Client's Initials __________

GOVERNOR'S OFFICE OF ELDERLY AFFAIRS
Louisiana Independent Living Assessment (LILA)
Statewide Comprehensive Needs Assessment SHORT Form

COVER SHEET

Assessment Date:___________ **Re-Assessment Date:**__________			**Client's Initials** __________ **Client a Veteran?** ○-Y ○-N **Nutrition Score**__________ **Client a Veteran dependent?** ○-Y ○-N	
First Name	**Middle Name**	**Last Name**	**Client's Suffix**	**Client's Maiden Name** **Client's AKA Name**
Marital Status ○-D=Divorced ○-L=Legally Separated ○-M=Married ○-S=Single ○-W=Widowed			**Client's Gender** ○-Male ○-Female	**Client's Date of Birth** __ _/ _ _/ _ _ _ _
Client's SS # ____-____-____	**Client's ID #**	**Information Release Authorization** ○-Y=Yes ○-N=No	**Client's Age in Years.**	**Client's Home Phone** (_ _ _)_ _ _-_ _ _ _
Client's Residence Address Street /P.O. Box___________________________ Town___________________________________ State________________ Zip Code________________		**Client's Mailing Address** Street Address____________________________ Town___________________________________ State______________________ Zip Code_____		**COA MEMBERSHIP CARD** **ACCEPTED**____ **DECLINED**____

NAPIS

Ethnicity	**Lives Alone?**	**In Poverty ?**	**High Nutritional Risk?**	**Is Client Rural?**	**Insurance**		
○-H=Hispanic or L= Latino ○N= Not Hispanic or Latino ○-U=Unknown	○-Y=Yes ○-N=No	○-Y=Yes ○-N=No	○-D=Don't Know ○-Y=Yes ○-N=No	○-D=Don't Know ○-Y=Yes ○-N=No	Medicaid # Medicaid Policy # Medicare # Medical Assistance ID		

Other			
Monthly Household Income $ _______________	**Household Size** _________	**Monthly Individual Income** $ ______________	**Email Address**

Characteristics			
Abuse/Neglected/Exploited ○-Y=Yes ○-N=No **Cognitive Impairment** ○- Mild ○-Moderate ○-None ○-Severe ○-Unknown **Disabled** ○-Y=Yes ○-N=No	**Employment Status** ○-Declined to state ○-Full Time ○-None ○-Part Time ○-Retired ○-Unemployed ○-Unknown **Female Head of Household** ○-Y=Yes ○-N=No **Frail** ○-Y=Yes ○-N=No **Homebound** ○-Y=Yes ○-N=No	**Medicare Eligible** ○-Y=Yes ○-N=No **Receiving Social Security** ○-Y=Yes ○-N=No **State Resident** ○-Y=Yes ○-N=No **Tribal** ○-Y=Yes ○-N=No **Understand English** ○-Y=Yes ○-N=No **U.S. Citizen** ○-Y=Yes ○-N=No	**NSIP Meals Eligible** ○-Y=Yes ○-N=No **Eligibility Type** ○-Age 60 or over ○-Disabled in Elderly Housing ○-Disabled living with elderly person ○- Food Handler ○-Guest/Staff under sixty ○-I&R Client ○-Not Indicated ○-Other **Veteran** ○-Y=Yes ○-N=No **Veteran dependent** ○-Y=Yes ○-N=No

Language	**Race**	**Nationality**				
○-English ○-French ○-German ○-Spanish	○-American Indian-Alaska Native ○-Asian ○-Black/African American ○-Native Hawaiian/Other Pacific Islander ○-White ○-Other	○-Asian Indian ○-Cambodian ○-Chinese ○-Cuban ○-Eastern European ○-English ○-Filipino	○-French ○-German ○-Guamanian-Chamorro ○-Irish ○-Japanese ○-Korean ○-Laotian ○-Mexico	○-Puerto Rican ○-Native Hawaiian ○-Other Asian ○-Other Hispanic/ Latino ○-Other Pacific Islander	○-Portuguese ○-Russian ○-Samoan ○-Thai ○-Tongan ○-Unknown ○-Vietnamese ○-Western European	

Assessment Document	
Emergency Contact: **(Lines 1.a.b.c.d.) Primary Physician** Name:________________________________ Address:_______________________________ Phone:________________________________	**Relative/ Friend:** (other than Spouse/Partner not living in the household) to contact in case of emergency.) Name:____ Address:____ Phone:____ Relationship:____________________________________
Directions to Client's Home:	

Do you have prescription drug insurance? ○-Y=Yes ○-N=No ○-D=Don't know	**Donations the client has been advised that he/she has an opportunity to make voluntary and anonymous donations for any service they may receive.** ○-Y=Yes ○-N=No ○-D=Don't know
The client formally authorized release of information. Attached copy of signed and dated authorization to this assessment. ○-Y=Yes ○-N=No ○-D=Don't know	**Client's Signature:**__________________________________ **Date of Signature:** _________/_________/_________
List all services the client will receive in the bottom of this form.	**Assessor's Signature: ________________________________** **Date of Signature: _________/_________/_________**

Client's Initials __________

DETERMINE YOUR NUTRITIONAL HEALTH (Addendum to PAF4019)

(CIRCLE YOUR ANSWERS AND ADD UP YOUR SCORE	YES	NO
Has the client made any changes in lifelong eating habits because of health problems?	2	0
Does the client eat fewer than two (2) meals per day?	3	0
Does the client eat fewer than five (5) serving (1/2 cup each of fruits and vegetables	1	0
Does the client eat fewer than two (2) servings of dairy products (such as milk, yogurt, or cheese) everyday?	1	0
Does the client have biting, chewing, or swallowing problems that make it difficult to eat?	2	0
Does the client have enough money to buy food?	0	4
Does the client eat alone most of the time	1	0
Does the client takes three (3) or more different prescriptions or over the counter drugs per day?	1	0
Without warning to, has the client lost or gained ten (10) pounds in the past six (6) months	2	0
Is the client not always physically able to shop, cook and or feed themselves (or to get someone to do it for them)?	0	2
Does the client have three (3) or more drinks of beer, liquor, or wine almost every day?	2	0
TOTALS		

(Add Yes and No columns) for your total nutrition score **COMBINED TOTALS: ____________**

If it is:

0-2 GOOD!

3-5 You are at moderate nutritional risk. See 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, dietitian, or other qualified health or social service professional. Talk with them about problems you may have. Ask for help to improve your nutritional health.

MEDICATION REVIEW (Addendum to PAF4019)

A. MEDICATION USE: ***(Ask the client if you can see the medications so that you can verify frequency, dosage, etc. Include over the counter drugs like aspirin, laxatives, and vitamins. Some medicines may be refrigerated.)***

1. Are you taking any medicines? If so, could you show them to me so we can list their names and dosage?

MEDICATION	PRIMARY DIAGNOSIS	DIRECTIONS/STRENGTH/DOSAGE	PRESCRIBING DOCTOR AND PHONE	MANUFACTURER AND COST

2. Do you have problems or difficulty remembering to take your medications? a. ☐ Yes b. ☐ No
(If necessary, prompt the client by asking if s/he is concerned about forgetting. What steps does s/he take to remember?)

3. Please list your drug allergies: ____

4. Referral made: ______Yes _______ No ______ **What agency**: _________________________________