

Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

Case Number: \_\_\_\_\_

# O L D E R   A D U L T S   A S S E S S M E N T

This document serves as a combined screening and assessment summary. In each domain, please enter the Summary Rating Scores based on your clinical assessment and check if it is a Service Planning Target for the consumer. Use the rating scale provided for each domain; enter a "1" if there is no problem. A summary rating of moderate impairment or greater suggests further assessment.

### Diagnostic Status:

*Please list diagnoses and DSM-IV-TR code numbers below. If there is more than one diagnosis, please list all in order of treatment priority.*

1. **Axis I/DSM-IV code:** \_\_\_\_\_  
\_\_\_\_\_

2. **Axis II DSM-IV code/description:** \_\_\_\_\_ **DSM-IV code:** \_\_\_\_\_

3. **Axis III:** *List all current general medical conditions.*  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. **Axis IV**  
Primary Support Group: \_\_\_\_\_ Economic Support: \_\_\_\_\_  
Social Environment: \_\_\_\_\_ Health Care Access: \_\_\_\_\_  
Education: \_\_\_\_\_ Legal System: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Other: \_\_\_\_\_  
Housing: \_\_\_\_\_

Physician signature (if required by agency) \_\_\_\_\_ DATE: \_\_\_\_\_

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## I. General Health & Medical Comorbidity

**A. Treatment Accessibility and Health Status** (*Note: Checkmarks indicate a problem*) Do you, (client) have a medical doctor? Have you (client) had a checkup with a medical doctor or nurse in the last 12 months? ... with a dentist in the last 12 months? Are all your (client's) dental problems being corrected? Do you (client) have any medical problems affecting your daily functioning? Number of medications taken daily?

### Summary Rating Scale

1. **NO PROBLEMS**: Functioning is consistently good. No medical/physical difficulties.
2. **SLIGHT PROBLEMS**: The problem or symptoms are not urgent and have little impact on functioning, or are controlled by medications or treatment.
3. **MODERATE PROBLEMS**: Medical/physical problem(s) cause moderate problems in functioning; may require therapeutic intervention(s).
4. **SEVERE PROBLEMS**: Medical/physical problem(s) almost always extend to problems in functioning and generally may require hospitalization or other therapeutic intervention(s).
5. **EXTREME PROBLEMS**: A medical/physical problem is potentially life-threatening; results in severe and global functional disability.

SUMMARY RATING OF HEALTH STATUS: PAST MONTH: \_\_\_\_\_ PAST YEAR: \_\_\_\_\_  
CHECK IF THIS IS A SERVICE PLANNING TARGET:

Comments:

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## B. Memory & Orientation

Use of formal assessment of cognition is required at intake and yearly. (See Toolkit for Examination Tool.) The MOCA is recommended. SCORE REQUIRED

### Summary Rating Scale

#### Memory

1. **NONE**: No memory loss or inconsistent forgetfulness.
2. **MILD**: Mild consistent forgetfulness; partial recollection of events; "benign" forgetfulness.
3. **MODERATE**: Moderate memory loss more marked for recent events; defect interferes with everyday activities. Some difficulty with time relationships.
4. **SEVERE**: Severe memory loss, only highly learned material retained; New material rapidly lost.
5. **EXTREMELY SEVERE**: Severe memory loss; only fragments remain.

MENTAL STATUS ASSESSMENT USED/SCORE: \_\_\_\_\_

SUMMARY RATING OF MEMORY AND ORIENTATION: PAST MONTH: \_\_\_\_\_ PAST YEAR: \_\_\_\_\_

CHECK IF THIS IS A SERVICE PLANNING TARGET:

Comments:

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## II. Symptoms

### A. Depression (*Sample Screening Questions*)

*Use of a Depression Scale is required at intake and annually. See Toolkit for Scale. The Geriatric Depression Scale is recommended.*

Have you (client)... been bothered by having little interest or pleasure in doing things? Been bothered by feeling down, depressed or hopeless? Had difficulty sleeping or had a poor appetite with weight loss? Felt irritated or annoyed by little things?

#### Summary Rating Scale

1. **NONE**: No symptoms noted.
2. **VERY MILD**: Feels sad/unhappy/depressed more than usual. Requires some effort to distract self from depression.
3. **MODERATE**: Frequent periods of feeling depressed and/or some areas of functioning are disrupted by depression.
4. **SEVERE**: Deeply depressed most of the time OR many areas of functioning are disrupted by depression.
5. **EXTREME**: Constantly deeply depressed OR most areas of functioning are disrupted by depression.

DEPRESSION ASSESSMENT SCALE USED/SCORE: \_\_\_\_\_

SUMMARY RATING FOR DEPRESSION: PAST MONTH: \_\_\_\_\_ PAST YEAR: \_\_\_\_\_

CHECK IF THIS IS A SERVICE PLANNING TARGET:

Comments:

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### B. Elevated Mood/Mania (*Sample Screening Questions*)

In the past month, have you (client) been feeling 'high', confident, or so full of energy, for several days in a row, such that you (client) got into trouble, or that people thought you were not your usual self? (Do not include times due to alcohol or drugs.) During "high times" have you needed less sleep for several days in a row, talked too much without stopping, or been so active that others worried about you?

#### Summary Rating Scale

1. **NONE**: No symptoms noted.
2. **MILD**: Some unaccountable feelings of cheerfulness or well-being that persist for more than four days in a row. Occasional eccentric or inappropriate behavior with no impact on functioning or risk to personal welfare.
3. **MODERATE**: Excessive or unrealistic feelings of well-being, cheerfulness, confidence or optimism inappropriate to circumstances, some of the time. May describe feeling on top of the world, "like everything is falling into place," "or better than ever before" OR instances of marked elevated mood with euphoria.
4. **SEVERE**: Many instances of marked elevated mood with euphoria OR mood definitely elevated almost constantly throughout the interview and inappropriate to content, persisting for more than four days.
5. **EXTREME**: Elated or appears almost intoxicated, laughing, joking, giggling, constantly euphoric, feeling invulnerable, all inappropriate to immediate circumstances, persisting for more than four days.

MANIA RATING SCALE (MRS) SCORE (IF ADMINISTERED): \_\_\_\_\_

SUMMARY RATING FOR ELEVATED MOOD/MANIA: PAST MONTH: \_\_\_\_\_ PAST YEAR: \_\_\_\_\_

CHECK IF THIS AREA IS A SERVICE PLANNING TARGET:

Comments:

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**C Suicidality (Sample Screening Questions)**

In the past month/year have you (client) felt that life wasn't worth living? Had thoughts that you would be better off dead? Thought of harming yourself in any way?

**Summary Rating Scale**

1. **NONE:** No symptoms noted.
2. **MILD:** Occasional feelings of being tired of life/ would be better off dead or occasional suicidal thoughts without intent or specific plan.
3. **MODERATE:** Many fantasies of suicide by various methods. May seriously consider making an attempt with specific time and plan OR impulsive suicide attempt using non-lethal method or in full view of potential saviors.
4. **SEVERE:** Clearly wants to kill self. Searches for appropriate means and time OR potentially serious suicide attempt with patient knowledge of possible rescue.
5. **EXTREME:** Specific suicidal plan or intent (e.g., "as soon as I "X" will do it by doing "X"), OR suicide attempt characterized by plan client thought was lethal or attempt in secluded environment.

**PAYKEL SCALE FOR SUICIDALITY SCORE (IF ADMINISTERED):** \_\_\_\_\_

**SUMMARY RATING FOR SUICIDALITY: PAST MONTH:** \_\_\_\_\_ **PAST YEAR:** \_\_\_\_\_

**CHECK IF THIS AREA IS A SERVICE PLANNING TARGET:**

**Note to Clinician:**

Summary Ratings  $\geq 4$  indicates the need for a thorough suicide assessment (See Toolkit for Paykel Scale for Suicidality.)

**Comments:**

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**D. Anxiety (Sample Screening Questions)**

**Note to clinician:** In this domain, explore and rate symptoms of anxiety disorders (such as GAD, OCD, Panic Disorders, Phobias, etc.) Have you (client) felt worried, nervous, or anxious? Do unpleasant thoughts constantly go round and round in your mind? (If yes) How much of the time?

**Summary Rating Scale**

1. **NONE:** No symptoms noted.
2. **MILD:** Reports some discomfort due to worry OR worried frequently but can readily turn attention to other things.
3. **MODERATE:** Worried most of the time and cannot turn attention to other things easily OR occasional anxiety with physical signs of anxiety with some areas of functioning disrupted by anxiety or worry.
4. **SEVERE:** Physical signs of anxiety daily but not persisting throughout the day OR many areas of functioning are disrupted by anxiety or constant worry.
5. **EXTREME:** Anxiety with autonomic accompaniment persisting through the day OR most areas of functioning are disrupted by anxiety or constant worry.

**SYMPTOM QUESTIONNAIRE TOTAL SCORE (IF ADMINISTERED):** \_\_\_\_\_

**SUMMARY RATING FOR ANXIETY: PAST MONTH:** \_\_\_\_\_ **PAST YEAR:** \_\_\_\_\_

**CHECK IF THIS AREA IS A SERVICE PLANNING TARGET:**

**Comments:**

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\_\_\_\_\_

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**E. Post-Traumatic Symptoms (Sample Screening Questions)**

Have you (client) ever undergone a traumatic experience (such as a serious accident, assault, war) and reacted with fear, helplessness, or horror? (Does client have a history of emotional, physical or sexual abuse?) Do you have upsetting thoughts, images or bad dreams about the trauma, or sometimes feel like it is happening again? Do you try to avoid thinking about, or being reminded of, the trauma?

**Summary Rating Scale**

1. **NONE**: No symptoms noted.
2. **MILD**: Occasional distressing recollections, infrequent images of traumatic events, dreams infrequently refer to trauma and are no more than mildly distressing.
3. **MODERATE**: Distressing recollections and images of trauma occur most days. Occasional to frequent trauma-related nightmares.
4. **SEVERE**: Frequent intrusive and distressing thoughts and images, more than occasional trauma-related nightmares, has had a flashback (feeling like trauma was happening again).
5. **EXTREME**: Nearly continuous intrusive and distressing thoughts or images, frequent nightmares, has flashbacks.

**POST-TRAUMATIC CHECKLIST-CIVILIAN VERSION SCORE (IF ADMINISTERED):** \_\_\_\_\_

**SUMMARY RATING FOR POST-TRAUMATIC SYMPTOMS: PAST MONTH:** \_\_\_\_\_ **PAST YEAR:** \_\_\_\_\_

**CHECK IF THIS AREA IS A SERVICE PLANNING TARGET:**

**Comments:**

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**F. Psychosis: Suspiciousness & Hallucinations (Sample Screening Questions)**

During the past month/year have you (client) ever felt as if people were watching you or talking about you? Heard any sounds or heard people talking to you when there has been nobody around? Seen any visions or smelled any smells others don't seem to notice?

**Summary Rating Scale - Suspiciousness**

1. **NONE**: No symptoms noted.
2. **MILD**: Seems on guard. Reluctant to respond to some "personal" questions. Describes incidents in which others have harmed or wanted to harm him/her that sound plausible. Patient feels as if others are watching, laughing, or criticizing him/her in public, but this occurs only occasionally or rarely. Little or no preoccupation.
3. **MODERATE**: Says others are talking about him/her maliciously, have negative intentions, or may harm him/her. Beyond the likelihood of plausibility, but not delusional OR persecutory delusions expressed with much doubt (e.g., partial delusion). Incidents of suspected persecution occur occasionally (less than once per week) with some preoccupation. Patient is moderately preoccupied with ideas of persecution.
4. **SEVERE**: Delusional---speaks of Mafia plots, the FBI, or others poisoning his/her food, persecution by supernatural forces.
5. **EXTREME**: Same as 4, but the beliefs are bizarre or more preoccupying. Patient tends to disclose or act on persecutory delusions.

**Summary Rating Scale – Hallucinations**

1. **NONE**: No symptoms noted.
2. **MILD**: While in a clear state of consciousness, hears a voice calling the subject's name, experiences non-verbal auditory hallucinations
3. **MODERATE**: More than occasional verbal, visual, gustatory, olfactory, or tactile hallucinations with no functional impairment OR some areas of functioning are disrupted by these hallucinations.
4. **SEVERE**: Daily verbal or visual hallucinations throughout the day OR most areas of functioning are disrupted by these hallucinations.
5. **EXTREME**: Frequent verbal or visual hallucinations throughout the day OR most areas of functioning are disrupted by these hallucinations.

**SYMPTOM CHECK LIST-90 SCORE (IF ADMINISTERED):** \_\_\_\_\_

**SUMMARY RATING OF SUSPICIOUSNESS: PAST MONTH:** \_\_\_\_\_ **PAST YEAR:** \_\_\_\_\_

**SUMMARY RATING OF HALLUCINATIONS: PAST MONTH:** \_\_\_\_\_ **PAST YEAR:** \_\_\_\_\_

**CHECK IF THIS AREA IS A SERVICE PLANNING TARGET:**

**Comments:**

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**G. Hostile, Dangerous, or Problem Behaviors (*Sample Screening Questions*)**

Over the past month have you (client) lost your temper, or gotten really angry with others? Felt really angry or hostile or had thoughts of harming others? Threatened others or harmed other people or property? Engaged in behaviors that others have felt were inappropriate? (e.g., behaviors such as inappropriate sexual behaviors, loud disruptive speech, etc.)

**Summary Rating Scale**

1. **NONE**: No symptoms noted.
2. **MILD**: Irritable, grumpy, argumentative, or sarcastic.
3. **MODERATE**: Overtly angry on several occasions such as yelling at others excessively OR has threatened, slammed about or thrown things.
4. **SEVERE**: Has assaulted others but with no harm likely, e.g., slapped or pushed OR destroyed property, e.g., knocked over furniture, broken windows.
5. **EXTREME**: Has attacked others with definite possibility of harming them or with actual harm, e.g., assault with weapon.

**BRIEF BEHAVIOR SYMPTOM RATING SCALE SCORE (IF ADMINISTERED):** \_\_\_\_\_

**SUMMARY RATING OF HOSTILE, DANGEROUS, OR PROB. BEHAVIOR: PAST MONTH:** \_\_\_\_\_ **PAST YEAR:** \_\_\_\_\_

**CHECK IF THIS AREA IS A SERVICE PLANNING TARGET:**

**Comments:**

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**H. Substance Use and Abuse & Medication Misuse (Sample Screening Questions)**

Have you (client) had a drink of alcohol in the past month, past year? If yes: On average how many days per week do you drink? On a typical day, how many drinks do you have? Do you ever take any drugs that are not prescribed or take more medication than is prescribed to relax or get high? Smoke or chew any tobacco products, or use a lot of caffeine? Take more medication than is directed by the label on the bottle? Use medications prescribed for a family member or a friend?

**Summary Rating Scale**

1. **NO USE OR NO INAPPROPRIATE USE OF MEDICATIONS:** Client has not used substances or has not used medications inappropriately during this time interval.
2. **USE WITHOUT IMPAIRMENT:** Client has used substances or occasionally used their own (or someone else's) medications inappropriately, but with no evidence of problems related to use and no evidence of recurrent dangerous use.
3. **MODERATE IMPAIRMENT:** Client has used substances or used their own (or someone else's) medications inappropriately with some evidence of problems related to use or evidence of recurrent dangerous use.
4. **SEVERE IMPAIRMENT:** Meets criteria for moderate impairment plus greater substance use than intended or serious medication misuse resulting in frequent intoxication, related medical complications, marked tolerance, characteristic withdrawal, or problems in functioning (e.g. falls or confusion).
5. **EXTREMELY SEVERE IMPAIRMENT:** Meets criteria for severe-plus related problems are so severe that they make non-institutional living difficult.

**PROVIDE RATING FOR BOTH**

	<b>PAST MONTH</b>	<b>PAST YEAR</b>
<b>MICHIGAN ALCOHOLISM SCREENING TEST-GERIATRIC SCORE (IF ADMINISTERED):</b>	_____	_____
<b>SUMMARY RATING OF IMPAIRMENT DUE TO ALCOHOL USE:</b>	_____	_____
<b>SUMMARY RATING OF IMPAIRMENT DUE TO STREET DRUG USE:</b>	_____	_____
<b>SUMMARY RATING OF IMPAIRMENT DUE TO TOBACCO USE:</b>	_____	_____
<b>SUMMARY RATING OF IMPAIRMENT DUE TO CAFFEINE USE:</b>	_____	_____
<b>SUMMARY RATING OF IMPAIRMENT DUE TO MEDICATION MISUSE:</b>	_____	_____
<b>PRESCRIPTION MISUSE: PAST YEAR: <input type="checkbox"/> PAST MONTH: <input type="checkbox"/></b>		
<b>OVER-THE-COUNTER MISUSE: PAST YEAR: <input type="checkbox"/> PAST MONTH: <input type="checkbox"/></b>		
<b>CHECK IF THIS AREA IS A SERVICE PLANNING TARGET: <input type="checkbox"/></b>		

**Comments:**

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### III. Functioning

**Note to Clinician:** When assessing these domains, observe and note the consumer's ability to concentrate and follow-through on tasks, including this assessment. When determining summary ratings, assessments should incorporate consumer self-reports and reports from collateral contacts.

#### Rating scores for Personal Care Skills and Community Living Skills

1. **TOTALLY SELF-SUFFICIENT**
2. **NEEDS VERBAL ADVICE OR GUIDANCE**
3. **NEEDS SOME ASSISTANCE FROM OTHERS**
4. **NEEDS SUBSTANTIAL ASSISTANCE FROM OTHERS**
5. **TOTALLY DEPENDENT ON OTHERS**

#### **A. Personal Care Skills (*Sample Screening Questions*)**

Do you (client) need help in caring for your personal needs? Do you (client) have any difficulty with your daily routines, like eating, bathing or dressing yourself, using the toilet, or moving around the house?

*(Note: Leave blank if impairment is solely due to a physical condition, a developmental disability, substance abuse, or a neurological condition.)*

**KATZ INDEX OF ACTIVITIES OF DAILY LIVING SCORE (IF ADMINISTERED):** \_\_\_\_\_

**SUMMARY RATING FOR PERSONAL CARE SKILLS: PAST MONTH:** \_\_\_\_\_ **PAST YEAR:** \_\_\_\_\_

**CHECK IF PROBLEM IN FUNCTIONING IS WORSENERED BY PSYCHIATRIC CONDITION:**

**CHECK IF THIS AREA IS A SERVICE PLANNING TARGET:**

**COMMENTS:**

\_\_\_\_\_  
\_\_\_\_\_

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#### **B. Community Living Skills (*Sample Screening Questions*)**

Are you (client) able to take care of your day-to-day needs on your own? Do you (client) need help with preparing meals, doing housework, shopping, paying bills, using the telephone, or getting to places on your own? Do you (client) find it difficult to take your medications as prescribed, such as missing or increasing doses on your own? How often? Do you (client) need help remembering to take your medications? Have you (client) put off purchasing or taking prescribed medications because they were too expensive? (If yes, explore)

**OARS INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCORE (IF ADMINISTERED):** \_\_\_\_\_

**SUMMARY RATING FOR COMMUNITY LIVING SKILLS: PAST MONTH:** \_\_\_\_\_ **PAST YEAR:** \_\_\_\_\_

**CHECK IF PROBLEM IN FUNCTIONING IS WORSENERED BY PSYCHIATRIC CONDITION:**

**CHECK IF THIS AREA IS A SERVICE PLANNING TARGET:**

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_

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**C. Interpersonal Functioning and Community Integration (*Sample Screening Questions*)**

How much time do you (client) typically spend with other people (family and/or friends)? Are you (client) satisfied with the amount of time you spend with others or would you prefer to have more friends or more time with other people (family/friends)? Do you (client) have a person or persons that you feel very close to, that is, a person or persons you share confidences and feelings with and can depend on? Are you (client) involved in any other community activities such as a church group, the senior center, volunteer work, paid work, classes, peer support, self-help groups?

**Summary Rating Scale**

1. **EXTREMELY ACTIVE/COMPETENT:** Has extensive, reliable, supportive social network and is very satisfied with the quality and quantity of relationships. Is very actively engaged in meaningful community activities (at least two activities that are pursued on a regular basis).
2. **VERY ACTIVE/COMPETENT:** Has generally reliable, supportive social network and is satisfied for the most part with the quantity and quality of relationships. Is involved in at least one meaningful community activity on a regular basis.
3. **SOMEWHAT ACTIVE/COMPETENT:** Has some interpersonal relationships but the quantity and/or quality are lacking such that relationships are not entirely reliable and/or supportive. May be involved in meaningful community.
4. **QUITE INACTIVE/INCOMPETENT:** Quantity and/or quality of interpersonal relationships is minimal so that social network is rather unreliable and only occasionally supportive. Minimally or only sporadically involved in community activities.
5. **SERIOUSLY INACTIVE/INCOMPETENT:** Little or no social support. Very little or no involvement in community activities.

**SPECIFIC LEVEL OF FUNCTIONING SCALE SCORE (IF ADMINISTERED):** \_\_\_\_\_

**SUMMARY RATING OF FUNCTIONING: PAST MONTH:** \_\_\_\_\_ **PAST YEAR:** \_\_\_\_\_

**CHECK IF PROBLEM IN FUNCTIONING IS WORSENERED BY PSYCHIATRIC CONDITION:**

**CHECK IF THIS AREA IS A SERVICE PLANNING TARGET:**

**Comments (Please address any difficulties with effective communication):**

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#### IV. Supports, Safety, & Self-Management

*Clinician must make a report if exploitation of an older adult is discovered.*

**Note to Clinician:** When determining summary ratings, assessments should incorporate consumer self-reports and reports from collateral contacts over the past month.

##### A. Support & Safety (*Sample Screening Questions*)

What kind of help or support do you (client) get where you live? Who gives you help? Do you (client) feel safe and comfortable living where you are now? Do you (client) feel that you have the care and support you need to live where you are now?

**To what extent is the consumer at risk of requiring a living setting that provides more intensive care and support if problems with their safety, well-being, or lack of insight about their needs are not corrected? (risks may include being injured, being lost, being exploited, abused, or neglected, including self neglect. Has there been or is there a need for BEAS involvement?)**

##### Summary Rating Scale

1. **NO RISK:** Consumer has no unmet needs or has adequate supports in current setting such that there is no risk to safety or well-being.
2. **NOT VERY MUCH RISK:** Consumer has few unmet needs; and/or has supports or care adequate to result in low risk of needing a more intensive setting.
3. **MODERATE RISK:** Consumer has some unmet needs, and/or limited supports resulting in moderate risk to safety and well-being in their current setting.
4. **SUBSTANTIAL RISK:** Consumer has several unmet needs, with inadequate support and care resulting in substantial risk to safety and well-being in their current setting.
5. **GREAT RISK:** Consumer has numerous unmet needs with very poor care or highly stressed supports in their current setting resulting in great risk to safety and well-being.

**SUPPORTS AND SAFETY SCALE SCORE (IF ADMINISTERED):** \_\_\_\_\_

**SUMMARY RATING OF SUPPORT & SAFETY: PAST MONTH:** \_\_\_\_\_ **PAST YEAR:** \_\_\_\_\_

**CHECK IF RISK IS INCREASED BY PSYCHIATRIC CONDITION:**

**CHECK IF THIS AREA IS A SERVICE PLANNING TARGET:**

**Comments:**

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##### B. Residential Status

1. Has the client been in jail in the past 30 days? Yes  No
2. Has the client been in the hospital in the past 30 days? Yes  No   
If yes how many admissions? \_\_\_\_\_ How many days? \_\_\_\_\_
3. Has the client been homeless in the past 30 days? Yes  No

## Overall Summary Rating of Treatment Self-Management

In general, to what extent is the consumer skilled in understanding, participating in, and successfully managing and following through with MH treatment services, including medications?

### Summary Rating Scale

1. **HIGHLY SKILLED:** Fully understands symptoms and effects of the mental disorder; is actively involved in planning treatment; always follows through on service plans; uses medications appropriately.
2. **QUITE SKILLED:** Good understanding of symptoms and effects of the mental disorder; is quite involved in planning treatment; usually follows through on service plans; uses medications appropriately most of the time.
3. **SOMEWHAT SKILLED:** Understands symptoms and effects of the mental disorder in a general sense; limited involvement in planning treatment; is inconsistent in following through on service plans; is inconsistent in using medications appropriately.
4. **POORLY SKILLED:** Displays limited understanding of symptoms and effects of the mental disorder; minimal involvement in planning treatment; often does not follow through on service plans; rarely uses medications appropriately.
5. **UNSKILLED:** Very little understanding of symptoms and effects of the mental disorder; no active involvement in planning treatment; does not follow through on service plans; does not use medications appropriately.

### SUMMARY RATING FOR OVERALL

TREATMENT SELF-MGMT: PAST MONTH: \_\_\_\_\_ PAST YEAR: \_\_\_\_\_

CHECK IF TREATMENT SELF-MANAGEMENT SKILLS ARE WORSENERED BY PSYCHIATRIC CONDITION:

CHECK IF THIS AREA IS A SERVICE PLANNING TARGET:

Comments:

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Physician signature (if required by agency): \_\_\_\_\_ DATE: \_\_\_\_\_

Client Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

Client Name: \_\_\_\_\_ Case Number: \_\_\_\_\_

**ELIGIBILITY DETERMINATION FORM FOR OLDER ADULTS WITH MENTAL ILLNESS**

**Eligibility Criterion 1: Diagnosis**

Primary Diagnosis for Eligibility: \_\_\_\_\_ Code: \_\_\_\_\_

Meets Criteria? Yes  No

Other Psychiatric Diagnosis: \_\_\_\_\_

**Eligibility Criterion 2: Symptoms**

Is any score  $\geq 3$  from the Annual Summary Ratings (or Q1 ratings for new consumers) for; Depression, Elevated Mood/Mania, Suicidality, Anxiety, Post-traumatic Symptoms, Psychosis, Hostile, Dangerous, or Problem Behaviors, and Substance Abuse & Medication Misuse? (whether or not related to Alzheimer's or other dementia)?

Yes  No

**Eligibility Criterion 3: Functional Impairment**

For the functional domains below, circle the OAA Annual Summary Ratings (or Q1 ratings for new consumers) that are  $\geq 3$  and are caused or worsened by mental illness.

Personal Care Skills	3	4	5
Community Living Skills	3	4	5
Interpersonal Functioning and Community Integration	3	4	5
Supports & Safety	3	4	5
Overall Treatment Self-Management	3	4	5

Sum the circled scores: \_\_\_\_\_

Is the total of criterion 3  $\geq 9$  Yes  No

**Eligibility Criterion 4: Duration**

Has documented duration of impairments been 12 months or more? Yes  No

**Final Eligibility Determination: (Check one)**

- SPMI** - Meets all criteria: diagnosis (1), symptom (2), functional impairments (3), and duration (4); or meets criteria 1, 2, and 4 but does not meet criteria 3 due to Clozaril which requires regular on-going monitoring, or as a result of close supervision in a community residence
- SMI** - Meets criteria: 1, 2 and 3
- Low Utilizer** - Meets criteria for diagnosis; has a mental illness, but no longer meets criteria for SPMI or SMI and receives services that are designed to prevent relapse and promote recovery; has functional impairments that are due to a developmental disability and/or receives services primarily through another agency such as a provider for the developmentally disabled or NH Hospital; meets criteria for SPMI or SMI but is not interested in other services and for whom the community mental health program is providing outreach...  
 *Relapse Prevention*...  *Other*....  *Outreach*
- Not Eligible**
- Waiver Request** - If the person does not meet the above eligibility criteria and you think he/she should be eligible, have you requested a waiver?

Licensed Staff Signature \_\_\_\_\_ Date: \_\_\_\_\_

Clinician Signature \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature (if required by agency) \_\_\_\_\_ Date: \_\_\_\_\_