Person Information

Items below in orange are from MnCHOICES. Items below in blue are from CARE.

A. Assessment Type

1. What is the reason for your call today? _____
   _____
2. Reason for assessment
   - Acute discharge
   - PAC admission
   - PAC discharge
   - Interim
   - Expired
3. Assessment reference date (mm/dd/yyyy): _____

B. Provider Information

1. Provider's Name: _____

C. Caller Information

1. Are you calling about yourself or someone else?
   - Myself [Skip to section D. Participant Information]
   - Someone else
2. Caller Name:
   a) First Name:
   b) Middle Name:
   c) Last Name:

3. Caller Address:
    a) Type:
        - Home
        - Mailing
        - Physical location

    b) Street Address Line 1:
    c) Street Address Line 2:
    d) Street Address Line 3:
    e) City:
    f) State:
    g) Zip:
    h) Zip + 4:
    i) County:
    j) Directions/Comments:

4. Phone Numbers:
    a) Home:
    b) Work:
    c) Ext:
    d) Cell:

5. E-Mail
    a) Home:
    b) Work:
    c) Comments:

6. Caller's relationship to the participant:
    - Community agency
    - County social services
    - Education/school
    - Family/relative
    - Foster parent
    - Friend/acquaintance/neighbor
    - Guardian/conservator
    - Medical/dental
    - Mental health case manager
    - Parent

- Personal care provider
- Private agency
- Public health nurse
- Residential facility
- Social worker
- Tribal social services
- Other _____

D. Participant Information

1. Participant's First Name: _____
2. Participant's Middle Initial or Name: _____
3. Participant's Last Name: _____
4. Participant's Nickname (Optional):_____
5. Participant's Medicare Health Insurance Number:_____
6. Participant's Medicaid Number: _____
7. Participant's Facility/Agency Identification Number (for internal tracking):_____

8a. Admission Date (mm/dd/yyyy): _____

8b. Birth Date (mm/dd/yyy):_____

9. Social Security Number (Optional): _____
10. Gender: ❍Male ❍Female
11. Race/Ethnicity (Check all that apply)
    - ☐ American Indian or Alaska Native
    - ☐ Asian
    - ☐ Black or African American
    - ☐ Hispanic or Latino
    - ☐ Native Hawaiian or Pacific Islander
    - ☐ White
    - ☐ Unknown
12. Is English the participant's primary language?
    - No
    - Yes [Skip to D13.]

12a. If English is not the participant's primary language, what is the participant's primary language?

_____

13. Does the participant want or need an interpreter (oral or sign language) to communicate with a doctor or health care staff?
    - No
    - Yes

14. Marital Status:
    - Divorced
    - Legally separated
    - Married, involuntarily separated
    - Married, living with spouse
    - Married, separated without
15. Preference to be contacted:
    - Email
    - Mail
    - Phone
16. Is the participant a veteran?
    - No
    - Yes
    - Chose not to answer
17. Does the person to be assessed need any additional accommodations?
    - No
    - Yes, Explain: _____

E. Decision-Making & Emergency Contact

1. Does the person have someone who helps make decisions about health care, money or other issues who does NOT have legal or official authority?

    - No [Skip to 2]
    - Yes

    A) Type:
        - Informal decision-making support
        - Responsible party
        - Other

    B) First Name:
    C) Last Name:
    D) Phone Number
    E) Relationship

2. Does the person have someone who signs documents or makes decisions about health care, finances or other issues who HAS legal or official authority?

    - No [Skip to 4]
    - Yes

3. Type of Decision Making Authority Table

☐ **Commitment** Name: _____ Address _____	Has a copy of the legal paperwork been obtained? O No O Yes Commitment for: O CD O DD O MH Organization: _____ Phone Number: _____ City _____ State _____ Zip _____
☐ **Conservator for finances/property only** Name: _____ Address _____	Has a copy of the legal paperwork been obtained? O No O Yes Organization: _____ Phone Number: _____ City _____ State _____ Zip _____
☐ **Guardian Ad Litem** Name: _____ Address: _____	Has a copy of the legal paperwork been obtained? O No O Yes Organization: _____ Phone Number: _____ City _____ State _____ Zip _____
☐ **Health Directive Agent** Name: _____ Address: _____	Has a copy of the legal paperwork been obtained? O No O Yes Organization: _____ Phone Number: _____ City _____ State _____ Zip _____
☐ **Power of Attorney** Name: _____ Address: _____	Has a copy of the legal paperwork been obtained? O No O Yes Organization: _____ Phone Number: _____ City _____ State _____ Zip _____
☐ **Private Guardian** Name: _____ Address: _____	Has a copy of the legal paperwork been obtained? O Paid O Unpaid Type: O No O Yes Organization: _____ Phone Number: _____ City _____ State _____ Zip _____

☐ **Public Guardian** Name: _____ Address: _____	Has a copy of the legal paperwork been obtained? O No O Yes Type: O Adult O Juvenile Organization: _____ Phone Number: _____ City _____ State _____ Zip _____
☐ **Representative Payee** Name: _____ Address: _____	Has a copy of the legal paperwork been obtained? O No O Yes Organization: _____ Phone Number: _____ City _____ State _____ Zip _____
☐ **Trustee for Supplemental/Special needs**	Has a copy of the legal paperwork been obtained? O No O Yes Organization: _____ Phone Number: _____ City _____ State _____ Zip _____
☐ **Tribal Guardianship** Name: _____ Address: _____	Has a copy of the legal paperwork been obtained? O No O Yes Organization: _____ Phone Number: _____ City _____ State _____ Zip _____
☐ **Other:** _____ Name: _____ Address: _____	Has a copy of the legal paperwork been obtained? O No O Yes Organization: _____ Phone Number: _____ City _____ State _____ Zip _____

4. Does the person have a Healthcare Directive?
   - No
   - Yes
   - Unsure
5. Would they like assistance in making a record of his/her wishes?
   - No
   - Yes – make the appropriate referral
   - Unsure

F. EMERGENCY CONTACT

6. Contact Name:
    a) First Name:
    b) Middle Name:
    c) Last Name:
7. Relationship to participant:
    - Friend
    - Guardian/Legal Representative
    - Neighbor
    - Parent
8. Contact Address:
    a) Type:
        - Home
        - Mailing
        - Physical location

    b) Street Address Line 1:
    c) Street Address Line 2:
    d) Street Address Line 3:
    e) City:
    f) State:
    g) Zip:
    h) Zip + 4:
    i) County:
    j) Directions/Comments:

9. Phone Numbers:
    e) Home:
    f) Work:
    g) Ext:
    h) Cell:

10. E-Mail
    d) Home:
    e) Work:
    f) Comments:

Notes/Comments:

F. Finance

1. Payer information: Current payment source(s) (Select all that apply)

- ☐ None (no charge for current services)
- ☐ Medicare (traditional fee for service)
- ☐ Medicare (HMO/managed care)
- ☐ Medicaid (traditional fee for service)
- ☐ Medicaid (HMO/managed care)
- ☐ Workers' compensation
- ☐ Title programs (e.g., Title III, V, or XX)
- ☐ Other government (e.g., VA)
- ☐ Private insurance/Medigap
- ☐ Private HMO/managed care
- ☐ Self-pay
- ☐ Other (specify) _____
- ☐ Unknown

2. Is the person on medical assistance?

- ○ No
- ○ No – applied and found not eligible
- ○ Yes
- ○ Pending

Comments: _____

2a. Would you like any assistance obtaining medical assistance?
[Displays if 'No' to above question]

- ○ No
- ○ Yes
- ○ Chose not to answer

2b. Date application submitted: _____
[Displays if 'Pending' to "Is the person on medical assistance" question]

3. Is the person certified disabled by Social Security or through the State review process?

- ○ No
- ○ Yes
- ○ Unsure

- Certification Pending

[If no or unsure, skip to 4]

3a. Type of Certification:

- State Medicaid agency
- Social Security determination

4. Are your medical needs being met by your insurer (e.g. getting wheelchairs, medical supplies, long term care insurance, etc.)?
   - No, Explain: _____
   - Yes
   - Unsure
   - Chose not to answer

Notes/Comments: _____

Referral Reason/ Assessment Type/ Intake Summary

Reason for Referral

- ☐ Caregiver
- ☐ Permanent loss of caregiver
- ☐ Supports requested
- ☐ Temporary absence or inability of caregiver
- ☐ Other _____

Comments: _____

Functional Capacity

- ☐ ADL or IADL assistance
- ☐ Behavioral or emotional concerns
- ☐ Disorientation or confusion
- ☐ Other _____

Comments: _____

Health

- ☐ Concerns for managing health and medications
- ☐ Unstable/Change in health
- ☐ Other _____

Comments: _____

Safety

- ☐ Abuse, neglect or exploitation
- ☐ Falls
- ☐ Harmful behaviors
- ☐ Supervision
- ☐ Other _____ *(Displays when this option is checked)*

Comments: _____

Services and Supports

- ☐ Current services not adequate
- ☐ Education/school/transition
- ☐ Employment/training

- [ ] Environmental accessibility and modifications
- [ ] Specialized equipment and supplies
- [ ] Other _____ *(Displays when this option is checked)*

Comments: _____

Advanced Planning

- [ ] Informational
- [ ] Other _____ *(Displays when this option is checked)*

Comments: _____

Other **Specify:** _____

Services and Supports currently receiving:

- [ ] None
- [ ] Assisted Living
- [ ] Child Welfare Targeted Case Management
- [ ] Foster Care
- [ ] Home Health Aide
- [ ] Mental Health Assessment and/or Treatment
- [ ] Mental Health Targeted Case Management
- [ ] Nurse Visits
- [ ] PCA
- [ ] PDN
- [ ] Rule 185 Case Management
- [ ] School Services through School District
- [ ] Transportation
- [ ] Other _____ *(Displays when this option is checked)*
- [ ] Other _____ *(Displays when this option is checked)*

Additional Notes on Supports: _____

Referrals Needed

- [ ] Adult Protection
- [ ] Child Protection
- [ ] Advocacy Services
- [ ] Home care Services
- [ ] Mental Health

- [ ] School
- [ ] Disability Linkage Line (DLL)
- [ ] Senior Linkage Line (SLL)
- [ ] Veterans Linkage Line and/or Veteran Services
- [ ] Medical Assistance and other Minnesota Health Care Programs (MHCP)
- [ ] Resources for alternative decision-making
- [ ] Other Lead Agency Divisions, e.g., Family Services, Public Health, Corrections, etc.
- [ ] Other _____ *(Displays when this option is checked)*
- [ ] Other _____ *(Displays when this option is checked)*

Narrative summary of conversation: _____

Comments: _____

Staff Warning: _____