct answer b. Incorrect answer

25. Does client have problems with hearing, vision, or speech that is not corrected with aids such as glasses, hearing aids, etc?

Aids/Device	Yes	No	Are aids working in order?	Yes	No
a. Hearing	<input type="checkbox"/>	<input type="checkbox"/>	e. Hearing	<input type="checkbox"/>	<input type="checkbox"/>
b. Vision	<input type="checkbox"/>	<input type="checkbox"/>	f. Vision	<input type="checkbox"/>	<input type="checkbox"/>
c. Speech	<input type="checkbox"/>	<input type="checkbox"/>	g. Speech	<input type="checkbox"/>	<input type="checkbox"/>
d. Other _____	<input type="checkbox"/>	<input type="checkbox"/>	h. Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Was a referral made? Yes, to whom _____ If no, why a referral was not made.
made. _____

*26. In the past 6 months, have you lost more than 10 pounds without trying? a. Yes b. No

*27. Do you often feel sad or isolated? a. Yes b. No If yes, referred to: _____

*28. How often do you have contact with persons outside your home? Daily Weekly Monthly
 Not often

29. How many prescription medications do you take? _____

30. Can you:	Without Help		If No, do you have help?		If Yes, is it enough help?		ADL	IADLS	Comments
	Yes	No	Yes	No	Yes	No			
a) Get around inside your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		_____
b) Bathe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		_____
c) Dress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		_____
d) Get in and out of bed/chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		_____
e) Use toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		_____
f) Eat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		_____
g) Manage your money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	_____
h) Take care of shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	_____
i) Take your medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	_____
j) Prepare your meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	_____
k) Perform heavy home chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	_____
l) Perform ordinary housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	_____
m) Use transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	_____
n) Use Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	_____

Total number of ADLS _____ Total number of IADLS _____

*Record the number of ADLs and IADLs on the Cover Page and number 4 and 5 on the GOEA Score Sheet.

Ask Questions 31 and 32 only if it is determined that the client has limitations in ADLS and / or IADLS.

31. Would you like to talk to someone in detail about wheelchairs, walkers, canes, safety rails, ramp, etc. and other devices such as speaker phones with large letters?

Yes No

If yes, referral made to: _____ **Date:** _____

32. Would you like to talk to someone about how your home can be better adapted to help you get around and perform your daily activities?

Yes No

If yes, referral made to: _____ **Date:** _____

SECTION 3.3 HOME ENVIRONMENT

A. Are any of these problems or safety hazards present in your home?

1. ENVIRONMENT CHECKLIST

	Yes	No
a. Dangerous stairs/floors	<input type="checkbox"/>	<input type="checkbox"/>
b. Difficult to get to home entrance	<input type="checkbox"/>	<input type="checkbox"/>
c. Difficult to get to bathroom/bedroom	<input type="checkbox"/>	<input type="checkbox"/>
d. Major appliances/toilet not working	<input type="checkbox"/>	<input type="checkbox"/>
e. Problems with heating/cooling	<input type="checkbox"/>	<input type="checkbox"/>
f. Problems getting water/hot	<input type="checkbox"/>	<input type="checkbox"/>
g. Difficulties keeping home free from odor/pests	<input type="checkbox"/>	<input type="checkbox"/>
h. Smoke alarm needed	<input type="checkbox"/>	<input type="checkbox"/>
i. Electrical hazards	<input type="checkbox"/>	<input type="checkbox"/>
j. Poor lighting	<input type="checkbox"/>	<input type="checkbox"/>
k. Unsafe stove	<input type="checkbox"/>	<input type="checkbox"/>
l. Loose/slippery rugs	<input type="checkbox"/>	<input type="checkbox"/>
m. Inadequate locks for doors/windows	<input type="checkbox"/>	<input type="checkbox"/>
n. Difficult to keep home clean/free of clutter	<input type="checkbox"/>	<input type="checkbox"/>
o. Other problems?	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

2. In case of an emergency, such as a fire, do you think you would be able to get out of your house or apartment safely?

Yes No

3. In case of an emergency, such as a fire or fall, do you think you could summon help to your home?

Yes No

Comments

SECTION 3.4 INFORMAL SUPPORTS

1. FOR THE CLIENT Can you tell me who helps you on a regular basis? Yes No

Record information on primary caregiver, as well as other caregivers:

Primary Caregiver

NAME	RELATIONSHIP	ADDRESS	PHONE
			Day Eve.

Other Caregivers

NAME	RELATIONSHIP	PHONE	TYPE OF CARE/HELP
		Day Eve.	
		Day Eve.	

2. FOR THE PRIMARY CAREGIVER

	Yes	No	Comments
a. Personal care (such as help with bathing, dressing, using the toilet, getting in and out of bath or eating)	<input type="checkbox"/>	<input type="checkbox"/>	
b. Housekeeping (such as help with meal preparation, cleaning, laundry and taking out the garbage)	<input type="checkbox"/>	<input type="checkbox"/>	
c. Transportation	<input type="checkbox"/>	<input type="checkbox"/>	
d. Shopping/errands	<input type="checkbox"/>	<input type="checkbox"/>	
e. Supervision	<input type="checkbox"/>	<input type="checkbox"/>	
f. Taking Medication	<input type="checkbox"/>	<input type="checkbox"/>	
g. Managing Money	<input type="checkbox"/>	<input type="checkbox"/>	
h. Other, please specify:	<input type="checkbox"/>	<input type="checkbox"/>	

3. If services were not in place, would there be anything that would make it difficult for you to provide care?

Yes No

(If yes, discuss and note any factors that might limit caregiver)

Caregiver's comments		
Possible factors include:		
	Yes	No
a. Job	<input type="checkbox"/>	<input type="checkbox"/>
b. Finances	<input type="checkbox"/>	<input type="checkbox"/>
c. Family responsibilities	<input type="checkbox"/>	<input type="checkbox"/>
d. Physical burden	<input type="checkbox"/>	<input type="checkbox"/>
e. Emotional burden	<input type="checkbox"/>	<input type="checkbox"/>
f. Caregiver's mental health	<input type="checkbox"/>	<input type="checkbox"/>
g. Other	<input type="checkbox"/>	<input type="checkbox"/>

Comments

