



NEW MEXICO POLICIES & PROCEDURES

RESOURCE SECTION CONTENTS

UNIVERSAL CONSUMER INFORMATION TOOL (UCIT) GUIDANCE DOCUMENT

SEPTEMBER 2025

THE DOCUMENT CONTAINED HEREIN IS SUBJECT TO CHANGE.

VERSION: 8.2025

History of the Universal Consumer Information Tool (UCIT) Collaborative Development

Key Dates of UCIT Collaboration

Goal: To comply with ACL, NM State data requirements while including AAA input.

| | |
|------------|---|
| 12/16/2019 | Initial Webinar—OAAPS login |
| 12/12/2019 | OAAPS User Guide published |
| 3/20/2020 | Webinar—ACL’s vision for data collection and reporting |
| 5/4/2021 | Webinar—AAA users training sponsored by ACL |
| 8/7/2021 | Email—Initial feedback from the AAAs |
| 10/1/2021 | The requirements for the State Performance Report for Titles III and VII (Chapters 3 and 4) for federal fiscal year 2022 (FFY 2022) starting 10/01/2021 and subsequent years by all State Units on Aging. |
| 4/11/2022 | Initial Combined Intake Form |
| 6/1/2022 | ALTSD Consumer Assessment Planning Discussion |
| 7/13/2022 | Training for AAAs and Providers on OAAPS requirements |
| 12/12/2022 | Assessment (UCIT) Planning team met |
| 9/1/2023 | Universal tool workgroup meeting with the AAAs |
| 12/12/2023 | Crosswalk combining ACL, NM, ALTSD, AAA requirements sent to WellSky |
| 3/15/2024 | ACL new rule 13.21 in effect—impacting data collection requirements |
| 2023–2024 | Refining UCIT Tool with WellSky (6 iterations) Four training sessions (with accepted revisions from attendees) provided during August and September of 2024 |
| 10/1/2024 | UCIT Implementation |
| 9/15/2025 | Update UCIT questions and responses |

Title III Cluster 1: Registered Services—A service provided for older adults under OAA Title III for which ADL limitations and IADL limitations characteristics are reported in addition to the other consumer demographics and characteristics.

| Service | Demographic/characteristic |
|---|---|
| Personal Care Homemaker Chore Home Delivered Meals Adult Day Care/Health Case Management | <ul style="list-style-type: none"> • Age • Gender • Geographic Distribution • Poverty Status • Household Status • Ethnicity Distribution • Race Distribution • Minority Distribution • ADLs • IADLs • Nutrition Risk (for Home Delivered Meals Only) |

UCIT Sections: 1, 2, 4

Title III Cluster 2: Registered Services—A service provided for older adults under OAA Title III for which ADL limitations and IADL limitations characteristics are *not* reported in addition to the other consumer demographics and characteristics.

| Service | Demographic/characteristic |
|---|--|
| Assisted Transportation Congregate Nutrition Nutrition Counseling | <ul style="list-style-type: none"> • Age • Gender • Geographic Distribution • Poverty Status • Household Status • Ethnicity Distribution • Race Distribution • Minority Distribution • Nutrition Risk (for Congregate Meals Only) |

UCIT Sections: 1, 2.E, 4

Title III Cluster 3 Non-Registered Services—Services provided using OAA funds in whole or in part for which demographic and consumer characteristics are not reported.

| | |
|---|---|
| Service | Basic Eligibility Requirements (Local Policy Determines Information) |
| Transportation Nutrition Education Other Services Evidence-based health promotion disease prevention Non-evidence-based health promotion disease prevention Information and Assistance Outreach | Name Age |
| UCIT Section: 1.C.1, 1.C.2, 1.C.3, 1.C.5 | |

Title III, VII, State Funded Legal Assistance—Demographic and Consumer Characteristics

| | |
|--|--|
| <ul style="list-style-type: none"> • Age • Gender • Geographic Distribution • Poverty Status | <ul style="list-style-type: none"> • Household Status • Ethnicity Distribution • Race Distribution • Minority Distribution |
| Does not complete the UCIT – Provider completes the information on each client based – Sent by the AAA | |

Title III E Caregiver Support Categories—Caregivers of Older Adults AND Older Relative Caregivers

| | |
|---|---|
| Registered Service | Demographic/characteristic |
| <ul style="list-style-type: none"> • Counseling • Training • Supplemental • Case Management Assistance • Respite <ul style="list-style-type: none"> ○ In-home ○ Out-of-Home (day) ○ Out-of-Home (overnight) ○ Other Respite | <ul style="list-style-type: none"> • Age • Gender • Geographic Distribution • Poverty Status • Ethnicity Distribution • Relationship Status |
| UCIT Section: 3 | |

Title III E Caregiver Support Categories—Caregivers of Older Adults AND Older Relative Caregivers

| |
|---|
| Unregistered Service |
| <ul style="list-style-type: none"> • Support Groups • Information and Assistance • Public Information Services |
| No Demographic Data Required |

New Mexico Universal Consumer Information Tool (UCIT)

Section 1—Consumer Demographics

A. Consumer Details

| <i>Question</i> | <i>Response</i> | <i>Guidance</i> |
|---|---|---|
| This column lists each question | This column is for each response | <p>The questions in this tool have been marked with either (ACL) or (NM)</p> <p>ACL = refers to the federal Administration for Community Living Data Requirements / Guidance</p> <p>NM = references New Mexico State Requirements / Guidance</p> <p>If there is not a mark by the question, it was collaboratively developed and refined by the UCIT team which includes: ALTSD, AAAs, and providers.</p> |
| 1. What is your first name? (ACL) | | <p>Ask the questions entirely and precisely as written. Record the responses accurately. Then, add any additional information provided in the notes section of the tool. (online and printed)</p> |
| 2. What is your middle name? (ACL) | | |
| 3. What is your last name? (ACL) | | |
| 4. What is your date of birth? (ACL) | | |
| 5a. Eligible consumer who is under 60 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Place a note describing the relationship of the eligible participant. Example: Spouse under 60 |
| 5b. If yes, select reason for NSIP Meal eligibility for under 60 (If an eligibility type under 60 is selected, make sure to manually set the corresponding data element on the Consumer Details page) | <input type="checkbox"/> Disabled in Elderly Housing <input type="checkbox"/> Disabled Living with Elderly Person <input type="checkbox"/> Spouse of Elderly Person <input type="checkbox"/> Volunteer <input type="checkbox"/> Other | <p>Ask the questions entirely and precisely as written. Record the responses accurately. Then, add any additional information provided in the notes section of the tool. (online and printed)</p> |

| B. Assessment Information (For Internal Use Only) | | |
|---|---|--|
| <i>Question</i> | <i>Response</i> | <i>Guidance</i> |
| 1. Type of assessment | <input type="checkbox"/> Initial Assessment <input type="checkbox"/> Reassessment | Complete the assessment information section by accurately answering the questions. |
| 2. Initial Assessment: What service are you interested in? | | |
| 3a. Reassessment: Do you want to continue with your current service? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 3b. If yes, what service is the consumer currently receiving? | | |
| 4. This form is being completed for a: | <input type="checkbox"/> Consumer who is seeking or using Cluster 1, 2, or 3 services only <input type="checkbox"/> Care Recipient, who also has a caregiver where both parties need services <input type="checkbox"/> Caregiver of an Older Adult <input type="checkbox"/> Older Relative Caregiver (formerly Grandparents raising Grandchildren) | Complete the assessment information section by accurately answering the questions. You may select more than one option for the answer to this question. |
| 5. The assessor works for which agency? | <input type="checkbox"/> Community Provider <input type="checkbox"/> ALTSD <input type="checkbox"/> ADRC <input type="checkbox"/> APS <input type="checkbox"/> Health Professional <input type="checkbox"/> Home Care Provider <input type="checkbox"/> IAAA Provider <input type="checkbox"/> Other | Complete the assessment information section by accurately answering the questions. |

Section 1—Consumer Demographics—continued

C. Basic Information ^(ACL)

| <i>Question</i> | <i>Response</i> | <i>Guidance</i> |
|---|--|--|
| 1. What is your primary phone #? | | Ask the questions entirely and precisely as written. Record the responses accurately. Then, add any additional information provided in the notes section of the tool (online and printed). |
| 2. What is your cell phone #? | | |
| 3. What is your email address? | | |
| 4a. What is your marital status? | <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Significant Other <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | |
| 4b. What is the name of your spouse / partner? | | |
| 5a. What is your primary language? | <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other | |
| 5b. If your primary language is other, specify language | | |
| 6. What is your gender? ^(ACL) | <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other Delete | |
| 7. What is your sexual orientation? ^(NM) | <input type="checkbox"/> Heterosexual / Straight <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay / Lesbian <input type="checkbox"/> Declined to answer | This question is deleted. |
| 7. What is your ethnicity? ^(ACL) | <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino | Ask the questions entirely and precisely as written. Record the responses accurately. Then, add any additional information provided in the notes section of the tool. (online and printed) |

Section 1—Consumer Demographics—continued

C. Basic Information—continued

| <i>Question</i> | <i>Response</i> | <i>Guidance</i> |
|--|---|--|
| 8a. What is your race? ^(ACL) | <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Non-Minority (White, Non-Hispanic) <input type="checkbox"/> White-Hispanic | Ask the questions entirely and precisely as written. Record the responses accurately. Then, add any additional information provided in the notes section of the tool. (online and printed) |
| 8b. If you are American Indian, Alaska Native or Native Hawaiian / Pacific Islander, specify Tribal affiliation ^(ACL) | | |
| 9. Is your household income at or below 100% poverty threshold based on the Federal Poverty Guidelines? (website reference below) ^(ACL) https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references/2024-poverty-guidelines-computations | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10. What is your veteran status? | <input type="checkbox"/> Veteran <input type="checkbox"/> Eligible spouse of veteran <input type="checkbox"/> Not a Veteran | |
| 11a. Do you live alone? ^(ACL) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 11b. If no, how many people live in the home? | | |
| 12. Do you have permanent housing? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

D. Address

| <i>Question</i> | <i>Response</i> | <i>Guidance</i> |
|--|-----------------|--|
| 1a. What is your residential street address? | | Ask the questions entirely and precisely as written. Record the responses accurately. Then, add any additional information provided in the notes section of the tool. (online and printed) |
| 1b. What is the city or town? | | |
| 1c. What is the county? | | |
| 1d. What is the state? | | |
| 1e. What is the zip code? | | |

Section 1—Consumer Demographics—continued

C. Basic Information—continued

D. Address—Continued

| | | |
|--|--|---|
| 2. Do you live in a rural or non-rural area? (RUCA Code) | <input type="checkbox"/> Rural <input type="checkbox"/> Non-Rural | <p>Ask the questions entirely and precisely as written. Record the responses accurately. Then, add any additional information provided in the notes section of the tool. (online and printed)</p> |
| 3.a. What is your mailing address or PO box? | | |
| 3.b. What is the city or town? | | |
| 3.c. What is the state? | | |
| 3.d. What is the zip code? | | |

E. Consumer’s Emergency Contacts

| <i>Question</i> | <i>Response</i> | <i>Guidance</i> |
|--------------------------------------|-----------------|---|
| 1a. Who is your primary contact? | | <p>Ask the questions entirely and precisely as written. Record the responses accurately. Then, add any additional information provided in the notes section of the tool. (online and printed)</p> |
| 1b. What is their phone number? | | |
| 1c. What is their work phone number? | | |
| 1d. What is their cell phone number? | | |
| 2a. Who is your primary physician? | | |
| 2b. What is their work phone number? | | |

F. Physical Health

| <i>Question</i> | <i>Response</i> | <i>Guidance</i> |
|---|---|---|
| 1. How do you rate your overall health? | <input type="checkbox"/> Excellent <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Information Unavailable | <p>Ask the questions entirely and precisely as written. Record the responses accurately. Then, add any additional information provided in the notes section of the tool. (online and printed)</p> |
| 2. Have you seen your Primary Care Physician in the last year? (doctor) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 3a. Have you fallen in the last six months? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 3b. If yes, please indicate why you fell | | |
| 4. Have you been hospitalized in the last six months? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Section 1—Consumer Demographics—continued

C. Basic Information—continued

G. Benefits ^(NM)

| <i>Question</i> | <i>Response</i> | <i>Guidance</i> |
|-------------------------------|---|--|
| 1. What benefits do you have? | <input type="checkbox"/> SNAP (food benefits) <input type="checkbox"/> Social Security Disability <input type="checkbox"/> Supplemental Security Income <input type="checkbox"/> General Cash Assistance <input type="checkbox"/> Senior Farmers Market <input type="checkbox"/> Subsidized Housing <input type="checkbox"/> Section 8 Housing <input type="checkbox"/> Commodities <input type="checkbox"/> LIHEAP (energy assistance) | Ask the questions entirely and precisely as written. Record the responses accurately. Then, add any additional information provided in the notes section of the tool. (online and printed) |

G. Health Insurance ^(NM)

| | | |
|---|--|--|
| 1. Do you have health insurance? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ask the questions entirely and precisely as written. Record the responses accurately. Then, add any additional information provided in the notes section of the tool. (online and printed) |
| 2. Do you have any of the following types of insurance or benefits? | <input type="checkbox"/> Medicare—Part A <input type="checkbox"/> Medicare—Part B <input type="checkbox"/> Medicaid <input type="checkbox"/> Employer-based Insurance <input type="checkbox"/> Private Insurance | |
| 3a. Medicare number, if applicable | | (ONLY to be asked, if necessary, depending on the service) |
| 3b. Medicaid number, if applicable | | |

I. Emergency Preparedness ^(NM)

| | | |
|---|---|--|
| 1. Do you depend on electricity for medical needs, for example, for oxygen, etc.? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ask the questions entirely and precisely as written. Record the responses accurately. Then, add any additional information provided in the notes section of the tool. (online and printed) |
| 2. Do you use a wheelchair, scooter, walker, or cane? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 3. Can you get out of your home in case of an emergency? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 4a. If there is an emergency / power outage, will your home remain heated? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 4b. If yes, what main source of heat / energy does your home use? | <input type="checkbox"/> Wood <input type="checkbox"/> Propane <input type="checkbox"/> Natural Gas <input type="checkbox"/> Other | |

| Section 1—Consumer Demographics—continued | | |
|---|--|--|
| C. Basic Information—continued | | |
| I. Emergency Preparedness—continued | | |
| Question | Response | Guidance |
| 4c. If there is an emergency / power outage, will your home remain cooled? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ask the questions entirely and precisely as written. Record the responses accurately. Then, add any additional information provided in the notes section of the tool. (online and printed) |
| 5. If there is an emergency / power outage, will you have clean water in your home? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| Section 2— ADLs / IADLs / Nutritional Health Assessment | | |
|--|--|--|
| A. Section Trigger | | |
| This section shall be complete with the following services: Adult Day Care/Health, Assisted Transportation, Case Management, Chore, Congregate Nutrition, Home Delivered Nutrition, Nutrition Counseling, Personal Care | | |
| B. Supports Overview | | |
| Question | Response | Guidance |
| <input type="checkbox"/> Yes—Complete Section <input type="checkbox"/> No | | Is the service you wish to provide listed above? If so, complete this section. |
| 1a. Do you have family or other support you need? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ask the questions entirely and precisely as written. Record the responses accurately. Then, add any additional information provided in the notes section of the tool. (online and printed) |
| 1b. If yes, how much support is given each week? | <input type="checkbox"/> None <input type="checkbox"/> 24 hours or less <input type="checkbox"/> 25–40 hours <input type="checkbox"/> 41+ hours | |
| 1c. Please describe the type of support(s) | | |
| 2a. Do you receive services from another program / provider? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 2b. If yes, please indicate the program / provider name and describe the type of service(s) | | |
| | | |

Section 2— ADLs / IADLs / Nutritional Health Assessment

C. **Katz Index (evidence based) of Activities of Daily Living (ADLs)**— (1=Independence. 0=Dependence. **Total the number of ones [1] for the score.**
 6=High=Independent. 0=Low=Dependent.) **Independence** = No supervision, direction, or personal assistance = 1
Dependence = With supervision, direct, personal assistance, or total care = 0

| <input type="checkbox"/> Consumer refuses to answer | | Score | <i>Guidance</i> |
|---|---|-------|--|
| 1. Do you need help bathing? | <input type="checkbox"/> Independence=1 <input type="checkbox"/> Dependence=0 | | 6 = Consumer is very independent, requires no assistance 5 = Consumer is independent, rarely may require assistance 4 = Consumer is moderately dependent, may require assistance 3 = Consumer is dependent, requires assistance 2 = Consumer is very dependent, requires assistance 1 = Consumer is very dependent, requires assistance 0 = Consumer is very dependent, requires assistance Ask the questions as entirely and precisely as written. Record the responses accurately. Then, add any additional information provided in the notes section of the tool. (online and printed) |
| 2. Do you need help dressing? | <input type="checkbox"/> Independence=1 <input type="checkbox"/> Dependence=0 | | |
| 3. Do you need help using the toilet? | <input type="checkbox"/> Independence=1 <input type="checkbox"/> Dependence=0 | | |
| 4. Do you need help transferring from one place to another? | <input type="checkbox"/> Independence=1 <input type="checkbox"/> Dependence=0 | | |
| 5. Are you able to control your bladder and bowel movements? | <input type="checkbox"/> Independence=1 <input type="checkbox"/> Dependence=0 | | |
| 6. Are you able to eat by yourself? | <input type="checkbox"/> Independence=1 <input type="checkbox"/> Dependence=0 | | |
| Total ADL Score | | | |
| <p>Number of ADLs for Administration for Community Living (ACL) Older Americans Act Performance System (OAAPS) Reporting (Internal reference only)</p> | | | |

Section 2— ADLs / IADLs / Nutritional Health Assessment

D. LAWTON-BRODY SCALE (evidence based) OF INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs) — Select ONLY one (1) answer per question. Total the points. 0 (low function, dependent) to 8 (high function, independent)

| <input type="checkbox"/> Consumer refuses to answer | | Score | |
|--|---|-------|--|
| <i>Question</i> | <i>Response</i> | | <i>Guidance</i> |
| 1. Can you use the telephone? | <ul style="list-style-type: none"> Operates telephone on own initiative - looks up and dials numbers, etc. (1 point) Dials a few well-known numbers (1 point) Answers telephone but does not dial (1 point) Does not use telephone at all (0 points) | | <p>The IADL scale measures the functional impact of emotional, cognitive, and physical impairments.</p> <p>Only four (4) IADLs are used when determining if an individual is eligible to receive in-home/Cluster 1 services.</p> <p>If an individual is eligible for in-home/Cluster 1 services, he/she may receive assistance with IADLs that are not considered when determining the eligibility for personal care services but have been scored a 1 or 2.</p> <p>IADLs are scored based on what an individual can do rather than what he/she is doing. IADLs should be scored based on how an individual usually performs a task.</p> <p>A score ranges from 0 (low function or dependent) to 8 (high function or independent).</p> <p>Ask the questions entirely and precisely as written. Record the responses accurately. Then, add any additional information provided in the notes section of the tool. (online and printed)</p> |
| 2. Are you able to complete you own shopping? | <ul style="list-style-type: none"> Takes care of all shopping needs independently (1 point) Shops independently for small purchases (0 points) Needs to be accompanied on any shopping trip (0 points) Completely unable to shop (0 points) | | |
| 3. Are you able to prepare your own food? | <ul style="list-style-type: none"> Plans, prepares and serves adequate meals independently (1 point) Prepares adequate meals if supplied with ingredients (0 points) Heats, serves and prepares meals, or prepares meals but does not maintain diet (0 points) Needs to have meals prepared and served (0 points) | | |
| 4. Are you able to complete you own housekeeping tasks | <ul style="list-style-type: none"> Maintains house alone or with occasional assistance (1 point) Performs light daily tasks such as dish washing, bed making (1 point) Performs light daily tasks but cannot maintain acceptable level of cleanliness (1 point) Needs help with all home maintenance tasks (1 point) Does not participate in any housekeeping tasks (0 points) | | |

Section 2— ADLs / IADLs / Nutritional Health Assessment

D. LAWTON-BRODY SCALE (evidence based) OF INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs) —continued

| <i>Question</i> | <i>Response</i> | <i>Guidance</i> |
|---|--|--|
| 5. Do you take care of your own laundry? | <ul style="list-style-type: none"> • Does personal laundry completely (1 point) • Launders small items - rinses stockings, etc. (1 point) • All laundry must be done by others (0 points) | <p>The IADL scale measures the functional impact of emotional, cognitive, and physical impairments.</p> <p>Only four (4) IADLs are used when determining if an individual is eligible to receive in-home/Cluster 1 services.</p> |
| 6. Are you able to transport yourself where you need to go? | <ul style="list-style-type: none"> • Travels independently on public transportation or drive own car (1 point) • Arranges own travel via taxi, but does not otherwise use public transportation (1 point) • Travels on public transportation when accompanied by another (1 point) • Travel limited to taxi or automobile with assistance of another (0 points) • Does not travel at all (0 points) | <p>If an individual is eligible for in-home/Cluster 1 services, he/she may receive assistance with IADLs that are not considered when determining the eligibility for personal care services but have been scored a 1 or 2.</p> |
| 7. Do you take care of your medications? | <ul style="list-style-type: none"> • Is responsible for taking medication in correct dosages at correct time (1 point) • Takes responsibility if medication is prepared in advance in separate dosage (0 points) • Is not capable of dispensing own medication (0 points) | <p>IADLs are scored based on what an individual can do rather than what he/she is doing. IADLs should be scored based on how an individual usually performs a task.</p> |
| 8. Do you handle your financial matters? | <ul style="list-style-type: none"> • Manages financial matters independently, collects and keeps track of income (1 point) • Manages day-to-day purchases, but needs help with banking, major purchases, etc. (1 point) • Incapable of handling money (0 points) | <p>A score ranges from 0 (low function or dependent) to 8 (high function or independent).</p> <p>Ask the questions entirely and precisely as written.</p> <p>Record the responses accurately.</p> |
| <p>A summary score ranges from 0 (low function, dependent) to 8 (high function, independent)</p> <p>Number of ADLs for Administration for Community Living (ACL) Older Americans Act Performance System (OAAPS) Reporting (Internal reference only)</p> | | <p>Total IADL Score</p> <p>Then, add any additional information provided in the notes section of the tool. (online and printed)</p> |

Section 2— ADLs / IADLs / Nutritional Health Assessment

E. Nutritional Health Assessment (Yes = 1 point. No = 0 points. Total the points.)
0 – 2 = Good. 3 – 5= Moderate Nutritional Risk. 6 or more = High Nutritional Risk.

| <input type="checkbox"/> Consumer refuses to answer | | | |
|--|--|--------------|--|
| <i>Question</i> | <i>Response</i> | Score | <i>Guidance</i> |
| 1. Do you have an illness or condition that makes you change the kind and /or amount of food you eat? | <input type="checkbox"/> Yes (2 points) <input type="checkbox"/> No | | Nutritional Health Assessment (11 questions) Total Nutritional Score 0–2: Good 3–5: Moderate Nutritional Risk 6 or more: High Nutritional Risk Ask the questions entirely and precisely as written. Record the responses accurately. Then, add any additional information provided in the notes section of the tool. (online and printed) |
| 2. Do you eat fewer than two meals per day-? | <input type="checkbox"/> Yes (3 points) <input type="checkbox"/> No | | |
| 3. Do you eat fewer than 5 servings of fruits or vegetables per day? | <input type="checkbox"/> Yes (1 point) <input type="checkbox"/> No | | |
| 4. Do you eat fewer than 2 servings of dairy per day? | <input type="checkbox"/> Yes (1 point) <input type="checkbox"/> No | | |
| 5. Do you have three or more drinks of beer, liquor or wine almost every day-? | <input type="checkbox"/> Yes (2 points) <input type="checkbox"/> No | | |
| 6. Do you have tooth or mouth problems that make it hard for you to eat-? | <input type="checkbox"/> Yes (2 points) <input type="checkbox"/> No | | |
| 7. Answer this statement with a yes or no, “I don’t always have enough money to buy the food I need.” | <input type="checkbox"/> Yes (4 points) <input type="checkbox"/> No | | |
| 8. Do you eat alone most of the time-? | <input type="checkbox"/> Yes (1 point) <input type="checkbox"/> No | | |
| 9. Do you take three or more different prescribed or over-the-counter drugs a day? | <input type="checkbox"/> Yes (1 point) <input type="checkbox"/> No | | |
| 10. Without wanting to, have you lost or gained 10 pounds in the last six months-? | <input type="checkbox"/> Yes (2 points) <input type="checkbox"/> No | | |
| Total Nutritional Health Assessment Score | | | |
| Number of ADLs for Administration for Community Living (ACL) Older Americans Act Performance System (OAAPS) Reporting (Internal reference only) | | | |

| Section 3— Caregiver Services | | |
|---|---|--|
| A. Caregiver Information | | |
| <i>Question</i> | <i>Response</i> | <i>Guidance</i> |
| 1. Does the consumer have a primary caregiver? | <input type="checkbox"/> Yes—Complete Caregiver Assessment On Caregiver <input type="checkbox"/> No | Caregiver Information (5 questions—Numbers 3–7) Ask the questions entirely and precisely as written. Record the responses accurately. Then, add any additional information provided in the notes section of the tool. (online and printed) |
| 2. Is the person requesting the service a primary caregiver? | <input type="checkbox"/> Yes—Complete Caregiver Assessment <input type="checkbox"/> No | |
| 3. What is the name of the primary caregiver? | | |
| 4. What is the date of birth of the primary caregiver? | | |
| 5. What is the date of birth for the care recipient? | | |
| 6. What is the phone number for the primary caregiver? | | |
| 7. What is the relationship of the caregiver to the care recipient? | <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Domestic Partner, including civil union <input type="checkbox"/> Son / Son-in-law <input type="checkbox"/> Daughter / Daughter-in-law <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative <input type="checkbox"/> Grandparent <input type="checkbox"/> Parent <input type="checkbox"/> Other Elderly Relative <input type="checkbox"/> Elderly Non-Relative | |

Section 4— Assessment Outcome

A. Assessment Outcome

| <i>Question</i> | <i>Response</i> | <i>Guidance</i> |
|--|---|---|
| 1a. Did you have help from a family member or friend answering the questions on this form? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Assessment Outcome (2 questions) |
| 1b. If yes, by whom | | |
| 2. Assessor recommended services—Subservices vary with each AAA and Provider. | <input type="checkbox"/> Cluster 1: Personal Care <input type="checkbox"/> Cluster 1: Homemaker <input type="checkbox"/> Cluster 1: Chore <input type="checkbox"/> Cluster 1: Home Delivered Nutrition <input type="checkbox"/> Cluster 1: Adult Day Care / Health <input type="checkbox"/> Cluster 1: Case Management <input type="checkbox"/> Cluster 2: Congregate Nutrition <input type="checkbox"/> Cluster 2: Nutrition Counseling <input type="checkbox"/> Cluster 2: Assisted Transportation <input type="checkbox"/> Cluster 3: Transportation <input type="checkbox"/> Cluster 3: Information and Assistance <input type="checkbox"/> Cluster 3: Evidence-based Health Promotion <input type="checkbox"/> Cluster 3: Non-Evidence-based Health Promotion <input type="checkbox"/> Cluster 3: Nutrition Education <input type="checkbox"/> Cluster 3: Legal Assistance <input type="checkbox"/> Cluster 3: Other Services <input type="checkbox"/> Caregiver Counseling <input type="checkbox"/> Caregiver Training <input type="checkbox"/> Caregiver Support Group <input type="checkbox"/> Caregiver Respite (In-Home) <input type="checkbox"/> Caregiver Respite (Out-of-Home, Day) <input type="checkbox"/> Caregiver Respite (Out-of-Home, Overnight) <input type="checkbox"/> Caregiver Respite (Other) <input type="checkbox"/> Caregiver Assistance: Case Management <input type="checkbox"/> Caregiver Assistance: Information and Assistance <input type="checkbox"/> Caregiver Information Services <input type="checkbox"/> Caregiver Supplemental Services | <p>(Assessor, select which service(s) the consumer is eligible for based on the services available.)</p> <p>Ask the questions entirely and precisely as written. Record the responses accurately.</p> <p>Then, add any additional information provided in the notes section of the tool (online or printed).</p> |

| Section 4— Assessment Outcome | | |
|---|--|--|
| Assessment Outcome—continued | | |
| <i>Question</i> | <i>Response</i> | <i>Guidance</i> |
| 3. Follow through needed? | <input type="checkbox"/> Yes <input type="checkbox"/> No | (Assessor, after selecting which service(s) the consumer is eligible for based on the services available, determine if follow through is needed.) |
| Section 4— Assessment Outcome / Scoring / Recommendations | | |
| 4. Assessment Summary—Scores attained on the following: | | |
| <i>Question</i> | <i>Response</i> | <i>Guidance</i> |
| Section 2 C. Katz Index of ADLs→ enter score | | Summarize the scores from the UCIT. Add any additional notes from your observation during the assessment. |
| Section 2 D. Lawton-Brody IADLs→ enter score | | |
| Section 2 E. Nutritional Health Assessment → enter score | | |
| Additional Factors | | |
| Lives Alone (Section 1 12a.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Do you have permanent housing? (Section 1 13.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |