# MINIMUM DATA SET - HOME CARE (MDS-HC)© • Unless otherwise noted, score for last 3 days

• Examples of exceptions include IADLs/Continence/Services/Treatments where status scored over last 7 days SECTION AA. NAME AND IDENTIFICATION NUMBERS

1.	NAME OF CLIENT		2.	REASONS FOR	Type of assessment 1. Initial assessment
2.	CASE	a. (Last/Family Name) b. (First Name) c. (Middle Initial)			<ol> <li>Follow-up assessment</li> <li>Routine assessment at fixed intervals</li> </ol>
2.	RECORD NO.				<ol> <li>Review within 30-day period prior to discharge from the program</li> <li>Review at return from hospital</li> <li>Change in status</li> </ol>
3.	GOVERN- MENT	a. Pension (Social Security) Number			7. Other
	PENSION AND HEALTH	b. Health insurance number (or other comparable insurance number)	SE	CTION B.	COGNITIVE PATTERNS
	INSURANCE NUMBERS		1.	MEMORY RECALL	(Code for recall of what was learned or known) 0. Memory OK 1. Memory problem
				ABILITY	a. Short-term memory OK — seems/appears to recall after 5 minutes
SE	CTION B	B. PERSONAL ITEMS (Complete at Intake Only)			b. Procedural memory OK-Can perform all or almost all steps in a
1.	GENDER	1. Male 2. Female	2.	COGNITIVE	multitask sequence without cues for initiation a. How well client made decisions about organizing the day (e.g., when
2.	BIRTHDATE		2.	SKILLS FOR DAILY DECISION-	<ul> <li>to get up or have meals, which clothes to wear or activities to do)</li> <li><i>INDEPENDENT</i>—Decisions consistent/reasonable/safe</li> </ul>
3.	RACE/	Month Day Year (Check all that apply)		MAKING	MODIFIED INDEPENDENCE—Some difficulty in new situations     only
J.	ETHNICITY	RACE Native Hawaiian or other Pacific			<ol> <li>MINIMALLY IMPAIRED—In specific situations, decisions become poor or unsafe and cues/supervision necessary at those times</li> </ol>
		American Indian/Alaskan Islander d. Native e.			<ol> <li>MODERATELY IMPAIRED—Decisions consistently poor or un- safe, cues/supervision required at all times</li> </ol>
		Asian b. ETHNICITY:			4. SEVERELY IMPAIRED—Never/rarely made decisions
		Black or African American c. Hispanic or Latino f.			<b>b.</b> Worsening of decision making as compared to status of <b>90 DAYS</b>
4.	MARITAL STATUS	1. Never married         3. Widowed         5. Divorced           2. Married         4. Separated         6. Other			AGO (or since last assessment if less than 90 days) 0. No 1. Yes
5.		Primary Language	3.	INDICATORS OF DELIRIUM	a. Sudden or new onset/change in mental function over LAST 7 DAYS (including ability to pay attention, awareness of surroundings, being
6.	EDUCATION	0. English     1. Spanish     2. French     3. Other       1. No schooling     5. Technical or trade school			coherent, unpredictable variation over course of day) 0. No 1. Yes
ΰ.	(Highest Level	2. 8th grade/less 6. Some college 3.9-11 grades 7. Bachelor's degree			b. In the LAST 90 DAYS (or since last assessment if less than 90
	Completed)	4. High school 8. Graduate degree			days), client has become agitated or disoriented such that his or her safety is endangered or client requires protection by others
7.	BILITY/	(Code for responsibility/advanced directives) 0. No 1. Yes			0. No 1. Yes
	ADVANCED DIRECTIVES	a. Client has a legal guardian	SE	CTION C.	COMMUNICATION/HEARING PATTERNS
		b. Client has advanced medical directives in place (for example, a do	1.	HEARING	(With hearing appliance if used)
		not hospitalize order)			0. HEARS ADEQUATELY—Normal talk, TV, phone, doorbell 1. MINIMAL DIFFICULTY—When not in quiet setting UFARS ADEQUAL CITUATION COMMY. Service has to activate
SE		REFERRAL ITEMS (Complete at Intake Only)			2. HEARS IN SPECIAL SITUATIONS ONLY—Speaker has to adjust tonal quality and speak distinctly 3. HIGHLY IMPAIRED—Absence of useful hearing
1.	DATE CASE OPENED/		2.	MAKING	(Expressing information content—however able)
	REOPENED	Month Day Year		SELF UNDERSTOOD	0. UNDERSTOOD—Expresses ideas without difficulty 1. USUALLY UNDERSTOOD—Difficulty finding words or finishing thoughts
2.	REASON FOR	1. Post hospital care     4. Eligibility for home care       2. Community chronic care     5. Day care		(Expression)	BUT if given time, little or no prompting required 2. OFTEN UNDERSTOOD—Difficulty finding words or finishing thoughts,
3.	REFERRAL GOALS OF	3. Home placement screen 6. Other (Code for client/family understanding of goals of care)			2. OF TEN ONDERSTOOD—Dimitally initialing words of initial initial indugrits, prompting usually required 3. SOMETIMES UNDERSTOOD—Ability is limited to making concrete
J.	CARE	0.No 1. Ýes			requests 4. RARELY/NEVER UNDERSTOOD
		a. Skilled nursing treatments d. Client/family education	3.		(Understands verbal information—however able)
		b. Monitoring to avoid clinical complications e. Family respite		UNDER- STAND	0. UNDERSTANDS—Clear comprehension
	TR 45 60	c. Rehabilitation f. Palliative care		OTHERS	1. USUALLY UNDERSTANDS—Misses some part/intent of message, BUT comprehends most conversation with little or no prompting 2. OFTEN UNDERSTANDS—Misses some part/intent of message; with
4.	TIME SINCE LAST	Time since discharge from last in-patient setting ( <i>Code for most</i> recent instance in LAST 180 DAYS)		(Comprehen- sion)	<ol> <li>DF TEN DIADERS TANDS—Wisses some partitient of message, with prompting can often comprehend conversation</li> <li>SOMETIMES UNDERSTANDS—Responds adequately to simple, di-</li> </ol>
	HOSPITAL STAY	0. No hospitalization within 180 days       3. Within 15 to 30 days         1. Within last week       4. More than 30 days ago			3. SOME TIMES UNDERSTANDS—Responds adequately to simple, unrect communication 4. RARELY/NEVER UNDERSTANDS
5.	WHERE	2. Within 8 to 14 days 1. Private home/apt. with no home care services	4.		Worsening in communication (making self understood or understand-
	LIVED AT	2. Private home/apt. with home care services 3. Board and care/assisted living/group home		TION DECLINE	ing others) as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days)
		4. Nursing home 5. Other		1	0. No 1. Yes
6.	WHO LIVED WITH AT				VISION PATTERNS
		2. Lived with spouse and other(s) 4. Lived with child (not spouse)	1.	VISION	(Ability to see in adequate light and with glasses if used) 0. ADEQUATE—Sees fine detail, including regular print in newspapers/
		5. Lived with other(s) (not spouse or children)			LADE QUALE—Sees line detail, including regular print in newspapers/ books     LiMPAIRED—Sees large print, but not regular print in newspapers/
7.	PRIOR NH	6. Lived in group setting with non-relative(s) Resided in a nursing home at anytime during <b>5 YEARS</b> prior to case			2. MODERATELY IMPAIRED—Limited vision; not able to see newspa-
		opening 0. No 1. Yes			2. MODERALED INFANCED—Limited vision, not able to see newspa- per headlines, but can identify objects 3. HIGHLY IMPAIRED—Object identification in question, but eyes ap-
8.		Moved to current residence within last two years			<ol> <li>FIGHLY INFARCED—Object identification in question, but eyes appear to follow objects</li> <li>SEVERELY IMPARED—No vision or sees only light, colors, or shapes;</li> </ol>
	HISTORY	0. No 1. Yes			eyes do not appear to follow objects
SF		ASSESSMENT INFORMATION	2.	LIMITATION/	
	ASSESSMENT	Date of assessment		DIFFICUL- TIES	0.No 1.Yes
	REFERENCE DATE		3.	VISION	Worsening of vision as compared to status of <b>90 DAYS AGO</b> (or since last assessment if less than 90 days)
		Month Day Year			0. No 1. Yes

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### SECTION E. MOOD AND BEHAVIOR PATTERNS

••	INDICATODE	(Code for observed indicato	ors irrespective of the assumed cause)
	OF	(	, ••• <b>p</b> ••••••••••••••••••••••••••••••••
	DEPRES-	0. Indicator not exhibited in la	
	SION.	<ol> <li>Exhibited 1-2 of last 3 day</li> </ol>	
	ANXIETY.	<ol><li>Exhibited on each of last 3</li></ol>	3 days
	SAD MOOD	a. A FEELING OF SADNESS	e. REPETITIVE ANXIOUS COM-
		OR BEING DEPRESSED.	PLAINTS, CONCERNS-e.g.,
		that life is not worth living,	persistently seeks attention/
		that nothing matters, that	reassurance regarding sched-
		he or she is of no use to	ules, meals, laundry, clothing,
		anyone or would rather be	relationship issues
		dead	
			f. SAD, PAINED, WORRIED FA-
		b. PERSISTENT ANGER WITH SELF OR OTHERS—	CIAL EXPRESSIONS—e.g.,
			- furrowed brows
		e.g., easily annoyed, anger at care received	
		at care received	g. RECURRENT CRYING, TEAR- FULNESS
		c. EXPRESSIONS OF WHAT	FULNESS
		APPEAR TO BE UNREAL	h. WITHDRAWAL FROM ACTIVI-
		ISTIC FEARS—e.g., fear of	TIES OF INTEREST—e.g., no
		being abandoned, left alone,	interest in long standing ac-
		being with others	tivities or being with family/
		d. REPETITIVE HEALTH COM-	fui a sa alla
		PLAINTS—e.g., persistently seeks medical attention.	i. REDUCED SOCIAL INTER-
		obsessive concern with body	
		functions	
•	NOOD		
2.	MOOD		e worse as compared to status of <b>90</b>
	DECLINE	days ago (or since last asses 0. No 1. Yes	
~			
3.	BEHAVIORAL SYMPTOMS	altering the symptom when it	ed behavioral symptoms. If EXHIBITED, eas
	STIVIFICIVIS		occurred.
		0. Did not occur in last 3 day	/S
		1. Occurred, easily altered	5
		2 Occurred not easily altered	h
		2. Occurred, not easily altere	
		a. WANDERING-Moved with	ed h no rational purpose, seemingly oblivious
		a. WANDERING Moved with to needs or safety	
		a. WANDERING Moved with to needs or safety	h no rational purpose, seemingly oblivious           HAVIORAL SYMPTOMS         Threatened,
		a. WANDERING—Moved with to needs or safety b. VERBALLY ABUSIVE BEI screamed at, cursed at oth	h no rational purpose, seemingly oblivious HAVIORAL SYMPTOMS—Threatened, ners
		<ul> <li>a. WANDERING—Moved with to needs or safety</li> <li>b. VERBALLY ABUSIVE BEI screamed at, cursed at oth</li> <li>c. PHYSICALLY ABUSIVE BEI</li> </ul>	h no rational purpose, seemingly oblivious HAVIORAL SYMPTOMS—Threatened, hers EHAVIORAL SYMPTOMS—Hit, shoved,
		a. WANDERING—Moved with to needs or safety b. VERBALLY ABUSIVE BEI screamed at, cursed at oth	h no rational purpose, seemingly oblivious HAVIORAL SYMPTOMS—Threatened, hers EHAVIORAL SYMPTOMS—Hit, shoved,
		<ul> <li>a. WANDERING — Moved with to needs or safety</li> <li>b. VERBALLY ABUSIVE BEI screamed at, cursed at oth</li> <li>c. PHYSICALLY ABUSIVE BEI scratched, sexually abuse</li> </ul>	h no rational purpose, seemingly oblivious HAVIORAL SYMPTOMS—Threatened, hers EHAVIORAL SYMPTOMS—Hit, shoved,
		<ul> <li>a. WANDERING—Moved with to needs or safety</li> <li>b. VERBALLY ABUSIVE BEI screamed at, cursed at oth</li> <li>c. PHYSICALLY ABUSIVE BE scratched, sexually abuse</li> <li>d. SOCIALLY INAPPROPRIAT</li> </ul>	h no rational purpose, seemingly oblivious HAVIORAL SYMPTOMS—Threatened, hers EHAVIORAL SYMPTOMS—Hit, shoved, od others ITE/DISRUPTIVE BEHAVIORAL SYMP-
		<ul> <li>a. WANDERING—Moved with to needs or safety</li> <li>b. VERBALLY ABUSIVE BEI screamed at, cursed at oth</li> <li>c. PHYSICALLY ABUSIVE BE scratched, sexually abuse</li> <li>d. SOCIALLY INAPPROPRIAT TOMS—Disruptive sounds,</li> </ul>	h no rational purpose, seemingly oblivious HAVIORAL SYMPTOMS—Threatened, ners EHAVIORAL SYMPTOMS—Hit, shoved, ad others TE/DISRUPTIVE BEHAVIORAL SYMP- , noisiness, screaming, self-abusive acts,
		<ul> <li>a. WANDERING—Moved with to needs or safety</li> <li>b. VERBALLY ABUSIVE BEI screamed at, cursed at oth</li> <li>c. PHYSICALLY ABUSIVE BE scratched, sexually abuse</li> <li>d. SOCIALLY INAPPROPRIATOMS—Disruptive sounds, sexual behavior or disrobir</li> </ul>	h no rational purpose, seemingly oblivious HAVIORAL SYMPTOMS—Threatened, hers EHAVIORAL SYMPTOMS—Hit, shoved, od others ITE/DISRUPTIVE BEHAVIORAL SYMP-
		<ul> <li>a. WANDERING—Moved with to needs or safety</li> <li>b. VERBALLY ABUSIVE BET screamed at, cursed at oth</li> <li>c. PHYSICALLY ABUSIVE BE scratched, sexually abuse</li> <li>d. SOCIALLY INAPPROPRIAT TOMS—Disruptive sounds, sexual behavior or disrobin rummaging, repetitive behavior</li> </ul>	h no rational purpose, seemingly oblivious HAVIORAL SYMPTOMS—Threatened, ners EHAVIORAL SYMPTOMS—Hit, shoved, ad others ITE/DISRUPTIVE BEHAVIORAL SYMP- , noisiness, screaming, self-abusive acts, ng in public, smears/throws food/feces, avior, rises early and causes disruption
		<ul> <li>a. WANDERING—Moved with to needs or safety</li> <li>b. VERBALLY ABUSIVE BEI screamed at, cursed at oth</li> <li>c. PHYSICALLY ABUSIVE BEI scratched, sexually abuse</li> <li>d. SOCIALLY INAPPROPRIATOMS—Disruptive sounds, sexual behavior or disrobin rummaging, repetitive behave</li> <li>e. RESISTS CARE—Resister</li> </ul>	h no rational purpose, seemingly oblivious HAVIORAL SYMPTOMS—Threatened, hers EHAVIORAL SYMPTOMS—Hit, shoved, ad others TE/DISRUPTIVE BEHAVIORAL SYMP- is, noisiness, screaming, self-abusive acts, ng in public, smears/throws food/feces, avior, rises early and causes disruption ad taking medications/injections, ADL as-
		<ul> <li>a. WANDERING—Moved with to needs or safety</li> <li>b. VERBALLY ABUSIVE BEI screamed at, cursed at oth</li> <li>c. PHYSICALLY ABUSIVE BEI scratched, sexually abuse</li> <li>d. SOCIALLY INAPPROPRIATOMS—Disruptive sounds, sexual behavior or disrobin rummaging, repetitive beha</li> <li>e. RESISTS CARE—Resister sistance, eating, or change</li> </ul>	h no rational purpose, seemingly oblivious HAVIORAL SYMPTOMS—Threatened, hers EHAVIORAL SYMPTOMS—Hit, shoved, ad others TE/DISRUPTIVE BEHAVIORAL SYMP- is, noisiness, screaming, self-abusive acts, ng in public, smears/throws food/feces, avior, rises early and causes disruption ad taking medications/injections, ADL as- as in position
4.	CHANGES IN	<ul> <li>a. WANDERING—Moved with to needs or safety</li> <li>b. VERBALLY ABUSIVE BEI screamed at, cursed at oth</li> <li>c. PHYSICALLY ABUSIVE BEI scratched, sexually abuse</li> <li>d. SOCIALLY INAPPROPRIATIONS—Disruptive sounds, sexual behavior or disrobin rummaging, repetitive behavior</li> <li>e. RESISTS CARE—Resister sistance, eating, or change</li> <li>Behavioral symptoms have be</li> </ul>	h no rational purpose, seemingly oblivious HAVIORAL SYMPTOMS—Threatened, hers EHAVIORAL SYMPTOMS—Hit, shoved, ad others ITE/DISRUPTIVE BEHAVIORAL SYMP- i, noisiness, screaming, self-abusive acts, ng in public, smears/throws food/feces, avior, rises early and causes disruption ad taking medications/injections, ADL as- is in position ecome worse or are less well tolerated
4.	BEHAVIOR	<ul> <li>a. WANDERING—Moved with to needs or safety</li> <li>b. VERBALLY ABUSIVE BEI screamed at, cursed at oth</li> <li>c. PHYSICALLY ABUSIVE BE scratched, sexually abuse</li> <li>d. SOCIALLY INAPPROPRIAT TOMS—Disruptive sounds, sexual behavior or disrobin rummaging, repetitive behase</li> <li>e. RESISTS CARE—Resiste sistance, eating, or change</li> <li>Behavioral symptoms have be by family as compared to 90</li> </ul>	h no rational purpose, seemingly oblivious HAVIORAL SYMPTOMS—Threatened, hers EHAVIORAL SYMPTOMS—Hit, shoved, ad others TE/DISRUPTIVE BEHAVIORAL SYMP- is, noisiness, screaming, self-abusive acts, ng in public, smears/throws food/feces, avior, rises early and causes disruption ad taking medications/injections, ADL as- as in position
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4.	BEHAVIOR	<ul> <li>a. WANDERING—Moved with to needs or safety</li> <li>b. VERBALLY ABUSIVE BEI screamed at, cursed at oth</li> <li>c. PHYSICALLY ABUSIVE BE scratched, sexually abuse</li> <li>d. SOCIALLY INAPPROPRIAT TOMS—Disruptive sounds, sexual behavior or disrobin rummaging, repetitive behase</li> <li>e. RESISTS CARE—Resiste sistance, eating, or change</li> <li>Behavioral symptoms have be by family as compared to 90</li> </ul>	h no rational purpose, seemingly oblivious HAVIORAL SYMPTOMS—Threatened, hers EHAVIORAL SYMPTOMS—Hit, shoved, ad others TE/DISRUPTIVE BEHAVIORAL SYMP- is, noisiness, screaming, self-abusive acts, ng in public, smears/throws food/feces, avior, rises early and causes disruption ad taking medications/injections, ADL as- as in position ecome worse or are less well tolerated DAYS AGO (or since last assessment if

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	1.	INVOLVE- MENT	a. At ease interacting with others (e.g., likes to spend time with others) 0. At ease 1. Not at ease	
			b. Openly expresses conflict or anger with family/friends 0.No 1. Yes	
	2.	CHANGE IN SOCIAL	As compared to <b>90 DAYS AGO</b> (or since last assessment if less than 90 days ago), decline in the client's level of participation in social,	
		ACTIVITIES	religious, occupational or other preferred activities. IF THERE WAS A DECLINE, client distressed by this fact	
			0. No decline 1. Decline, not distressed 2. Decline, distressed	
	3.	ISOLATION	<ul> <li>a. Length of time client is alone during the day (morning and afternoon)</li> <li>0. Never or hardly ever</li> <li>1. About one hour</li> </ul>	
			2. Long periods of time—e.g., all morning 3. All of the time	
			<b>b.</b> Client says or indicates that he/she feels lonely	

## SECTION G. INFORMAL SUPPORT SERVICES

1.	TWO KEY	NAME OF PRIMARY AND SECONDARY HELPERS		
	HELPERS Primary (A)	a. (Last/Family Name) b. (First)		
	and Secondary	c. (Last/Family Name) d. (First)		
	(B)		(A) Prim	(B) Secn
		e. Lives with client 0. Yes 1. No 2. No such helper [skip other items in		
		the appropriate column]		
		f. Relationship to client		
		0. Child or child-in-law 2. Other Relative 1. Spouse 3. Friend/neighbor		
		Areas of help: 0. Yes 1. No		
		g.— Advice or emotional support		
		h.— IADL care		
		i. — ADL care		

1.	TWO KEY		(A) Prlm		(B) eci
	HELPERS	If needed, willingness (with ability) to increase help: 0. More than 2 hours 1. 1-2 hours per day 2. No			
	Primary (A) and	0. More than 2 hours 1. 1-2 hours per day 2. No j. — Advice or emotional support			
	Secondary (B)	k. — IADL care		+	
	(cont)	I. — ADL care		+	
2.	CAREGIVER	(Check all that apply)	i		
2.	STATUS	A caregiver is unable to continue in caring activities—e.g., decl the health of the caregiver makes it difficult to continue	ine in	a.	
		Primary caregiver is not satisfied with support received from fail and friends (e.g., other children of client)	mily	b.	
		Primary caregiver expresses feelings of distress, anger or depr	ession	c.	
		NONE OF ABOVE		d.	
3.	EXTENT OF INFORMAL	For instrumental and personal activities of daily living received LAST 7 DAYS, indicate extent of help from family, friends, and neighbors			
	HELP (HOURS	a.Sum of time across five weekdays	н		
	OF CARE, ROUNDED)	b. Sum of time across two weekend days		+	+
1.	the communit (A) IADL SEL 0. INDEP 1. SOME	ERFORMANCE—Code for functioning in routine activities around y during the LAST 7 DAYS, F <u>PERFORMANCE</u> CODE ( <i>Code for client's performance during ENDENT</i> —did on own ' <i>HELP</i> —help some of the time			
	2. FULL I 3. BY OT 8. ACTIV	HELP—performed with help all of the time HERS—performed by others ITY DID NOT OCCUR			
		FICULTY CODE How difficult it is (or would it be) for client to do		A)	(E
	activity or			ance	
	1. SOME	<i>DIFFICULTY</i> —e.g., needs some help, is very slow, or fatigues <i>T DIFFICULTY</i> —e.g., little or no involvement in the activity is		Pertormance	Difficulty
a. N a	IEAL PREPAR ssemblina inare	ATION—How meals are prepared (e.g., planning meals, cook edients, setting out food and utensils)	ting,		
o. O	RDINARYHOU	JSEWORK—How ordinary work around the house is performed ( sting, making bed, tidying up, laundry)	ə.g.,		
:.N	•	NANCE-How bills are paid, checkbook is balanced, house	nold		
d. N ta	IANAGING ME	DICATIONS—How medications are managed (e.g., rememberir opening bottles, taking correct drug dosages, giving injection	ig to ons,		
e. P	HONE USE-+	How telephone calls are made or received (with assistive devices s s on telephone, amplification as needed)	uch		
. s	-	ow shopping is performed for food and household items (e.g., selec	ting		
g. T		<b>ION</b> —How client travels by vehicle (e.g., gets to places beyond w	/alk-		
	ADL SELF-PE personal activi considering a dently, be sure	<b>ERFORMANCE</b> —The following address the client's physical function tities of daily life, for example, dressing, eating, etc. during the L all episodes of these activities. For clients who performed an act to determine and record whether others encouraged the activity o or oversee the activity [ <i>Note—For bathing, code for most dep</i> ST7 DAYS]	AST 3 ctivity in or were	DA dep pres	Sel Sel
		DENT—No help, setup, or oversight —OR— Help, setup, over ? times (with any task or subtask)	sight p	rovi	ide
	1. SETUP H	ELP ONLY—Article or device provided within reach of client 3 or	more ti	ime	s
	3 days —0	SION—Oversight, encouragement or cueing provided 3 or more tir DR— Supervision (1 or more times) plus physical assistance pro r a total of 3 or more episodes of help or supervision)			
	maneuveri Combinati	ASSISTANCE—Client highly involved in activity; received physical ing of limbs or other non-weight bearing assistance 3 or more t on of non-weight bearing help with more help provided only 1 or a total of 3 or more episodes of physical help)	timės –	-0	R–
	subtasks), — Weight-	VE ASSISTANCE—Client performed part of activity on own (50 but help of following type(s) were provided 3 or more times: bearing support—OR— formance by another during part (but not all) of last 3 days	)% or r	nor	e

- MAXIMAL ASSISTANCE—Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times
- 6. TOTAL DEPENDENCE—Full performance of activity by another
- 8. ACTIVITY DID NOT OCCUR (regardless of ability)

2.	ADL SELF-PE	RFORMANCE (cont)	3.	BOWEL	In LAST 7 DAYS, control of bow		oplianc	e or b	oowel
	OBILITY IN BE	ED—Including moving to and from lying position, turning side to side, and while in bed.		CONTI- NENCE	0. CONTINENT—Complete c		SF oet	mvd	evice
b.T	RANSFER-In	cluding moving to and between surfaces—to/from bed, chair, wheelchair, n. [ <i>Note—Excludes to/from bath/toilet</i> ]			1. CONTINENT WITH OST ostomy device that does n 2. USUALLY CONTINENT—	OMY—Complete con not leak stool	ntrol v	rith u	se of
standing position. [Note—Excludes to/from bath/toilet]     c.LOCOMOTION IN HOME—[Note—If in wheelchair, self-sufficiency once in chair]     d.LOCOMOTION OUTSIDE OF HOME—[Note—If in wheelchair, self-sufficiency once in chair]					weekly	•			
		OUTSIDE OF HOME—[Note—If in wheelchair, self-sufficiency once in			3. OCCÀSIONALLY INCONTI a week 4. FREQUENTLY INCONTIN				
	•	PER BODY—How client dresses and undresses (street clothes, under-			times a week				
W	vear) above the	e waist, includes prostheses, orthotics, fasteners, pullovers, etc.			5. INCONTINENT—Bowel in 8. DID NOT OCCUR—No b				
v		VER BODY—How client dresses and undresses (street clothes, under- waist down, includes prostheses, orthotics, belts, pants, skirts, shoes,	SE	CTION J. D	assessment period				
g. E	ATING-Includ	ling taking in food by any method, including tube feedings.			hat doctor has indicated is pres	ent and affects client	's stat	us, re	quire
0	on/off toilet, clear	ncluding using the toilet room or commode, bedpan, urinal, transferring ning self after toilet use or incontinent episode, changing pad, managing ces required (ostomy or catheter), and adjusting clothes.	mer	nt, or symptom the reason for	management. Also include if dise a hospitalization in <b>LAST 90 D/</b>	ase is monitored by a	home	care	profe
W	vashing/drying fa	GIENE—Including combing hair, brushing teeth, shaving, applying makeup, ace and hands (EXCLUDE baths and showers)		blank]. Not pres 1. Present—not 2. Present—mo	sent t subject to focused treatment or nitored or treated by home care p	monitoring by home o	care pi	ofess	sional
b	back and hair). I	client takes full-body bath/shower or sponge bath (EXCLUDE washing of ncludes how each part of body is bathed: arms, upper and lower legs,		If no disease ir	n list, check J1ac, None of Abov	e]			
С	hest, abdomen,	perineal area. Code for most dependent episode in LAST 7 DAYS	1.	DISEASES	HEART/CIRCULATION	p. Osteoporos	sis		
3.	ADLDECLINE	ADL status has become worse (i.e., now more impaired in self perfor- mance) as compared to status <b>90 days ago</b> (or since last assessment if loss the 00 days)			a. Cerebrovascular accident (stroke)	SENSES q. Cataract			
		if less than 90 days) 0.No 1. Yes			b. Congestive heart failure	<b>r.</b> Glaucoma			
4.	PRIMARY MODES OF	0. No assistive device 3. Scooter (e.g., Amigo) 1. Cane 4. Wheelchair			c. Coronary artery disease	PSYCHIATRIC	/MOOI	)	
		2. Walker/crutch 8. ACTIVITY DID NOT OCCUR			d. Hypertension	s. Any psychi			sis
		a. Indoors			e. Irregularly irregular pulse	INFECTIONS		5 -	
		b. Outdoors			f. Peripheral vascular disease	t. HIV infection	n		
5.	. STAIR CLIMBING	In the <b>last 3 days</b> , how client went up and down stairs (e.g., single or multiple steps, using handrail as needed)			NEUROLOGICAL	u. Pneumonia			
	CLINDING				g. Alzheimer's	v. Tuberculos	is		
		<ol> <li>Up and down stairs without help</li> <li>Up and down stairs with help</li> <li>Not go up and down stairs</li> </ol>			h. Dementia other than Alzheimer's disease	w. Urinary trac LAST 30 D		tion (i	in
6.	STAMINA	a. In a typical week, during the LAST 30 DAYS (or since last assessment), code the number of days client usually went out of the house			i. Head trauma	OTHER DISEA	SES		
		or building in which client lives (no matter how short a time period )			j. Hemiplegia/hemiparesis	x.Cancer(in	past 5	year	s)
		0. Every day 2. 1 day a week 1. 2-6 days a week 3. No days			k. Multiple sclerosis	not includir	ig skin	canc	er
		<b>b.</b> Hours of physical activities in the <b>last 3 days</b> (e.g., walking, cleaning			I. Parkinsonism	y. Diabetes	~/C^r		hme
		house, exercise) 0. Two or more hours 1. Less than two hours			MUSCULO-SKELETAL m.Arthritis	z. Emphysem aa. Renal Failu		u/ast	uina
7.	FUNCTIONAL POTENTIAL	Client believes he/she capable of increased functional independence (ADL, IADL, mobility)	a.		n. Hip fracture	ab.Thyroid dise	ease (l	nyper	or
		Caregivers believe client is capable of increased functional indepen-			o. Other fractures (e.g., wrist, vertebral)	hypo) ac. NONE OF	ABOVI	-	
			b. 2.	OTHER	a				
		Good prospects of recovery from current disease or conditions, im- proved health status expected	с.	CURRENT OR MORE	°				<u> ●</u>
		NONE OF ABOVE	d.	DETAILED DIAGNOSES	~			<u> </u>	<u> </u>
		NITINENCE IN LAST 7 DAYS		AND ICD-9 CODES	c		<u> </u>	<u>   </u> 	<u> </u>
3E 1.		DNTINENCE IN LAST 7 DAYS a. In LAST 7 DAYS control of urinary bladder function (with appliances such as catheters or incontinence program employed) [Note—if	SF		EALTH CONDITIONS AN		EHE		<u> </u>
	NENCE	dribbles, volume insufficient to soak through underpants]	52		IEASURES				•
		<ol> <li>CONTINENT —Complete control; DOES NOT USE any type of catheter or other urinary collection device</li> </ol>	1.		(Check all that apply—in PAS)	T2YEARS)			
		1. CONTINENT WITH CATHETER—Complete control with use of any		HEALTH (PAST TWO	Blood pressure measured				
		type of catheter or urinary collection device that does not leak urine		YEARS)	Received influenza vaccination	in a surday of			
		2. USUALLY CONTINENT-Incontinent episodes once a week or			Test for blood in stool or screen	• • • •	ara-1		
	1	less		I	IF FEMALE: Received breast ex	kamination of mammo	uradni		

3. OCCASIONALLY INCONTINENT—Incontinent episodes 2 or more times a week but not daily 4. FREQUENTLY INCONTINENT—Tends to be incontinent daily, but

some control present 5. INCONTINENT—Inadequate control, multiple daily episodes 8. DID NOT OCCUR —No urine output from bladder

b. Worsening of bladder incontinence as compared to status 90 DAYS AGO (or since last assessment if less than 90 days) 0. No 1. Yes

(Check all that apply in LAST 7 DAYS)

Use of an indwelling urinary catheter

NONE OF ABOVE

Use of pads or briefs to protect against wetness

BLADDER

2.

	NENCE	<ol> <li>CONTINENT—Complete control; DOES NOT USE ostomy device</li> <li>CONTINENT WITH OSTOMY—Complete control with use of ostomy device that does not leak stool</li> <li>USUALLY CONTINENT—Bowel incontinent episodes less than weekly</li> <li>OCCASIONALLY INCONTINENT—Bowel incontinent episode once a week</li> <li>FREQUENTLY INCONTINENT—Bowel incontinent episodes 2-3 times a week</li> <li>INCONTINENT—Bowel incontinent all (or almost all) of the time</li> <li>DID NOT OCCUR—No bowel movement during entire 7 day assessment period</li> </ol>
Dise	ease/infection that, or symptom r	SEASE DIAGNOSES hat doctor has indicated is present and affects client's status, requires treat- nanagement. Also include if disease is monitored by a home care professional a hospitalization in LAST 90 DAYS (or since last assessment if less than 90

•	DISEASES	HEART/CIRCULATION	p. Osteoporosis	
		a. Cerebrovascular accident (stroke)	SENSES	
		<b>b.</b> Congestive heart failure	<ul> <li>q. Cataract</li> <li>r. Glaucoma</li> </ul>	
		c.Coronary artery disease	PSYCHIATRIC/MOOD	
		d. Hypertension	s. Any psychiatric diagnosis	
		e. Irregularly irregular pulse	INFECTIONS	
		f. Peripheral vascular disease	t. HIV infection	
		NEUROLOGICAL	u. Pneumonia	
		g. Alzheimer's	v. Tuberculosis	
		h. Dementia other than Alzheimer's disease	w. Urinary tract infection (in LAST 30 DAYS)	
		i. Head trauma	OTHER DISEASES	
		j. Hemiplegia/hemiparesis		
		k.Multiple sclerosis	x. Cancer—(in past 5 years) not including skin cancer	
		I. Parkinsonism	y. Diabetes	
		MUSCULO-SKELETAL	z. Emphysema/COPD/asthma	
		<b>m.</b> Arthritis	aa. Renal Failure	
		n. Hip fracture	ab.Thyroid disease (hyper or	
		<b>o.</b> Other fractures (e.g., wrist, vertebral)	hypo) ac. NONE OF ABOVE	ac.
!	OTHER	a.		1
	CURRENT OR MORE	b.		1
	DETAILED	c.		1
	AND ICD-9			

#### ALTH CONDITIONS AND PREVENTIVE HEALTH ASURES

1.	PREVENTIVE	(Check all that apply—in PAS	ST2YE	ARS)	
	HEALTH (PAST TWO	Blood pressure measured		,	a.
	YEARS)	Received influenza vaccinatio	n		b.
		Test for blood in stool or scree	ening er	idoscopy	c.
		IF FEMALE: Received breast e	examina	tion or mammography	d.
		NONE OF ABOVE			e.
2.		(Check all that were present	on at le	east 2 of the last 3 days)	
	CONDITIONS PRESENT ON	Diarrhea	a.	Loss of appetite	d.
	2 OR MORE DAYS	Difficulty urinating or urinating 3 or more times at night	a. b.	Vomiting	e.
		Fever	c.	NONE OF ABOVE	f.
3.	PROBLEM	(Check all present at any poi	nt durin	g last 3 days)	
	CONDITIONS	PHYSICAL HEALTH		Shortness of breath	e.
		Chest pain/pressure at rest or		MENTAL HEALTH	
		on exertion	a.	Delusions	f.
		No bowel movement in 3 days	b.	Hallucinations	g.
		Dizziness or lightheadedness	c.	NONE OF ABOVE	y. h.
		Edema	d.		11.

4.	PAIN	a. Frequency with which client complains or shows evidence of pain         0. No pain (score b-e as 0)       2. Daily - one period         1. Less than daily       3. Daily - multiple periods (e.g., morning and evening)	
		b. Intensity of pain         2. Moderate         4. Times when pain is horrible           1. Mild         3. Severe         or excruciating	
		c. From client's point of view, pain intensity disrupts usual activities 0. No 1. Yes	
		d. Character of pain         0. No pain         1. Localized - single site         2. Multiple sites	
		e. From client's point of view, medications adequately control pain 0. Yes or no pain 1. Medications do not 2. Pain present, adequately control pain 2. Pain present, medication not taken	
5.	FALLS FREQUENCY	Number of times fell in LAST 90 DAYS (or since last assessment if less than 90 days) If none, code "0"; if more than 9, code "9"	
6.	DANGER OF FALL	( <i>Code for danger of falling</i> ) 0. No 1. Yes	
		a. Unsteady gait	
		b. Client limits going outdoors due to fear of falling (e.g., stopped using bus, goes out only with others)	
7.	LIFE STYLE (Drinking/	(Code for drinking or smoking) 0. No 1. Yes	
	`Smoking)	a. In the LAST 90 DAYS (or since last assessment if less than 90 days), client felt the need or was told by others to cut down on drinking, or others were concerned with client's drinking	
		b. In the LAST 90 DAYS (or since last assessment if less than 90 days), client had to have a drink first thing in the morning to steady nerves (i.e., an "eye opener") or has been in trouble because of drinking	
8.	HEALTH	c. Smoked or chewed tobacco daily (Check all that apply)	
0.	STATUS	Client feels he/she has poor health (when asked)	a.
		Has conditions or diseases that make cognition, ADL, mood, or behavior patterns unstable (fluctuations, precarious, or deteriorating)	b.
		Experiencing a flare-up of a recurrent or chronic problem	c.
		Treatments changed in LAST 30 DAYS (or since last assessment if less than 30 days) because of a new acute episode or condition	d.
		Prognosis of less than six months to live—e.g., physician has told client or client's family that client has end-stage disease	e.
9.	OTHER	NONE OF ABOVE (Check all that apply)	f.
	STATUS INDICATORS	Fearful of a family member or caregiver	a.
		Unusually poor hygiene	b.
		Unexplained injuries, broken bones, or burns Neglected, abused, or mistreated	c. d.
		Physically restrained (e.g., limbs restrained, used bed rails,	u.
		constrained to chair when sitting)	e.
		NONE OF ABOVE	f.
SE	CTION L. N	UTRITION/HYDRATION STATUS	
1.	WEIGHT	( <i>Code for weight items</i> ) 0. No 1. Yes	
		a. Unintended weight loss of 5% or more in the LAST 30 DAYS [or 10% or more in the LAST 180 DAYS]	
		b. Severe malnutrion (cachexia)	
2.	CONSUMP-	c. Morbid obesity (Code for consumption) 0. No 1. Yes	
	TION	a. In at least 2 of the last 3 days, ate one or fewer meals a day	
		<b>b. In last 3 days,</b> noticeable decrease in the amount of food client usually eats or fluids usually consumes	
		c. Insufficient fluid—did not consume all/almost all fluids during last	
		3 days d. Enteral tube feeding	
3.	SWALLOWING	0. NORMAL—Safe and efficient swallowing of all diet consistencies	
		REQUIRES DIET MODIFICATION TO SWALLOW SOLID FOODS (mechanical diet or able to ingest specific foods only)     REQUIRES MODIFICATION TO SWALLOW SOLID FOODS AND LIQUIDS (purce, thickened liquids)     DUC	
		3. COMBINÊD ORÂLAND TUBÊ FEÉDING 4. NO ORAL INTAKE (NPO)	
		ENTAL STATUS (ORAL HEALTH)	
1.	ORAL STATUS	(Check all that apply)	
		Problem chewing (e.g., poor mastication, immobile jaw, surgical resec- tion, decreased sensation/motor control, pain while eating)	a.
	1		

Mouth is "dry" when eating a meal

Problem brushing teeth or dentures

NONE OF ABOVE

SEC	CTION N. S	KIN CONDITION			
1.	SKIN PROBLEMS	Any troubling skin conditions or changes in skin condition (e.g., burns, bruises, rashes, itchiness, body lice, scabies) 0. No 1. Yes			
2.	ULCERS (Pressure/ Stasis)	Presence of an ulcer anywhere on the body. Ulcers include any area of persistent skin redness (Stage 1); partial loss of skin layers (Stage 2); deep craters in the skin (Stage 3); breaks in skin exposing muscle or bone (Stage 4). [Code 0 if no ulcer, otherwise record the highest ulcer stage (Stage 1-4).]			
		<b>a. Pressure ulcer</b> —any lesion caused by pressure, shear forces, resulting in damage of underlying tissues			
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities			
3.	OTHER SKIN PROBLEMS REQUIRING TREATMENT	(Check all that apply)         Burns (second or third degree)         Open lesions other than ulcers, rashes, cuts (e.g., cancer)         b.         NONE OF ABOVE         Skin tears or cuts	d. e. f.		
4.	HISTORY OF RESOLVED PRESSURE ULCERS	Client previously had (at any time) or has an ulcer anywhere on the body 0. No 1. Yes			
5.	WOUND/	(Check for formal care in LAST 7 DAYS)			
	ULCER CARE	Antibiotics, systemic or topical	a.		
		Dressings	b.		
		Surgical wound care	c.		
		- Other wound/ulcer care (e.g., pressure relieving device, nutrition, turn- ng, debridement)			
		NONE OF ABOVE	e.		

#### SECTION O. ENVIRONMENTAL ASSESSMENT

1.	HOME ENVIRON- MENT	Lighting in evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors)	a.
	[Check any of following	Flooring and carpeting (e.g., holes in floor, electric wires where client walks, scatter rugs)	b.
	that make home environment	Bathroom and toiletroom (e.g., non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)	с.
	hazardous or uninhabit- able (if none	Kitchen (e.g., dangerous stove, inoperative refrigerator, infestation by rats or bugs) $ \label{eq:constraint}$	d.
	apply, check NONE OF ABOVE; if	Heating and cooling (e.g., too hot in summer, too cold in winter, wood stove in a home with an asthmatic)	e.
	temporarily in institution, base	Personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street)	f.
	assessment	Access to home (e.g., difficulty entering/leaving home)	g.
	on home visit)]	Access to rooms in house (e.g., unable to climb stairs)	h.
		NONE OF ABOVE	i.
2.	LIVING ARRANGE-	a. As compared to 90 DAYS AGO (or since last assessment), client now lives with other persons—e.g., moved in with another person, other moved in with client	
	MENT	0. No 1. Yes	
		<ul> <li>b. Client or primary caregiver feels that client would be better off in another living environment</li> <li>0. No</li> <li>1. Client only</li> <li>2. Caregiver only</li> <li>3. Client and caregiver</li> </ul>	

# SECTION P. SERVICE UTILIZATION (IN LAST 7 DAYS)

1.	FORMAL CARE	Extent of care or care management in LAST 7 DAY assessment if less than 7 days) involving	(A)	since last (B)	(C)
	(Minutes		#of Days	Hours	Mins
	rounded to even 10 minutes)	a. Home health aides			
		<b>b.</b> Visiting nurses			
		c. Homemaking services			
		d. Meals			
		e. Volunteer services			
		f. Physical therapy			
		g. Occupational therapy			
		h. Speech therapy			
		i. Day care or day hospital			
		j. Social worker in home			

b.

c.

d.

2.	SPECIAL TREAT- MENTS, THERAPIES, PROGRAMS	Special treatments, therapies, and programs received or scheduled during th LAST 7 DAYS (or since last assessment if less than 7 days) and adherence to the required schedule. Includes services received in the home or on a outpatient basis. [Blank]. Not applicable 1. Scheduled, full adherence as prescribed 3. Scheduled, not received [If no treatments provided, check NONE OF ABOVE P2aa] RESPIRATORYTREATMENTS 0. Occupational therapy			
		a. Oxygen		<b>p.</b> Physical therapy	
		<b>b.</b> Respirator for assistive		PROGRAMS	
		breathing		q. Day center	
		<li>c. All other respiratory treat- ments</li>	1	r. Day hospital	
		OTHERTREATMENTS		s. Hospice care	
		d. Alcohol/drug treatment program		<ul><li>t. Physician or clinic visit</li><li>u. Respite care</li></ul>	
		e. Blood transfusion(s)		SPECIAL PROCEDURES DONE	
		f. Chemotherapy			
		<b>g.</b> Dialysis		<ul> <li>v. Daily nurse monitoring (e.g., EKG, urinary output)</li> </ul>	
		h. IV infusion - central		w. Nurse monitoring less than	
		i. IV infusion - peripheral		daily	
		<ul><li>j. Medication by injection</li><li>k. Ostomy care</li></ul>		<b>x.</b> Medical alert bracelet or electronic security alert	
		I. Radiation		y. Skin treatment	
		m. Tracheostomy care		z. Special diet	
				aa. NONE OF ABOVE	aa.
3.	MANAGE-	n. Exercise therapy			
5.	MENT OF EQUIPMENT (In Last 3 Days)	Management codes:         0. Not used         1. Managed on own         2. Managed on own if laid out or with verbal reminders         3. Partially performed by others         4. Fully performed by others			
		a. Oxygen		c.Catheter	
4.	VISITS IN	b.IV		d.Ostomy	
4.	LAST90 DAYS	Enter 0 if none, if more than 9, code "9" a. Number of times ADMITTED TO HOSPITAL with an overnight stay			
	OR SINCE LAST ASSESSMENT	b. Number of times VISITED EMERGENCY ROOM without an overnight stay			
		c.EMERGENT CARE—including unscheduled nursing, physician, or therapeutic visits to office or home			
5.	TREATMENT GOALS	Any treatment goals that have been met in the LAST 90 DAYS (or since last assessment if less than 90 days) 0. No 1. Yes			
6.	OVERALL CHANGE IN CARE NEEDS	Overall self sufficiency has changed significantly as compared to status of <b>90 DAYS AGO</b> (or since last assessment if less than 90 days) 0. No change 1. Improved—receives 2. Deteriorated— fewer supports receives more support			
7.	TRADE OFFS	Because of limited funds, during the last month, client made trade-offs among purchasing any of the following: prescribed medications, suffi- cient home heat, necessary physician care, adequate food, home care 0. No 1. Yes			
SE	CTION Q.M	EDICATIONS			
1.	NUMBER OF MEDICA- TIONS				
2.	RECEIPT OF PSYCHO- TROPIC	Psychotropic medications taken in the LAST 7 DAYS (or since last assessment) [Note—Review client's medications with the list that applies to the following categories] 0. No 1. Yes			
	MEDICATION	a. Antipsychotic/neuroleptic		c. Antidepressant	
		<b>b.</b> Anxiolytic		d. Hypnotic	
3.	MEDICAL OVERSIGHT	Physician reviewed client's medications as a whole in LAST 180 DAYS (or since last assessment) 0. Discussed with at least one physician (or no medication taken) 1. No single physician reviewed all medications			
4.	COMPLI-	Compliant all or most of time w	vith med	ications prescribed by physician	
	ANCE/ ADHERENCE	(both during and between therapy visits) in LAST 7 DAYS			
	WITH MEDICA- TIONS	<ol> <li>Always compliant</li> <li>Compliant 80% of time or more</li> <li>Compliant less than 80% of time, including failure to purchase prescribed medications</li> <li>NO MEDICATIONS PRESCRIBED</li> </ol>			

= When box blank, must enter number or letter a. = When letter in box, check if condition applies

5.	LIST OF ALL MEDICATIONS	List prescribed and nonprescribed medications taken in LAST 7 DAYS (or since last assessment) a. Name and Dose—Record the name of the medication and dose ordered. b. Form: Code the route of Administration using the following list:					
		1. By mouth (PO)       5. Subcutaneous (SQ)       9. Enteral tube         2. Sub lingual (SL)       6. Rectal (R)       10. Other         3. Intramuscular (IM)       7. Topical         4. Intravenous (IV)       8. Inhalation					
		<b>c. Number taken</b> —Record the amount of medication administered each time the medication is given					
		<b>d. Freq:</b> Code the number of times per day, week, or month the medication is administered using the following list:					
		PRN. As necessary       5D. Five times daily         QH. Every hour       QOD. Every other day         Q2H. Every two hours       QW. Once each wk         Q3H. Every three hours       QW. Two times every week         Q4H. Every four hours       3W. Three times every week         Q6H. Every six hours       4W. Four times each week         Q8H. Every eight hours       5W. Five times each week         QB. Once daily       6W. Six times each week         BID. Two times daily       1M. Once every month         (includes every 12 hrs)       2M. Twice every month         TID. Three times daily       0. Other					
	a. Name and D	Dose b. Form c. Number d. Freq. Taken					
	a						
	b						
	c						
	d						
	e						
	f						
	g						
	h						
	i						
	j						
	k						

# SECTION R. ASSESSMENT INFORMATION

1. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:						
a. Signature of Assessment Coordir	nator					
b. Title of Assessment Coordinator						
c. Date Assessment Coordinator signed as complete	Month	Day Yea	r			
d. Other Signatures	Title	Sections	Date			
е.			Date			
f.			Date			
g.			Date			
h.			Date			
i.			Date			