

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

RUG SCORES

RUG Category

ADL

RUG III Scoring

SECTION AA. NAME AND IDENTIFICATION NUMBERS

1.	Name of Client																																																		
		a. (Last/Family Name)	b. (First Name)	c. (Middle Name)																																															
2.	Case Record No.	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 3.33%;"></td><td style="width: 3.33%;"></td> </tr> </table>																																																	
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SECTION BB. PERSONAL ITEMS (Complete at Intake Only)

1.	Gender	1. Male	2. Female																					
2.	Birthdate	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td><td style="width: 10%;"></td> <td style="width: 5%; text-align: center;">-</td> <td style="width: 10%;"></td><td style="width: 10%;"></td> <td style="width: 5%; text-align: center;">-</td> <td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">Month</td> <td colspan="2" style="text-align: center;">Day</td> <td colspan="6" style="text-align: center;">Year</td> </tr> </table>					-			-					Month		Day		Year					
		-			-																			
Month		Day		Year																				
3.	Race / Ethnicity	0. No 1. Yes		(Answer All)																				
		Race: a. American Indian/ Alaskan Native b. Asian c. Black / African Amer		d. Native Hawaiian or other Pacific Islander e. White Ethnicity: f. Hispanic or Latino																				
4.	Marital Status	1. Never married	3. Widowed	5. Divorced																				
		2. Married	4. Separated	6. Other																				

5.	Language	Primary Language 0. English 1. Spanish 2. French 3. Other
6.	Education (Highest Level Completed)	1. No Schooling 5. Technical or trade school 2. 8th grade or less 6. Some college 3. 9 - 11 grades 7. Bachelor's degree 4. High school 8. Graduate degree
7.	Responsibility / Advanced Directives	(Code for responsibility/advanced directives) 0. No 1. Yes a. Client has a legal guardian b. Client has advanced medical directives in place. (for example, a do not hospitalize order)

SECTION CC. REFERRAL ITEMS (Complete at Intake Only)

1.	Date Case Opened/ Reopened	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 10px;">—</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 10px;">—</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> </div> <p style="text-align: center; margin-top: 5px;">Month Day Year</p>									
2.	Reason For Referral	1. Post hospital care 4. Eligibility for home care 2. Community chronic care 5. Day Care 3. Home placement screen 6. Other									
3.	Goals Of Care	(Code for client/family understanding of goals of care) 0. No 1. Yes (Answer All) <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border: 1px solid black; padding: 2px;">a. Skilled nursing treatments</td> <td style="width: 5%; border: 1px solid black; text-align: center;"> </td> <td style="width: 45%; border: 1px solid black; padding: 2px;">d. Client/family education</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;">b. Monitoring to avoid complications</td> <td style="border: 1px solid black; text-align: center;"> </td> <td style="border: 1px solid black; padding: 2px;">e. Family respite</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;">c. Rehabilitation</td> <td style="border: 1px solid black; text-align: center;"> </td> <td style="border: 1px solid black; padding: 2px;">f. Palliative care</td> </tr> </table>	a. Skilled nursing treatments		d. Client/family education	b. Monitoring to avoid complications		e. Family respite	c. Rehabilitation		f. Palliative care
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c. Rehabilitation		f. Palliative care									
4.	Time since Last Hospital Stay	Time since discharge from last in-patient setting (Code for most recent instance in LAST 180 DAYS) 0. No hospitalization within 180 days 3. Within 15 to 30 days 1. Within last week 4. More than 30 days ago 2. Within 8 to 14 days									
5.	Where Lived At Time Of Referral	1. Private home/apt. with no home care services 2. Private home/apt. with home care services 3. Board and care/assisted living/group home 4. Nursing home 5. Other									
6.	Who Lived With At Referral	1. Lived alone 2. Lived with spouse only 3. Lived with spouse and other(s) 4. Lived with child (not spouse) 5. Lived with other(s) (Not spouse or children) 6. Lived in group setting with non-relative(s)									

7.	Prior NH Placement	Resided in a nursing home at anytime du 5 YEARS prior to case opening 0. No 1. Yes	
8.	Residential History	Moved to current residence within last two years 0. No 1. Yes	

SECTION A. ASSESSMENT INFORMATION

1.	Assessment Reference Date	Date of assessment <div style="display: flex; justify-content: center; align-items: center; gap: 20px;"> <div style="border: 1px solid black; padding: 5px; display: flex; gap: 5px;"> </div> — <div style="border: 1px solid black; padding: 5px; display: flex; gap: 5px;"> </div> — <div style="border: 1px solid black; padding: 5px; display: flex; gap: 5px;"> </div> </div> <div style="display: flex; justify-content: center; align-items: center; gap: 100px;"> Month Day Year </div>	
2.	Reasons For Assessment	Type of assessment 1. Initial Assessment 2. Follow-up assessment 3. Routine assessment at fixed intervals 4. Review within 30-day period prior to discharge from program 5. Review at return from hospital 6. Change in status 7. Other	
3.	Time To Next Assessment	Number of days or months until next assessment is due 0. Follow up assessment not required 1. 30 days 2. 60 days 3. 90 days 4. 4 months 5. 5 months 6. 6 months 7. 9 months 8. 1 year	

SECTION B. COGNITIVE PATTERNS

1.	Memory Recall Ability	<i>(Code for recall of what was learned or known)</i> 0. Memory OK 1. Memory problem	
		a. Short-term memory OK -- seems/appears to recall after 5 min.	
		b. Procedural memory OK -- Can perform all or almost all steps in a multitask sequence without cues for initiation	

3.	Ability To Understand Others (Comprehension)	(Understands verbal information -- however able) 0. UNDERSTAND! -- Clear comprehension 1. USUALLY UNDERSTAND -- Misses part/intent of message, BUT, comprehends most conversation with little/no prompting 2. OFTEN UNDERSTAND -- Misses some part/intent of message; with prompting can often comprehend conversation 3. SOMETIMES UNDERSTAND -- Responds adequately to simple, direct communication 4. RARELY / NEVER UNDERSTANDS	
4.	Communication Decline	Worsening in communication (making self understood or understanding others) as compared to statu 90 DAYS AGO (or since last assessment if less than 90 days) 0. No 1. Yes	

SECTION D. VISION PATTERNS

1.	Vision	(Ability to see in adequate light and with glasses if used) 0. ADEQUATE -- Sees fine detail, including regular print in newspapers / books 1. IMPAIRED -- Sees large print, but not regular print in newspapers / books 2. MODERATELY IMPAIREI -- Limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY IMPAIREI -- Object identification in question, but eyes appear to follow objects 4. SEVERELY IMPAIRE -- No vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
2.	Visual Limitation/ Difficulties	Saw halos or rings around lights, curtains over eyes, or flashes of lights 0. No 1. Yes	
3.	Vision Decline	Worsening of vision as compared to status 90 DAYS AGO (or since last assessment if less than 90 days) 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1.	Indicators Of Depression, Anxiety, Sad Mood	<p><i>(Code for observed indicators irrespective of assumed cause)</i></p> <p>0. Indicator not exhibited in last 3 days 1. Exhibited 1-2 of last 3 days 2. Exhibited on each of last 3 days</p>	
		<p>a. A Feeling Of Sadness Or Being Depressed life is not worth living, nothing matters, that he or she is of no use to anyone or would rather be dead.</p> <p>b. Persistent Anger With Self Or Others -- e.g., easily annoyed, anger at care received</p> <p>c. Expressions of What Appear To Be Unrealistic Fears -- e.g., fear of being abandoned, left alone, being with others</p> <p>d. Repetitive Health Complaints -- e.g., persistently seeks medical attention, obsessive concern with body functions</p>	<p>e. Repetitive Anxious Complaints, Concern: -- e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues</p> <p>f. Sad, Pained, Worried Facial Expressions-- e.g., Furrowed brows</p> <p>g. Recurrent Crying, Tearfulness</p> <p>h. Withdrawal From Activities Of Interest-- e.g., no interest in long standing activities or being with family / friends</p> <p>i. Reduced Social Interaction</p>
2.	Mood Decline	<p>Mood indicators have become worse as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days)</p> <p>0. No 1. Yes</p>	

3.	Behavioral Symptoms	<p>Instances when client exhibited behavioral symptoms. If Exhibited, ease of altering the symptom when it occurred</p> <p>0. Did not occur in last 3 days 1. Occurred, easily altered 2. Occurred, not easily altered</p> <p>a. WANDERING -- Moved without rational purpose, seemingly oblivious to needs or safety</p> <p>b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS-- Threatened screamed at, cursed at others</p> <p>c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS-- Hit, shoved, scratched, sexually abused others</p> <p>d. SOCIALLY INAPPROPRIATE / DISRUPTIVE BEHAVIORAL SYMPTOMS -- Disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smears/throws food/feces, rummaging, repetitive behavior, rises early and causes disruption</p> <p>e. RESISTS CARE -- Resisted taking medications / injections, ADL assistance, eating, or changes in position</p>	
4.	Changes In Behavior Symptoms	<p>Behavioral symptoms have become worse or are less well tolerated by family as compared 90 DAYS AGO (or since last assessment if less than 90 days)</p> <p>0. No, or no change 1. Yes</p>	

SECTION F. SOCIAL FUNCTIONING

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

SECTION G. INFORMAL SUPPORT SERVICES

1.	<p>Two Key Informal Helpers</p> <p>Primary (A) and Secondary (B)</p>	<p>NAME OF PRIMARY AND SECONDARY HELPERS</p> <p>a. (Last / Family Name) _____ b. (First) _____</p> <p>c. (Last / Family Name) _____ d. (First) _____</p>		
			(A)	(B)
			Prim	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 4. None 1. Spouse 3. Friend / neighbor		
		0. Yes 1. No		
		g. Advice or emotional support		
		h. IADL care		
		i. ADL care		
		If needed, willingness (with ability) to increase help: 0. More than 2 hours 1. 1-2 hours per day 2. No		
		j. Advice or emotional support		
		k. IADL care		
		l. ADL care		
		m. Disabled 0. No 1. Yes		
		n. Date of Birth		
		(A) <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> — <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> — <input style="width: 40px; height: 20px;" type="text"/>		
		Month Day Year		
		(B) <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> — <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> — <input style="width: 40px; height: 20px;" type="text"/>		
		Month Day Year		

2.	Caregiver Status	0. No 1. Yes a. A caregiver is unable to continue in caring activities--e.g., decline in the health of the caregiver makes it difficult to continue b. Primary caregiver is not satisfied with support received from family and friends (.e.g., other children of client) c. Primary caregiver expresses distress, anger or depression	<table border="1"> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> </table>									
3.	Extent Of Informal Help (Hours Of Care, Rounded)	For instrumental and personal activities of daily living received over the LAST 7 DAYS indicate extent of help from family, friends, and neighbors a. Sum of time across five weekdays b. Sum of time across two weekend days	<table border="1"> <tr> <td colspan="3" style="text-align: center;">HOURS</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>	HOURS								
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2. ADL
Self
Performance

The following address the client's physical functioning in routine personal activities of daily life, for example, dressing, eating, etc. during the **LAST 3 DAYS considering all episodes of these activities.**

For clients who performed an activity independently. be sure to determine and record whether others encouraged the activity or were present to supervise or oversee the activity.

(NOTE - For bathing, code for most dependent single episode in **LAST 7 DAYS**)

0. *INDEPENDEN* -- No help, setup, or oversight -- OR -- Help, setup, oversight provided only 1 or 2 times (with any task or subtask)
1. *SETUP HELP ONL* -- Article or device provided within reach of client 3 or more times
2. *SUPERVISION* -- Oversight, encouragement or cueing provided 3 or more times during last 3 days -OR- Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision)
3. *LIMITED ASSISTANC* -- Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times -OR- Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help)
4. *EXTENSIVE ASSISTANC* -- Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times:
-- Weight-bearing support -- OR --
-- Full performance by another during part (but not all) of last 3 days
5. *MAXIMAL ASSISTANC* -- 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 DEPENDENC* -- Full performance of activity by another
8. *ACTIVITY DID NOT OCCU* (regardless of ability)

3. Bowel
Conti-
nence

In **LAST 7 DAY**: control of bowel movement (with appliance or
bowel continence program if employed)

0. *CONTINENT* -- Complete control; DOES NOT USE ostomy device
1. *CONTINENT WITH OSTOM* -- Complete control with use of ostomy device that does not leak stool
2. *USUALLY CONTINENT* -- Bowel incontinent episodes less than weekly
3. *OCCASIONALLY INCONTINENT* -- Bowel incontinent episodes once a week
4. *FREQUENTLY INCONTINENT* -- Bowel incontinent episodes 2 - 3 times a week
5. *INCONTINENT* -- Bowel incontinent all (or almost all) of time
8. *DID NOT OCCUR* -- No bowel movement during entire 7 day assessment period

SECTION J. DISEASE DIAGNOSES

Disease / infection that doctor has indicated is present and affects client's status, requires treatment, or symptom management. Also include if disease is monitored by a home care professional or is the reason for a hospitalizatic **LAST 90 DAYS** (or since last assessment if less than 90 days)

0. Not present
1. Present -- not subject to focused treatment or monitoring by home care professional
2. Present -- monitored or treated by home care professional

1.	Diseases	Heart / Circulation		p. Osteoporosis			
		a. Cerebrovascular accident (<i>stroke</i>)		Senses			
		b. Congestive heart failure		q. Cataract			
		c. Coronary artery disease		r. Glaucoma			
		d. Hypertension		Psychiatric / Mood			
		e. Irregularly irregular pulse		s. Any psychiatric diagnosis			
		f. Periph. vascular disease		Infections			
		Neurological		t. HIV infection			
		g. Alzheimer's		u. Pneumonia			
		h. Dementia other than Alzheimer's disease		v. Tuberculosis			
		i. Head trauma		w. Urinary tract infection (<i>in LAST 30 DAYS</i>)			
		j. Hemiplegia / hemiparesis		Other Diseases			
		k. Multiple sclerosis		x. Cancer--(in past 5 years) (<i>not including skin cancer</i>)			
		l. Parkinsonism		y. Diabetes			
		Musculo / Skeletal		z. Emphysema/COPD/asthma			
		m. Arthritis		aa. Renal failure			
		n. Hip fracture		ab. Thyroid disease (<i>Hyper or hypo</i>)			
		o. Other fractures (<i>e.g., wrist, vertebral</i>)					
		2.	Other Current Or More Detailed Diagnosis and ICD-9 Codes	a.			
				b.			
		c.					
		d.					

SECTION K. HEALTH CONDITIONS/PREVENTIVE HEALTH MEASURES

1.	Preventive Health (Past Two Years)	0. No 1. Yes (During past 2 years) (Answer all)	
		a. Blood pressure measured	
		b. Received influenza vaccination	
		c. Test for blood in stool or screening endoscopy	
		d. IF FEMALE: Received breast examination or mammography	
2.	Problem Conditions Present On 2 Or More Days	0. No 1. Yes (During 2 of last 3 days) (Answer all)	
		a. Diarrhea	
		b. Difficulty urinating or urinating 3 or more times a night.	
		c. Fever	
		d. Loss of appetite	
		e. Vomiting	
3.	Problem Conditions	0. No 1. Yes (Any time during last 3 days) (Answer all)	
		<i>Physical Health</i>	
		a. Chest pain / pressure at rest or on exertion	
		b. No bowel movement in 3 days	
		c. Dizziness or lightheadedness	
		d. Edema	
		e. Shortness of breath	
		<i>Mental Health</i>	
		f. Delusions	
		g. Hallucinations	
4.	Pain	a. Frequency that 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 0. No pain 2. Moderate 4. Times when pain is horrible or excruciating 1. Mild 3. Severe	
		c. From client's viewpoint, 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 viewpoint, medications adequately control pain 0. Yes or no pain 1. Medications do not adequately control pain 2. Pain present, medication not taken	
5.	Falls Frequency	Number of times fell 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	0. No 1. Yes	
		a. Unsteady gait	
7.	Life Style (Drinking / Smoking)	0. No 1. Yes	
		a. In the LAST 90 DAY! (or since last assessment if less than 90 days), client felt the need or was told by others to cut down on drinking, or other were concerned with client's drinking	
8.	Health Status Indicators	0. No 1. Yes	(Answer all)
		a. Client feels he / she has poor health (when asked)	
9.	Other Status Indicators	0. No 1. Yes	(Answer all)
		a. Fearful of a family member or caregiver	

SECTION L. NUTRITION/HYDRATION STATUS

1.	Weight	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 DAY!]	
		b. Severe malnutrition (Cachexia)	
		c. Morbid Obesity	

2.	Consumption	0. No 1. Yes	
		a. In at least 2 of the last 3 day ate one or fewer meals a day	
		b. In last 3 days 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. <i>NORMAL</i> -- Safe and efficient swallowing of all diet consistencies	
		1. <i>REQUIRES DIET CHANGE TO SWALLOW SOLID FOODS</i> (mechanical diet or able to ingest specific foods only)	
		2. <i>REQUIRES MODIFICATION TO SWALLOW SOLID FOODS AND LIQUIDS</i> (puree, thickened liquids)	
		3. <i>COMBINED ORAL AND TUBE FEEDING</i>	
		4. <i>NO ORAL INTAKE (NPO)</i>	

SECTION M. DENTAL STATUS (ORAL HEALTH)

1.	Oral Status	0. No 1. Yes	
		a. Problem chewing (e.g., poor mastication, immobile jaw, surgical resection, decreased sensation/motor control, pain while eating)	
		b. Mouth is "dry" when eating a meal	
		c. Problem brushing teeth or dentures	

SECTION N. SKIN 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:	
		0. No Ulcer	
		1. Any area of persistent skin redness	
		2. Partial loss of skin layers	
		3. Deep craters in the skin	
		4. Breaks in skin exposing muscle or bone	
		a. Pressure ulcer -- 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	0. No	1. Yes	(Answer All)	
		a. Burns (Second/third degree)		c. Skin tears or cuts	
		b. Open lesions other than ulcers, rashes, cuts (e.g., cancer)		d. Surgical wound	
				e. Corns, calluses, structural problems, infections, fungi	
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/ Ulcer Care	Have the following treatments been completed in the last 7 days ?			
		0. No	1. Yes	(Answer All)	
		a. Antibiotics, systemic or topical			
		b. Dressings			
		c. Surgical wound care			
		d. Other wound / ulcer care (e.g., pressure relieving device, nutrition, turning, debridement)			

SECTION O. ENVIRONMENTAL ASSESSMENT

1.	Home Environment	0. No	1. Yes	(Answer all)		
		a. Lighting in evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors)				
		b. Flooring and carpeting (e.g., holes in floor, electric wires where client walks, scatter rugs)				
		c. Bathroom and toiletroom (e.g., non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)				
		d. Kitchen (e.g., dangerous stove, operative refrigerator, infestation by rats or bugs)				
		e. Heating and cooling (e.g., too hot in summer, too cold in winter, wood stove in a home with an asthmatic)				
		f. Personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street)				
		g. Access to home (e.g., difficulty entering / leaving home)				
		h. Access to rooms in house (e.g., unable to climb stairs)				

2. **Special Treatments Therapies, Programs**

Special treatments, therapies, programs received or scheduled during **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 an outpatient basis.

0. Not Applicable
 1. Scheduled, full adherence as prescribed
 2. Scheduled, partial adherence
 3. Scheduled, not received

Respiratory Treatments		Therapies	
a. Oxygen		n. Exercise therapy	
b. Respirator for assistive breathing		o. Occupational therapy	
c. All other respiratory treatments		p. Physical therapy	
Other Treatments		Programs	
d. Alcohol / drug treatment program		q. Day center	
e. Blood transfusion(s)		r. Day hospital	
f. Chemotherapy		s. Hospice care	
g. Dialysis		t. Physician or clinic visit	
h. IV infusion - central		u. Respite care	
i. IV infusion - peripheral		Special Procedures Done In Home	
j. Medication by injection		v. Daily nurse monitoring (e.g., EKG, urinary output)	
k. Ostomy care		w. Nurse monitoring less than daily	
l. Radiation		x. Medical alert bracelet or electronic security alert	
m. Tracheostomy care		y. Skin treatment	
		z. Special diet	

3. **Management 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	
b. IV		d. Ostomy	

4.	Visits In Last 90 Days Or Since Last Assessment	<p>Enter 0 if none, if more than 9, code "9"</p> <p>a. Number of times ADMITTED TO HOSPIT with overnight stay</p> <p>b. Number of times VISITED EMERGENCY RC without overnight stay</p> <p>c. EMERGENCY CARE -- Including unscheduled nursing, physician, or therapeutic visits to office or home</p>	
5.	Treatment Goals	<p>Any treatment goals that have been met in 1 LAST 90 DAYS (or since last assessment if less than 90 days)</p> <p>0. No 1. Yes</p>	
6.	Overall Change In Care Needs	<p>Overall self sufficiency changed significantly compared to status of 90 DAYS AGO (or since last assessment if less than 90 days)</p> <p>0. No change 1. Improved-- receives fewer supports 2. Deteriorated-- receives more support</p>	
7.	Trade Offs	<p>Due to limited funds, during last month, client made trade-offs in purchasing any of the following: prescribed medications, sufficient home heat, physician care, adequate food, home care</p> <p>0. No 1. Yes</p>	

SECTION Q. MEDICATIONS

1.	Number of Medications	Record the number of different medicines (prescriptions and over the counter), including eye drops, taken regularly or on an occasional basis in th LAST 7 DAYS or since last assessment) [If none, code "0", if more than 9, code "9"]			
2.	Receipt of Psychotropic Medication	Psychotropic medications taker LAST 7 DAYS (or since last assessment) [Note-Review client's medications with list that applies to the following categories]			
		0. No 1. Yes			
		<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">a. Antipsychotic / neuroleptic</td> <td style="width: 50%;">c. Antidepressant</td> </tr> <tr> <td>b. Anxiolytic</td> <td>d. Hypnotic</td> </tr> </table>	a. Antipsychotic / neuroleptic	c. Antidepressant	b. Anxiolytic
a. Antipsychotic / neuroleptic	c. Antidepressant				
b. Anxiolytic	d. Hypnotic				
3.	Medical Oversight	<p>Physician reviewed client's medications as a whole in LAST 180 DAY (or since last assessment)</p> <p>0. Discussed with at least one phys. (or no medication taken)</p> <p>1. No single physician reviewed all medications</p>			
4.	Compliance / Adherence With Medications	<p>Compliant all or most of time wi medications prescribed by a physician (during and between therapy visits LAST 7 DAYS)</p> <p>0. Always compliant</p> <p>1. Compliant 80% of the time or more</p> <p>2. Compliant less than 80% of the time, including failure to purchase prescribed medications</p> <p>3. NO MEDICATIONS PRESCRIBED</p>			

5. List Of All Medications

List prescribed and nonprescribed medications taken in the **LAST 7 DAY** (or since last assessment)

a. **Name and Dose** -- Record name of the medication and dose ordered

b. **Form Code** the route of administration using the following list:

- | | | | |
|------------------|--------|-----------------|-------|
| 1. By Mouth | (PO) | 6. Rectal | (R) |
| 2. Sublingual | (SL) | 7. Topical | |
| 3. Intramuscular | (IM) | 8. Inhalation | |
| 4. Intravenous | (IV) | 9. Enteral tube | |
| 5. Subcutaneous | (SQ) | 10. Other | |

c. **Number Taken** -- Record the number of units (pills, cc, tsp, etc) taken each time the medication is administered.

d. **Freq** -- Code the number of times per day, week, or month the medication is administered using the following list:

- | | | | |
|-----|--|----|--------------------|
| PRN | As necessary | QW | Once each week |
| QH | Every hour | 2W | 2 times every week |
| Q2H | Every 2 hours | 3W | 3 times every week |
| Q3H | Every 3 hours | 4W | 4 times each week |
| Q4H | Every 4 hours | 5W | 5 times each week |
| Q6H | Every 6 hours | 6W | 6 times each week |
| Q8H | Every 8 hours | 1M | Once every month |
| QD | Once daily | 2M | Twice every month |
| BID | 2 times daily
(Includes every 12 hours) | C | Continuous |
| TID | 3 times daily | O | Other |
| QID | 4 times daily | | |
| 5D | 5 times daily | | |
| QOD | Every other day | | |

SECTION R. ASSESSOR INFORMATION

1. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:

a. Signature of Assessment coordinator

b. Title of Assessment Coordinator

c. Date Assessment Coordinator signed as complete

Month		Day		Year			

	Other Signatures	Title	Section	Date
d.				
e.				
f.				
g.				
h.				
i.				