I&A Brief Phone Assessment for LTS

Revised 2//25/14

Check CARES and PRINT COPY OF FORWARD HEALTH SHEET

Problem Codes:

Date of Interview _____

1st Time Request for LTS Referral ☐ NH Initiative ☐ CCI Case ☐

Crisis Respite Home ☐ Emergency Enrollee ☐ CLTS ☐

Re-Enrollment Most Recent PFLTC Program _____ Date Disenrolled _____

Requesting SSIE Supplement Yes ☐ No ☐

Client Last Name: _____ First Name: _____

DOB: _____ Home Phone: _____ Cell Phone: _____

Client Social Security # _____ Gender: M ☐ F ☐ PD ☐ DD ☐

Address: _____ Apt #: _____ City: _____ State: WI Zip: ____

Emergency Contact Name: _____ Relation to client: _____

Emergency Contact Phone # : _____ Emergency Contact Phone #2 : _____

Guardian: Yes ☐ No ☐ If yes, Name _____ Phone _____

Rep. Payee: Yes ☐ No ☐ If yes, Name _____ Phone _____

Original Referral Source: Self ☐ Relative ☐ Agency ☐ Other ☐

(specify) _____ Name _____ Phone: _____

Reason for Referral: _____

Attempts to contact client:

Date: _____ Phone Number Dialed: _____ Time: _____ Staff: _____

Date: _____ Phone Number Dialed: _____ Time: _____ Staff: _____

Date: _____ Phone Number Dialed: _____ Time: _____ Staff: _____

Financial: Receives SSI: Amount: _____ Receives SSDI: Amount _____

Other source(s) of income:

_____

Health Care Provider(s): _____

Name of Primary Care Physician: _____

Other source of health insurance or Agency that provide services? _____

_____

Who does client currently live with? Self ☐ Relative ☐ Agency ☐ Other ☐ _____

Disability Diagnosis/Health Concerns:

Arthritis: (Specify) _____ AODA____ Asthma_____ Autistic: (Specify) _____ Back Injuries: (Specify) _____

Brain Injury: (Specify) _____ Cancer: (Specify) _____ Cerebral Palsy_____ Cognitive Delayed_____ COPD____

Depression____ Diabetes: (Specify) _____ Epilepsy_____ Fibromyalgia_____ Gout____ Hearing Impairment_____

Heart Disease: (Specify) _____ High Blood Pressure_____ HIV____ Infectious Disease: (Specify) _____

Kidney Disease_____ Learning Disability: (Specify) _____ Lung_____ Mental Illness: (Specify) _____

Multiple Sclerosis____ Pancreatitis____ Paraplegia_____ Quadriplegia_____ PTSD_____ Seizure Disorder_____ Skeletal Problems: _____

Speech Impairment_____ Stroke____ Surgery(s): (Specify) _____ Vascular Disease: (Specify) _____

Visual Impairment_____ Other Disability: (Specify) _____.

Please advise Client(s) they need to meet Nursing Home level of Care needs and they need to provide medical documentation regarding their disability to the Enrollment Counselor assigned to their case.

What assistance does client need to complete activities of daily living?

Type of Assistance	Independent	Needs Assistance – Please describe
Bathing		
Dressing		
Mobility		
Toileting		
Transferring		
Meal Prep		
Meds:		
Money Mangmt		

Uses: Wheelchair____ Walker____ Scooter___ Cane___ Other_____

What other support services does the client currently need?

	Adaptive Aids or Communication Aids
	Case Management
	Chore services (house chores or errands)
	Guardianship or Legal
	Medical Care or Dental Care

	Rep/Payee or Financial Counseling
	Residential: Describe
	Respite
	Transportation

Comments/Overall Summary of Client needs and situation:

Assessment Completed by: _____ **Date:** _____