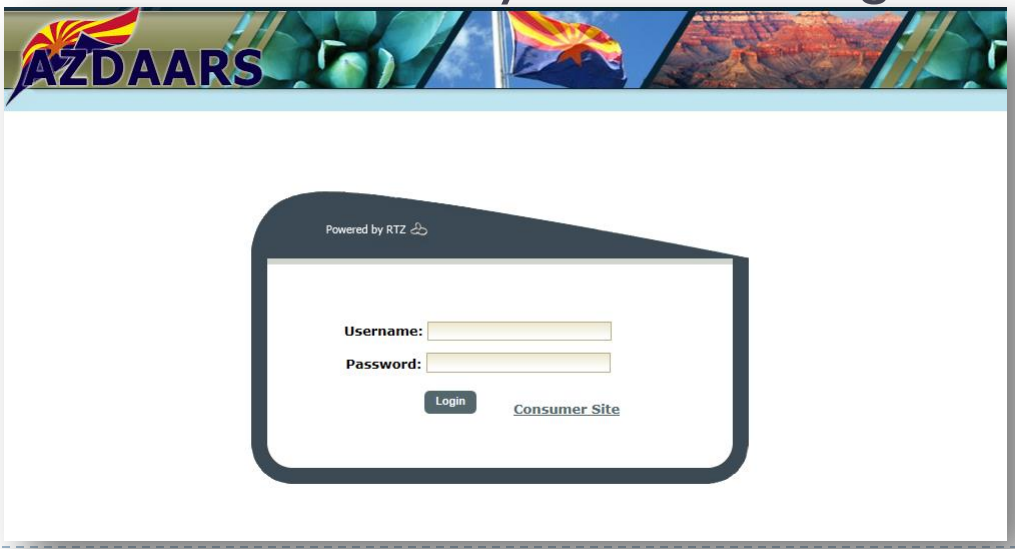
Short Form Intake Document (SFID) Reporting Overview

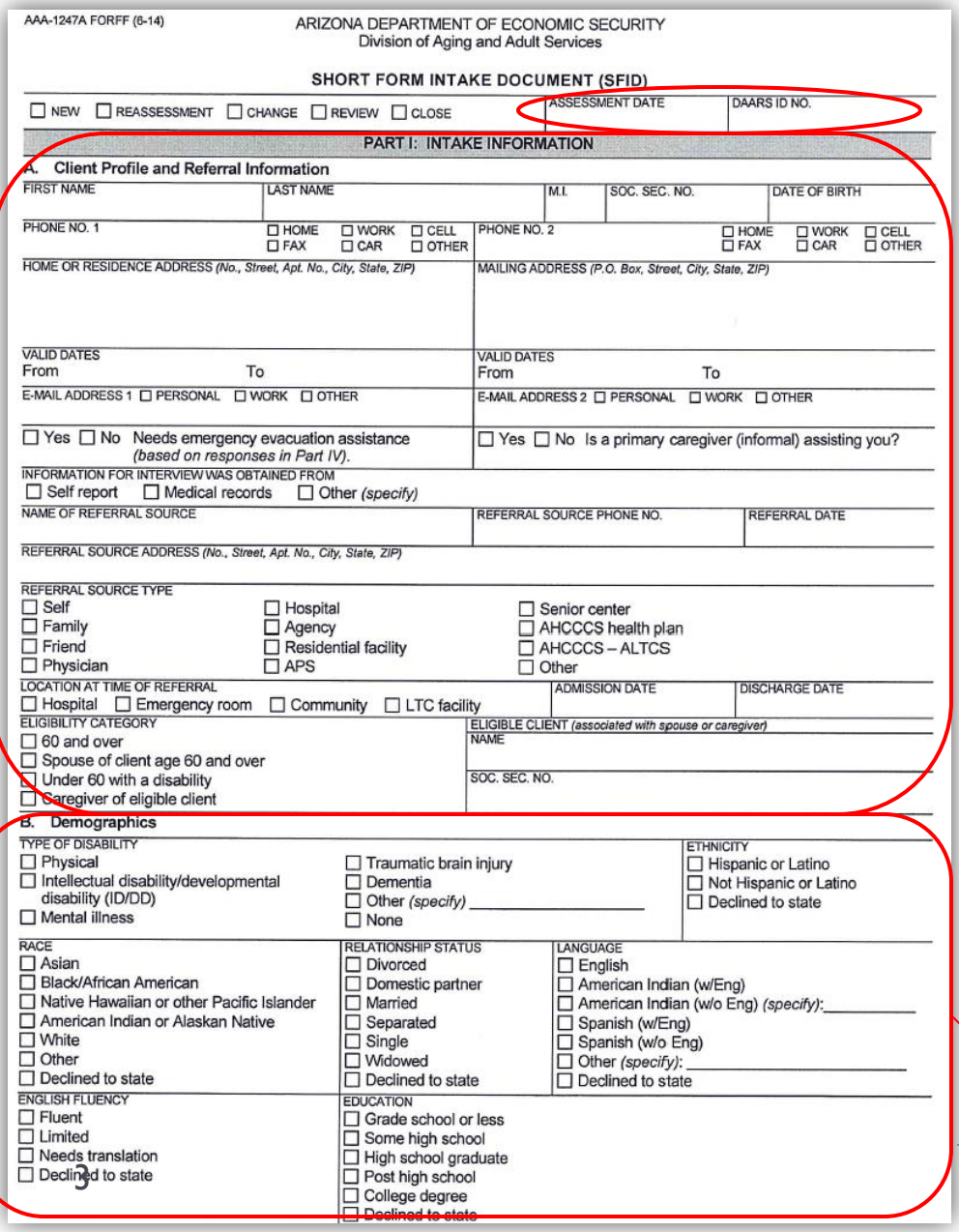
Area Agency on Aging, Region 8
Inter Tribal Council of Arizona, Inc.

SFID Overview

- DAARS – Title III Reporting Requirement
- RTZ – Website designer
- Accessing DAARS – AZ GETCARE Website:
  - Website: azdaars.getcare.com
  - Specified DAARS Users
  - Contact DES with any Password/Log-in issues



SFID Overview – Page #1



AAA-1247A FORFF (6-14)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Aging and Adult Services

SHORT FORM INTAKE DOCUMENT (SFID)

☐ NEW ☐ REASSESSMENT ☐ CHANGE ☐ REVIEW ☐ CLOSE | ASSESSMENT DATE | DAARS ID NO.

PART I: INTAKE INFORMATION

A. Client Profile and Referral Information

FIRST NAME | LAST NAME | M.I. | SOC. SEC. NO. | DATE OF BIRTH

PHONE NO. 1 ☐ HOME ☐ WORK ☐ CELL ☐ FAX ☐ CAR ☐ OTHER

PHONE NO. 2 ☐ HOME ☐ WORK ☐ CELL ☐ FAX ☐ CAR ☐ OTHER

HOME OR RESIDENCE ADDRESS *(No., Street, Apt. No., City, State, ZIP)*

MAILING ADDRESS *(P.O. Box, Street, City, State, ZIP)*

VALID DATES From To

VALID DATES From To

E-MAIL ADDRESS 1 ☐ PERSONAL ☐ WORK ☐ OTHER

E-MAIL ADDRESS 2 ☐ PERSONAL ☐ WORK ☐ OTHER

☐ Yes ☐ No Needs emergency evacuation assistance *(based on responses in Part IV).*

☐ Yes ☐ No Is a primary caregiver (informal) assisting you?

INFORMATION FOR INTERVIEW WAS OBTAINED FROM
☐ Self report ☐ Medical records ☐ Other *(specify)*

NAME OF REFERRAL SOURCE | REFERRAL SOURCE PHONE NO. | REFERRAL DATE

REFERRAL SOURCE ADDRESS *(No., Street, Apt. No., City, State, ZIP)*

REFERRAL SOURCE TYPE
☐ Self ☐ Family ☐ Friend ☐ Physician
☐ Hospital ☐ Agency ☐ Residential facility ☐ APS
☐ Senior center ☐ AHCCCS health plan ☐ AHCCCS – ALTCS ☐ Other

LOCATION AT TIME OF REFERRAL ☐ Hospital ☐ Emergency room ☐ Community ☐ LTC facility | ADMISSION DATE | DISCHARGE DATE

ELIGIBILITY CATEGORY
☐ 60 and over
☐ Spouse of client age 60 and over
☐ Under 60 with a disability
☐ Caregiver of eligible client

ELIGIBLE CLIENT *(associated with spouse or caregiver)*
NAME
SOC. SEC. NO.

B. Demographics

TYPE OF DISABILITY
☐ Physical
☐ Intellectual disability/developmental disability (ID/DD)
☐ Mental illness
☐ Traumatic brain injury
☐ Dementia
☐ Other *(specify)* _____
☐ None

ETHNICITY
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Declined to state

RACE
☐ Asian
☐ Black/African American
☐ Native Hawaiian or other Pacific Islander
☐ American Indian or Alaskan Native
☐ White
☐ Other
☐ Declined to state

RELATIONSHIP STATUS
☐ Divorced
☐ Domestic partner
☐ Married
☐ Separated
☐ Single
☐ Widowed
☐ Declined to state

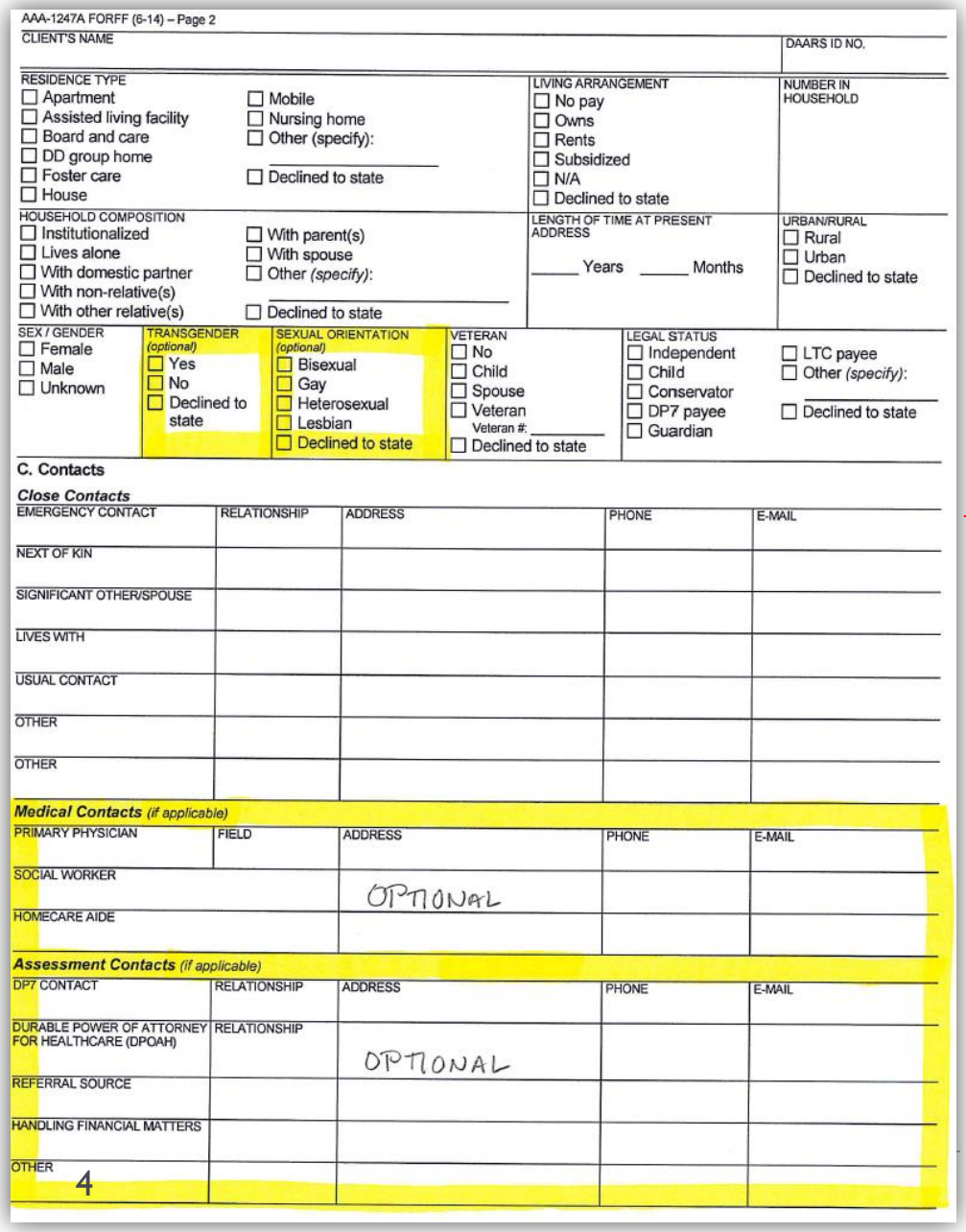
LANGUAGE
☐ English
☐ American Indian (w/Eng)
☐ American Indian (w/o Eng) *(specify)*:_____
☐ Spanish (w/Eng)
☐ Spanish (w/o Eng)
☐ Other *(specify)*: _____
☐ Declined to state

ENGLISH FLUENCY
☐ Fluent
☐ Limited
☐ Needs translation
☐ Declined to state

EDUCATION
☐ Grade school or less
☐ Some high school
☐ High school graduate
☐ Post high school
☐ College degree
☐ Declined to state

- Assessment Date = Date SFID completed
- DAARS ID = Once SFID is inputted into DAARS, client is issued ID number
- Client Profile and Referral Info
  - Name
  - SSN (optional)
  - DOB
  - Phone Number
  - Home Address
    - Valid Dates
  - Info for Interview obtained
    - Self Report
  - Referral Source
    - Only complete if not self-report
  - Eligibility Category
    - 60 and over, etc.
- Complete all Demographic questions

SFID Overview – Page #2



AAA-1247A FORFF (6-14) – Page 2

CLIENT'S NAME | DAARS ID NO.

RESIDENCE TYPE
- ☐ Apartment
- ☐ Assisted living facility
- ☐ Board and care
- ☐ DD group home
- ☐ Foster care
- ☐ House
- ☐ Mobile
- ☐ Nursing home
- ☐ Other (specify): _____
- ☐ Declined to state

LIVING ARRANGEMENT
- ☐ No pay
- ☐ Owns
- ☐ Rents
- ☐ Subsidized
- ☐ N/A
- ☐ Declined to state

NUMBER IN HOUSEHOLD

HOUSEHOLD COMPOSITION
- ☐ Institutionalized
- ☐ Lives alone
- ☐ With domestic partner
- ☐ With non-relative(s)
- ☐ With other relative(s)
- ☐ With parent(s)
- ☐ With spouse
- ☐ Other *(specify)*: _____
- ☐ Declined to state

LENGTH OF TIME AT PRESENT ADDRESS
_____ Years _____ Months

URBAN/RURAL
- ☐ Rural
- ☐ Urban
- ☐ Declined to state

SEX / GENDER
- ☐ Female
- ☐ Male
- ☐ Unknown

TRANSGENDER *(optional)*
- ☐ Yes
- ☐ No
- ☐ Declined to state

SEXUAL ORIENTATION *(optional)*
- ☐ Bisexual
- ☐ Gay
- ☐ Heterosexual
- ☐ Lesbian
- ☐ Declined to state

VETERAN
- ☐ No
- ☐ Child
- ☐ Spouse
- ☐ Veteran
  Veteran #: _____
- ☐ Declined to state

LEGAL STATUS
- ☐ Independent
- ☐ Child
- ☐ Conservator
- ☐ DP7 payee
- ☐ Guardian
- ☐ LTC payee
- ☐ Other *(specify)*: _____
- ☐ Declined to state

C. Contacts

Close Contacts

EMERGENCY CONTACT	RELATIONSHIP	ADDRESS	PHONE	E-MAIL
NEXT OF KIN				
SIGNIFICANT OTHER/SPOUSE				
LIVES WITH				
USUAL CONTACT				
OTHER				
OTHER				

***Medical Contacts** (if applicable)*

PRIMARY PHYSICIAN	FIELD	ADDRESS	PHONE	E-MAIL
SOCIAL WORKER		OPTIONAL		
HOMECARE AIDE				

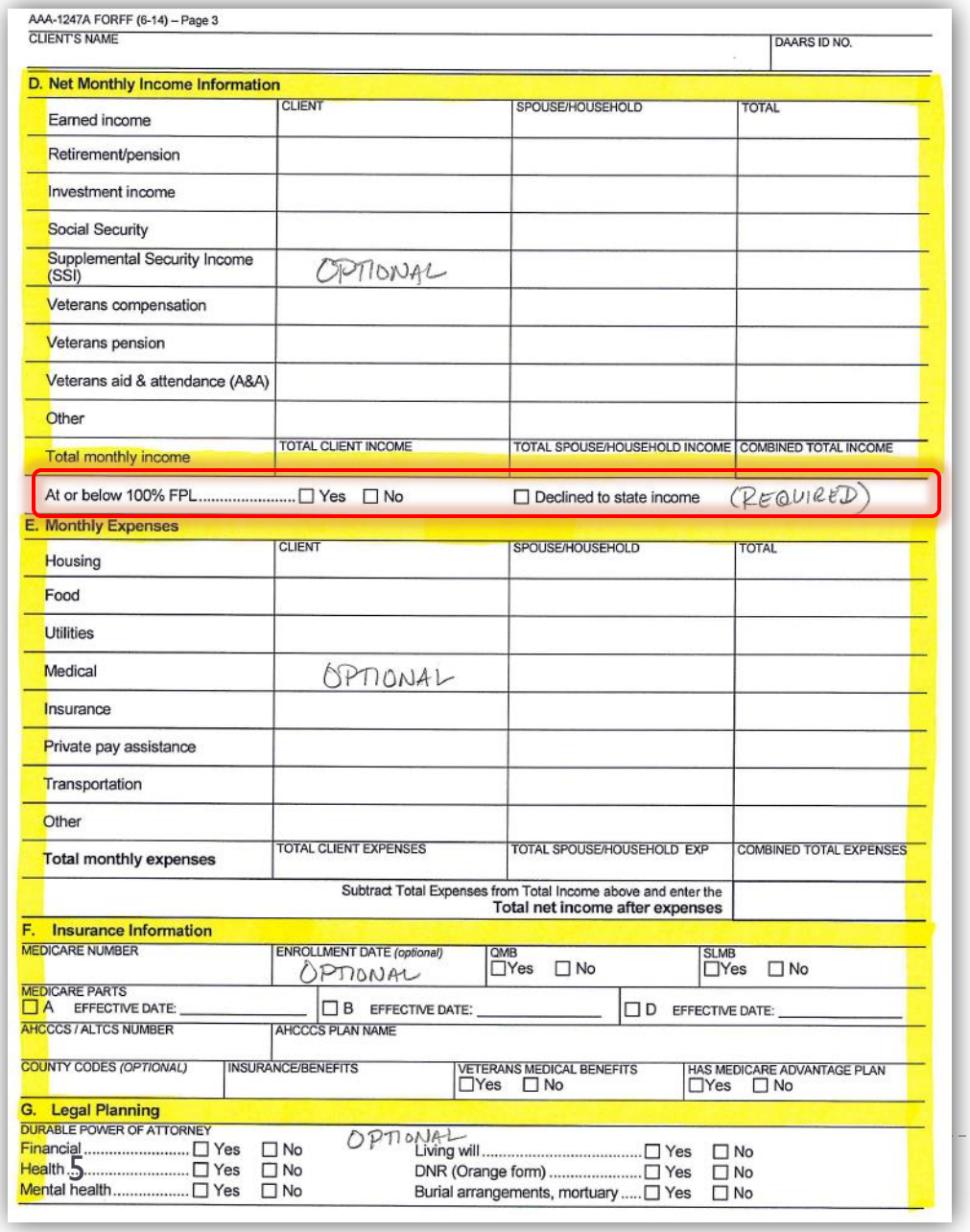
***Assessment Contacts** (if applicable)*

DP7 CONTACT	RELATIONSHIP	ADDRESS	PHONE	E-MAIL
DURABLE POWER OF ATTORNEY FOR HEALTHCARE (DPOAH)	RELATIONSHIP	OPTIONAL		
REFERRAL SOURCE				
HANDLING FINANCIAL MATTERS				
OTHER				

4

- All highlighted areas (optional)
- Demographics (Required)
  - Residence Type
  - Living arrangement
  - Number in Household
  - Household composition
  - Length of time at present address
  - Urban/rural
    - Rural for all clients residing on tribal reservation
  - Sex/Gender
  - Veteran
  - Legal Status
- Contacts
  - Emergency Contact Info

SFID Overview – Page #3



AAA-1247A FORFF (6-14) – Page 3

CLIENT'S NAME | DAARS ID NO.

D. Net Monthly Income Information

	CLIENT	SPOUSE/HOUSEHOLD	TOTAL
Earned income			
Retirement/pension			
Investment income			
Social Security			
Supplemental Security Income (SSI)	OPTIONAL		
Veterans compensation			
Veterans pension			
Veterans aid & attendance (A&A)			
Other			
Total monthly income	TOTAL CLIENT INCOME	TOTAL SPOUSE/HOUSEHOLD INCOME	COMBINED TOTAL INCOME

At or below 100% FPL..... ☐ Yes ☐ No ☐ Declined to state income (REQUIRED)

E. Monthly Expenses

	CLIENT	SPOUSE/HOUSEHOLD	TOTAL
Housing			
Food			
Utilities			
Medical	OPTIONAL		
Insurance			
Private pay assistance			
Transportation			
Other			
Total monthly expenses	TOTAL CLIENT EXPENSES	TOTAL SPOUSE/HOUSEHOLD EXP	COMBINED TOTAL EXPENSES

Subtract Total Expenses from Total Income above and enter the **Total net income after expenses**

F. Insurance Information

MEDICARE NUMBER | ENROLLMENT DATE *(optional)* OPTIONAL | QMB ☐Yes ☐ No | SLMB ☐Yes ☐ No

MEDICARE PARTS ☐ A EFFECTIVE DATE: _____ ☐ B EFFECTIVE DATE: _____ ☐ D EFFECTIVE DATE: _____

AHCCCS / ALTCS NUMBER | AHCCCS PLAN NAME

COUNTY CODES *(OPTIONAL)* | INSURANCE/BENEFITS | VETERANS MEDICAL BENEFITS ☐Yes ☐ No | HAS MEDICARE ADVANTAGE PLAN ☐Yes ☐ No

G. Legal Planning

DURABLE POWER OF ATTORNEY OPTIONAL

Financial..... ☐ Yes ☐ No
Health..... ☐ Yes ☐ No
Mental health..... ☐ Yes ☐ No

Living will..... ☐ Yes ☐ No
DNR (Orange form)..... ☐ Yes ☐ No
Burial arrangements, mortuary..... ☐ Yes ☐ No

- Optional = highlighted areas
- Not Required

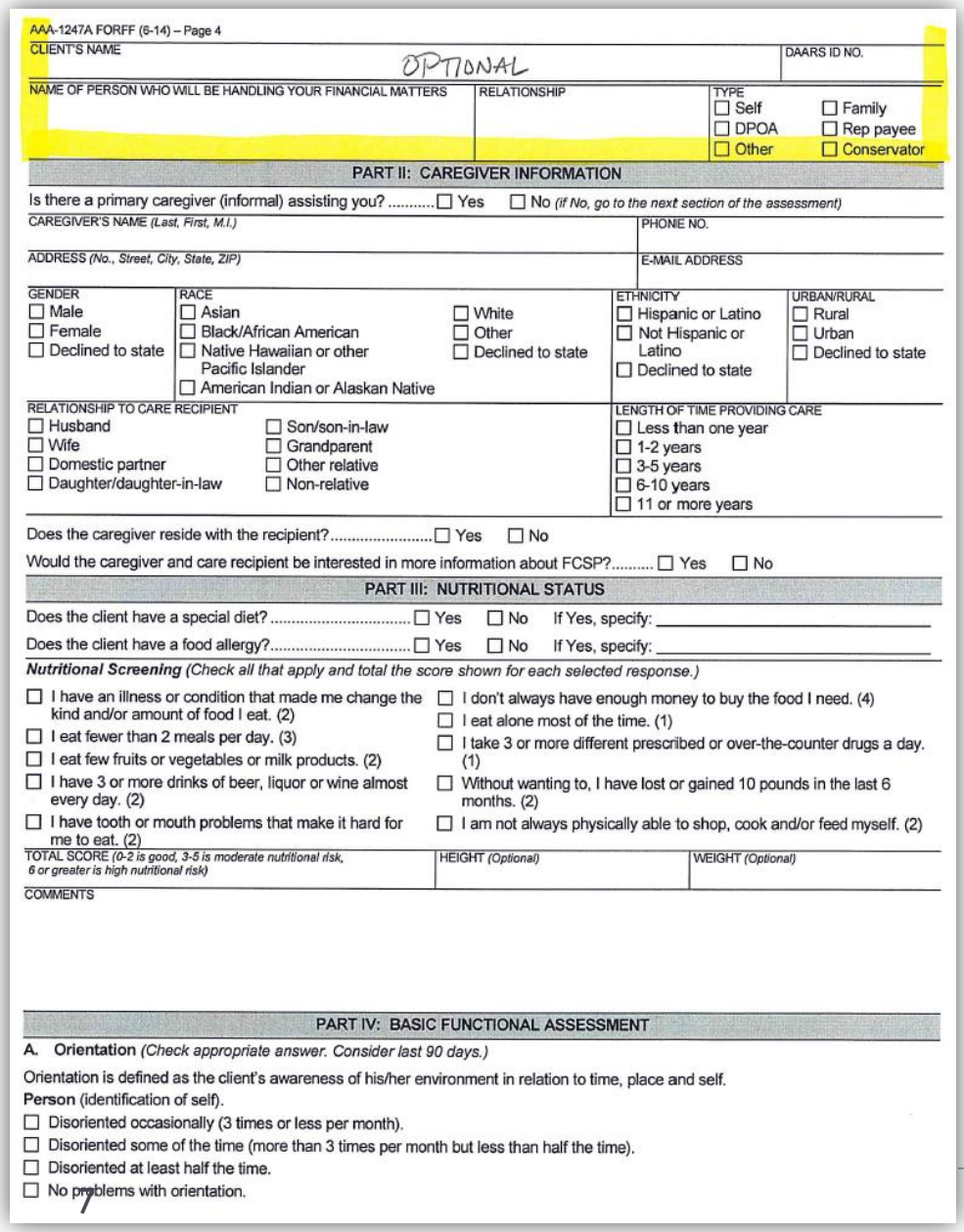
⇨ <u>Required section</u>

- Federal Poverty Level (FPL)
  - Yes/No
  - Decline to state income

Federal Poverty Level (FPL) Guide

2015 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES		
Persons in family/household	Poverty guideline	
	Annual Income	Monthly Income
1	$11,770	$981
2	15,930	$1,328
3	20,090	$1,674
4	24,250	$2,021
5	28,410	$2,368
6	32,570	$2,714
7	36,730	$3,061
8	40,890	$3,408
For families/households with more than 8 persons, add $4,160 per year or $347 per month for each additional person.		

SFID Overview – Page #4



AAA-1247A FORFF (6-14) – Page 4

CLIENT'S NAME: OPTIONAL | DAARS ID NO.

NAME OF PERSON WHO WILL BE HANDLING YOUR FINANCIAL MATTERS | RELATIONSHIP | TYPE: ☐ Self ☐ Family ☐ DPOA ☐ Rep payee ☐ Other ☐ Conservator

PART II: CAREGIVER INFORMATION

Is there a primary caregiver (informal) assisting you? ..... ☐ Yes ☐ No *(if No, go to the next section of the assessment)*

CAREGIVER'S NAME *(Last, First, M.I.)* | PHONE NO.

ADDRESS *(No., Street, City, State, ZIP)* | E-MAIL ADDRESS

GENDER: ☐ Male ☐ Female ☐ Declined to state

RACE: ☐ Asian ☐ Black/African American ☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaskan Native ☐ White ☐ Other ☐ Declined to state

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to state

URBAN/RURAL: ☐ Rural ☐ Urban ☐ Declined to state

RELATIONSHIP TO CARE RECIPIENT: ☐ Husband ☐ Wife ☐ Domestic partner ☐ Daughter/daughter-in-law ☐ Son/son-in-law ☐ Grandparent ☐ Other relative ☐ Non-relative

LENGTH OF TIME PROVIDING CARE: ☐ Less than one year ☐ 1-2 years ☐ 3-5 years ☐ 6-10 years ☐ 11 or more years

Does the caregiver reside with the recipient? ..... ☐ Yes ☐ No

Would the caregiver and care recipient be interested in more information about FCSP? ..... ☐ Yes ☐ No

PART III: NUTRITIONAL STATUS

Does the client have a special diet? ..... ☐ Yes ☐ No If Yes, specify: _____

Does the client have a food allergy? ..... ☐ Yes ☐ No If Yes, specify: _____

Nutritional Screening *(Check all that apply and total the score shown for each selected response.)*

- ☐ I have an illness or condition that made me change the kind and/or amount of food I eat. (2)
- ☐ I eat fewer than 2 meals per day. (3)
- ☐ I eat few fruits or vegetables or milk products. (2)
- ☐ I have 3 or more drinks of beer, liquor or wine almost every day. (2)
- ☐ I have tooth or mouth problems that make it hard for me to eat. (2)
- ☐ I don't always have enough money to buy the food I need. (4)
- ☐ I eat alone most of the time. (1)
- ☐ I take 3 or more different prescribed or over-the-counter drugs a day. (1)
- ☐ Without wanting to, I have lost or gained 10 pounds in the last 6 months. (2)
- ☐ I am not always physically able to shop, cook and/or feed myself. (2)

TOTAL SCORE *(0-2 is good, 3-5 is moderate nutritional risk, 6 or greater is high nutritional risk)* | HEIGHT *(Optional)* | WEIGHT *(Optional)*

COMMENTS

PART IV: BASIC FUNCTIONAL ASSESSMENT

A. Orientation *(Check appropriate answer. Consider last 90 days.)*

Orientation is defined as the client's awareness of his/her environment in relation to time, place and self.

Person (identification of self).

- ☐ Disoriented occasionally (3 times or less per month).
- ☐ Disoriented some of the time (more than 3 times per month but less than half the time).
- ☐ Disoriented at least half the time.
- ☐ No problems with orientation.

<u>Part Two: Caregiver Information</u>

- Complete section if client has a Caregiver (includes informal)
- This section connects with the CAT form (specifically for Caregivers)

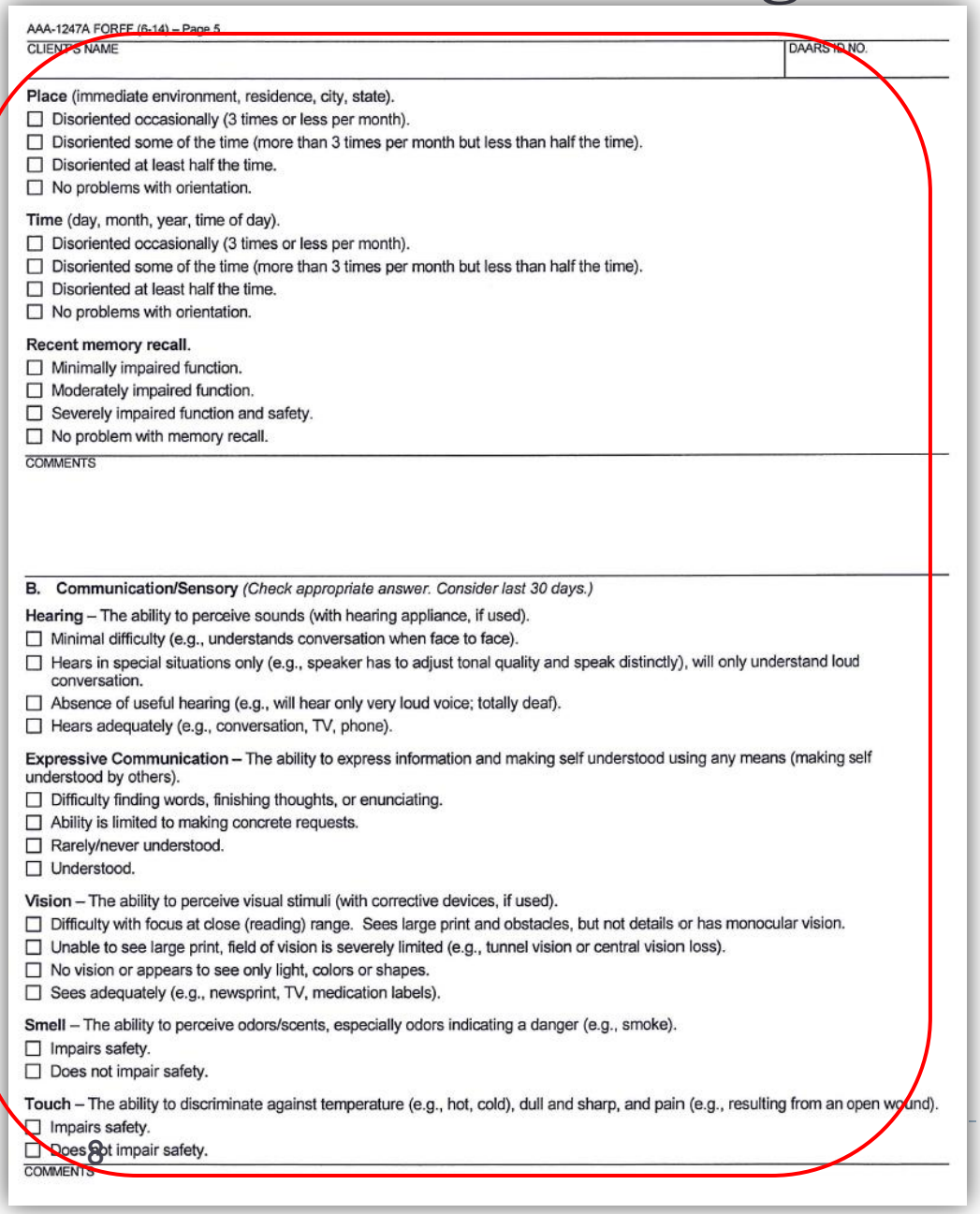
<u>Part Three: Nutritional Status</u>

- Special Diet
- Food Allergies
- Nutritional Screening
  - Automatically added in DAARS

<u>Part Four: Basic Functional Assessment</u>

- Orientation

SFID Overview – Page #5



AAA-1247A FORFF (6-14) – Page 5

CLIENT'S NAME | DAARS ID NO.

Place (immediate environment, residence, city, state).
- ☐ Disoriented occasionally (3 times or less per month).
- ☐ Disoriented some of the time (more than 3 times per month but less than half the time).
- ☐ Disoriented at least half the time.
- ☐ No problems with orientation.

Time (day, month, year, time of day).
- ☐ Disoriented occasionally (3 times or less per month).
- ☐ Disoriented some of the time (more than 3 times per month but less than half the time).
- ☐ Disoriented at least half the time.
- ☐ No problems with orientation.

Recent memory recall.
- ☐ Minimally impaired function.
- ☐ Moderately impaired function.
- ☐ Severely impaired function and safety.
- ☐ No problem with memory recall.

COMMENTS

B. Communication/Sensory *(Check appropriate answer. Consider last 30 days.)*

Hearing – The ability to perceive sounds (with hearing appliance, if used).
- ☐ Minimal difficulty (e.g., understands conversation when face to face).
- ☐ Hears in special situations only (e.g., speaker has to adjust tonal quality and speak distinctly), will only understand loud conversation.
- ☐ Absence of useful hearing (e.g., will hear only very loud voice; totally deaf).
- ☐ Hears adequately (e.g., conversation, TV, phone).

Expressive Communication – The ability to express information and making self understood using any means (making self understood by others).
- ☐ Difficulty finding words, finishing thoughts, or enunciating.
- ☐ Ability is limited to making concrete requests.
- ☐ Rarely/never understood.
- ☐ Understood.

Vision – The ability to perceive visual stimuli (with corrective devices, if used).
- ☐ Difficulty with focus at close (reading) range. Sees large print and obstacles, but not details or has monocular vision.
- ☐ Unable to see large print, field of vision is severely limited (e.g., tunnel vision or central vision loss).
- ☐ No vision or appears to see only light, colors or shapes.
- ☐ Sees adequately (e.g., newsprint, TV, medication labels).

Smell – The ability to perceive odors/scents, especially odors indicating a danger (e.g., smoke).
- ☐ Impairs safety.
- ☐ Does not impair safety.

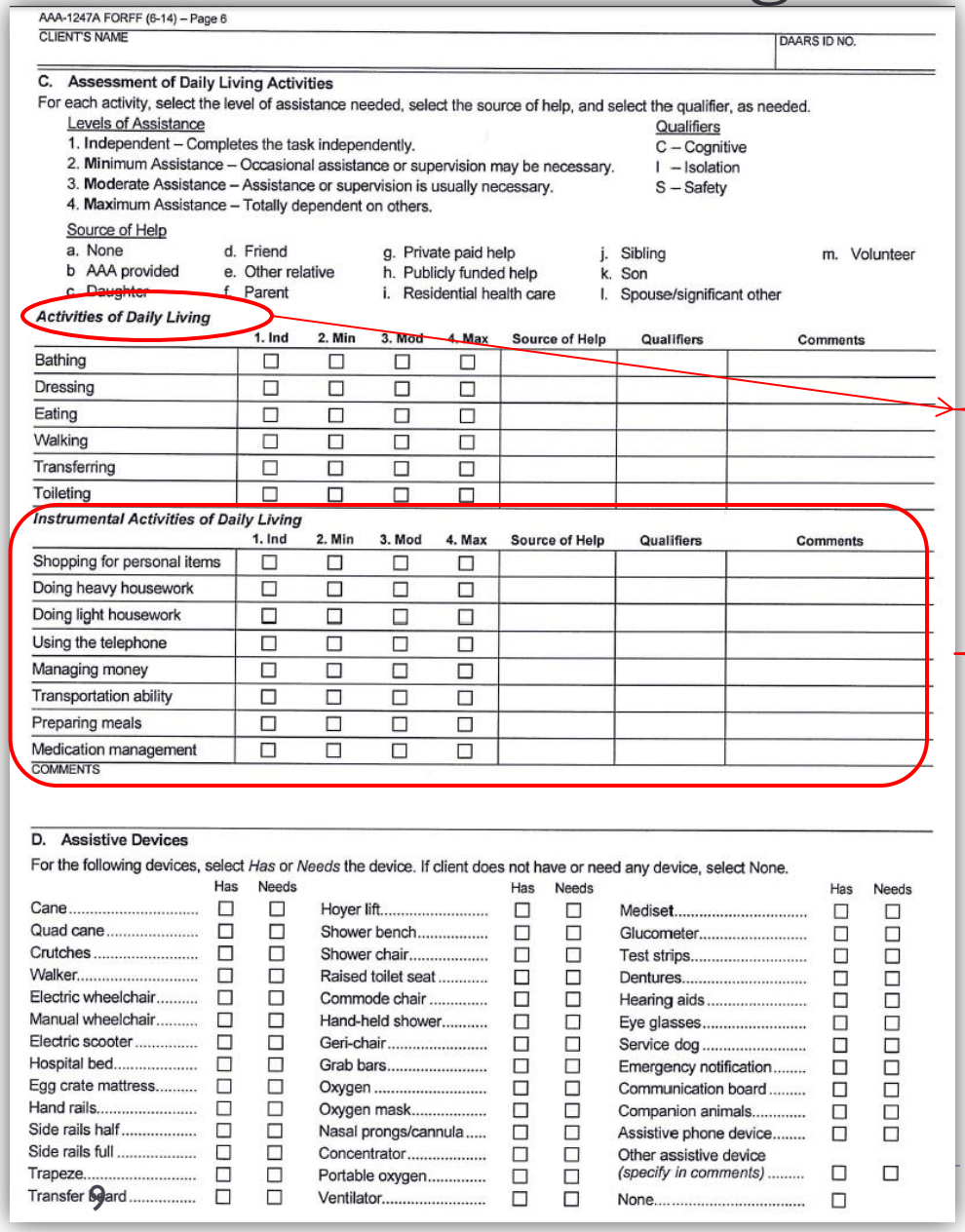
Touch – The ability to discriminate against temperature (e.g., hot, cold), dull and sharp, and pain (e.g., resulting from an open wound).
- ☐ Impairs safety.
- ☐ Does not impair safety.

COMMENTS

Basic Functional Assessment

- Place
- Time
- Recent Memory Recall
- Communication/Sensory
  - Hearing
  - Expressive
  - Vision
  - Smell
  - Touch

SFID Overview – Page #6



AAA-1247A FORFF (6-14) – Page 6

CLIENT'S NAME | DAARS ID NO.

C. Assessment of Daily Living Activities

For each activity, select the level of assistance needed, select the source of help, and select the qualifier, as needed.

Levels of Assistance
1. Independent – Completes the task independently.
2. Minimum Assistance – Occasional assistance or supervision may be necessary.
3. Moderate Assistance – Assistance or supervision is usually necessary.
4. Maximum Assistance – Totally dependent on others.

Qualifiers
C – Cognitive
I – Isolation
S – Safety

Source of Help
a. None; b. AAA provided; c. Daughter; d. Friend; e. Other relative; f. Parent; g. Private paid help; h. Publicly funded help; i. Residential health care; j. Sibling; k. Son; l. Spouse/significant other; m. Volunteer

Activities of Daily Living

	1. Ind	2. Min	3. Mod	4. Max	Source of Help	Qualifiers	Comments
Bathing	☐	☐	☐	☐			
Dressing	☐	☐	☐	☐			
Eating	☐	☐	☐	☐			
Walking	☐	☐	☐	☐			
Transferring	☐	☐	☐	☐			
Toileting	☐	☐	☐	☐			

Instrumental Activities of Daily Living

	1. Ind	2. Min	3. Mod	4. Max	Source of Help	Qualifiers	Comments
Shopping for personal items	☐	☐	☐	☐			
Doing heavy housework	☐	☐	☐	☐			
Doing light housework	☐	☐	☐	☐			
Using the telephone	☐	☐	☐	☐			
Managing money	☐	☐	☐	☐			
Transportation ability	☐	☐	☐	☐			
Preparing meals	☐	☐	☐	☐			
Medication management	☐	☐	☐	☐			

COMMENTS

D. Assistive Devices

For the following devices, select *Has* or *Needs* the device. If client does not have or need any device, select None.

	Has	Needs		Has	Needs		Has	Needs
Cane	☐	☐	Hoyer lift	☐	☐	Mediset	☐	☐
Quad cane	☐	☐	Shower bench	☐	☐	Glucometer	☐	☐
Crutches	☐	☐	Shower chair	☐	☐	Test strips	☐	☐
Walker	☐	☐	Raised toilet seat	☐	☐	Dentures	☐	☐
Electric wheelchair	☐	☐	Commode chair	☐	☐	Hearing aids	☐	☐
Manual wheelchair	☐	☐	Hand-held shower	☐	☐	Eye glasses	☐	☐
Electric scooter	☐	☐	Geri-chair	☐	☐	Service dog	☐	☐
Hospital bed	☐	☐	Grab bars	☐	☐	Emergency notification	☐	☐
Egg crate mattress	☐	☐	Oxygen	☐	☐	Communication board	☐	☐
Hand rails	☐	☐	Oxygen mask	☐	☐	Companion animals	☐	☐
Side rails half	☐	☐	Nasal prongs/cannula	☐	☐	Assistive phone device	☐	☐
Side rails full	☐	☐	Concentrator	☐	☐	Other assistive device *(specify in comments)*	☐	☐
Trapeze	☐	☐	Portable oxygen	☐	☐			
Transfer board	☐	☐	Ventilator	☐	☐	None	☐	

- ADL – Section must be completed as well

- IADLs: Home Delivered Meals
- 3 or higher = Moderate to Max assistance required
- Source of Help
- Qualifiers

- Assistive Devices
  - Select if client has/needs

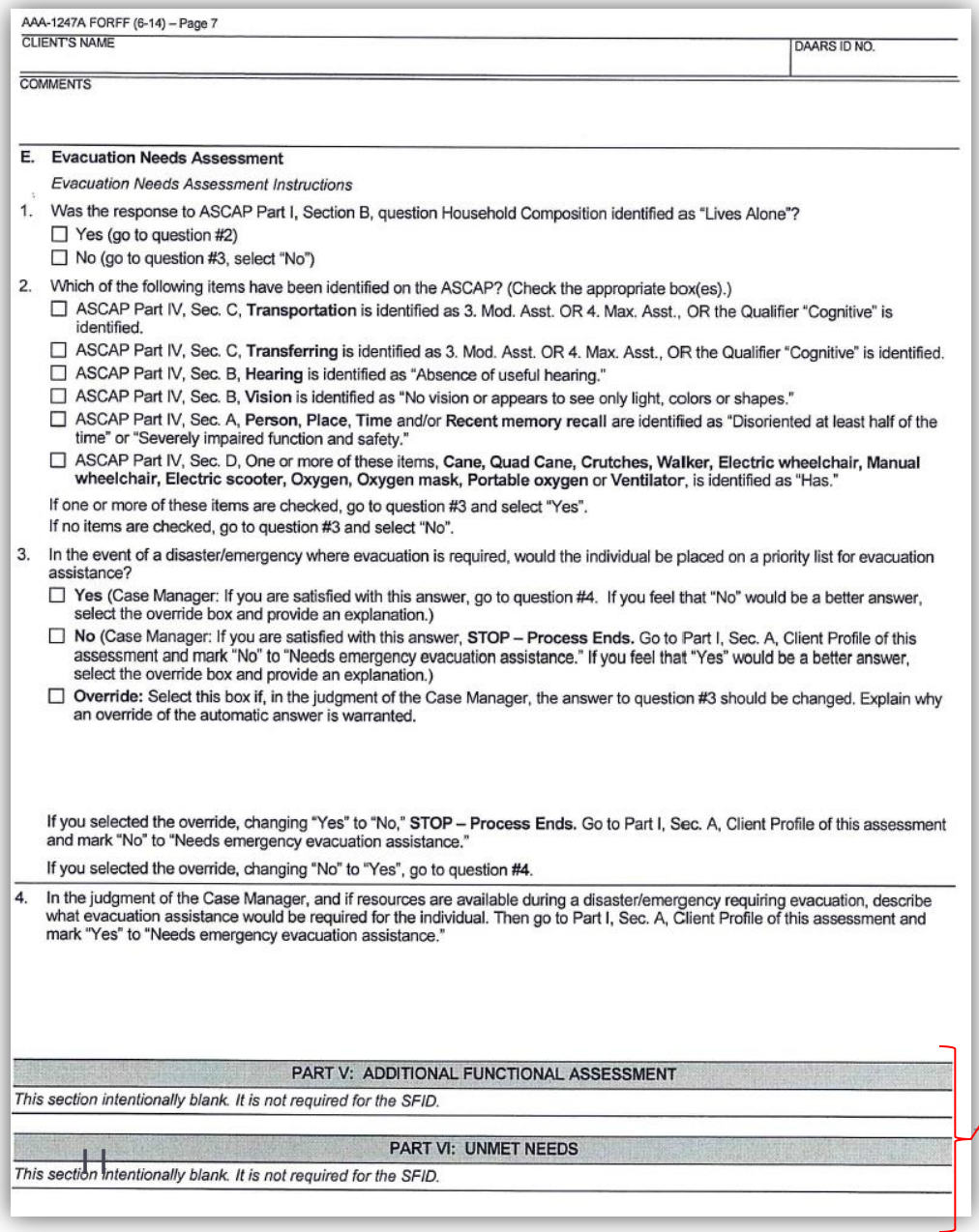
IADL/ADL DES Matrix

This matrix is intended to assist case managers to determine eligibility for services. The matrix should be used with the Division of Aging & Adult Services (DAAS) Policy Chapter 3000 and the ASCAP Manual. Services are authorized using assessment instruments. **A correlation must be demonstrated between an individual's impairment level(s) and the service(s) authorized. A minimum score of 3 is needed for each ADL/IADL**. Qualifiers may also be used in determining eligibility as outlined in the DAAS ASCAP Manual.

	Care Recipient ASCAP/SFID Requirements			Caregiver Assessment and Additional Requirements
Service	**ADL**		**IADL**	
Adaptive Aids and Devices	FCSP: 2 NMHCBS: n/a		n/a	For FCSP, this is a client-supported service. For NMHCBS, DAAS recommends an assessment be conducted prior to service delivery to ensure the best use of limited resources.
Adult Day Care (NMHCBS)	FCSP: 2 NMHCBS: 3		n/a	For Adult Day Care as respite, the caregiver must be assessed as moderate or high risk and monthly limits apply.
Attendant Care	3		n/a	
FCSP Respite Services (includes In-Home and Group Respite, and Adult/Child Day Care)	2		n/a	Caregiver must be assessed as moderate or high risk. Monthly limits apply.
FCSP Supplemental Services (includes AD5, IA5, RP5, TR5)	2		n/a	For FCSP, service must complement the care of the caregiver and can't be ongoing. Lifetime limits apply.
FCSP Counseling Services (includes GC5, PC5, CT5, CM5)	n/a		n/a	Must use Caregiver Registration Form.
Home Delivered Meals	n/a		2	One IADL must be Meal Preparation, and the second IADL must be Shopping or Transportation or Light Housework.
Home Health Aid	3		n/a	Documentation for medical need must be provided. See DAAS policy Section 3100 – NMHCBS Eligibility Requirements for additional details.
Home Nursing	3		n/a	Documentation for medical need must be provided. See DAAS policy Section 3100 – NMHCBS Eligibility Requirements for additional details.
Home Repair and Adaptation	FCSP: 2 NMHCBS: n/a		n/a	For FCSP, this is a client-supported service. For NMHCBS, DAAS recommends an assessment be conducted prior to service delivery to ensure the best use of limited resources.
Housekeeping/Homemaker	n/a	or	3	IADLs must be Shopping, or Light Housework or Heavy Housework, or Meal Preparation. The ADL of Walking or Transferring may substitute for one IADL.
Personal Care	3		n/a	

- (1) IADL
  > Meal Prep (req.)
- (2nd) IADL:
  > Shopping, or
  > Transportation, or
  > Light Housework

SFID Overview – Page #7



AAA-1247A FORFF (6-14) – Page 7

CLIENT'S NAME | DAARS ID NO.

COMMENTS

E. Evacuation Needs Assessment

Evacuation Needs Assessment Instructions

1. Was the response to ASCAP Part I, Section B, question Household Composition identified as "Lives Alone"?
   - ☐ Yes (go to question #2)
   - ☐ No (go to question #3, select "No")
2. Which of the following items have been identified on the ASCAP? (Check the appropriate box(es).)
   - ☐ ASCAP Part IV, Sec. C, **Transportation** is identified as 3. Mod. Asst. OR 4. Max. Asst., OR the Qualifier "Cognitive" is identified.
   - ☐ ASCAP Part IV, Sec. C, **Transferring** is identified as 3. Mod. Asst. OR 4. Max. Asst., OR the Qualifier "Cognitive" is identified.
   - ☐ ASCAP Part IV, Sec. B, **Hearing** is identified as "Absence of useful hearing."
   - ☐ ASCAP Part IV, Sec. B, **Vision** is identified as "No vision or appears to see only light, colors or shapes."
   - ☐ ASCAP Part IV, Sec. A, **Person, Place, Time** and/or **Recent memory recall** are identified as "Disoriented at least half of the time" or "Severely impaired function and safety."
   - ☐ ASCAP Part IV, Sec. D, One or more of these items, **Cane, Quad Cane, Crutches, Walker, Electric wheelchair, Manual wheelchair, Electric scooter, Oxygen, Oxygen mask, Portable oxygen** or **Ventilator**, is identified as "Has."

   If one or more of these items are checked, go to question #3 and select "Yes".
   If no items are checked, go to question #3 and select "No".
3. In the event of a disaster/emergency where evacuation is required, would the individual be placed on a priority list for evacuation assistance?
   - ☐ **Yes** (Case Manager: If you are satisfied with this answer, go to question #4. If you feel that "No" would be a better answer, select the override box and provide an explanation.)
   - ☐ **No** (Case Manager: If you are satisfied with this answer, **STOP – Process Ends.** Go to Part I, Sec. A, Client Profile of this assessment and mark "No" to "Needs emergency evacuation assistance." If you feel that "Yes" would be a better answer, select the override box and provide an explanation.)
   - ☐ **Override:** Select this box if, in the judgment of the Case Manager, the answer to question #3 should be changed. Explain why an override of the automatic answer is warranted.

   If you selected the override, changing "Yes" to "No," **STOP – Process Ends.** Go to Part I, Sec. A, Client Profile of this assessment and mark "No" to "Needs emergency evacuation assistance."

   If you selected the override, changing "No" to "Yes", go to question **#4**.
4. In the judgment of the Case Manager, and if resources are available during a disaster/emergency requiring evacuation, describe what evacuation assistance would be required for the individual. Then go to Part I, Sec. A, Client Profile of this assessment and mark "Yes" to "Needs emergency evacuation assistance."

PART V: ADDITIONAL FUNCTIONAL ASSESSMENT

This section intentionally blank. It is not required for the SFID.

PART VI: UNMET NEEDS

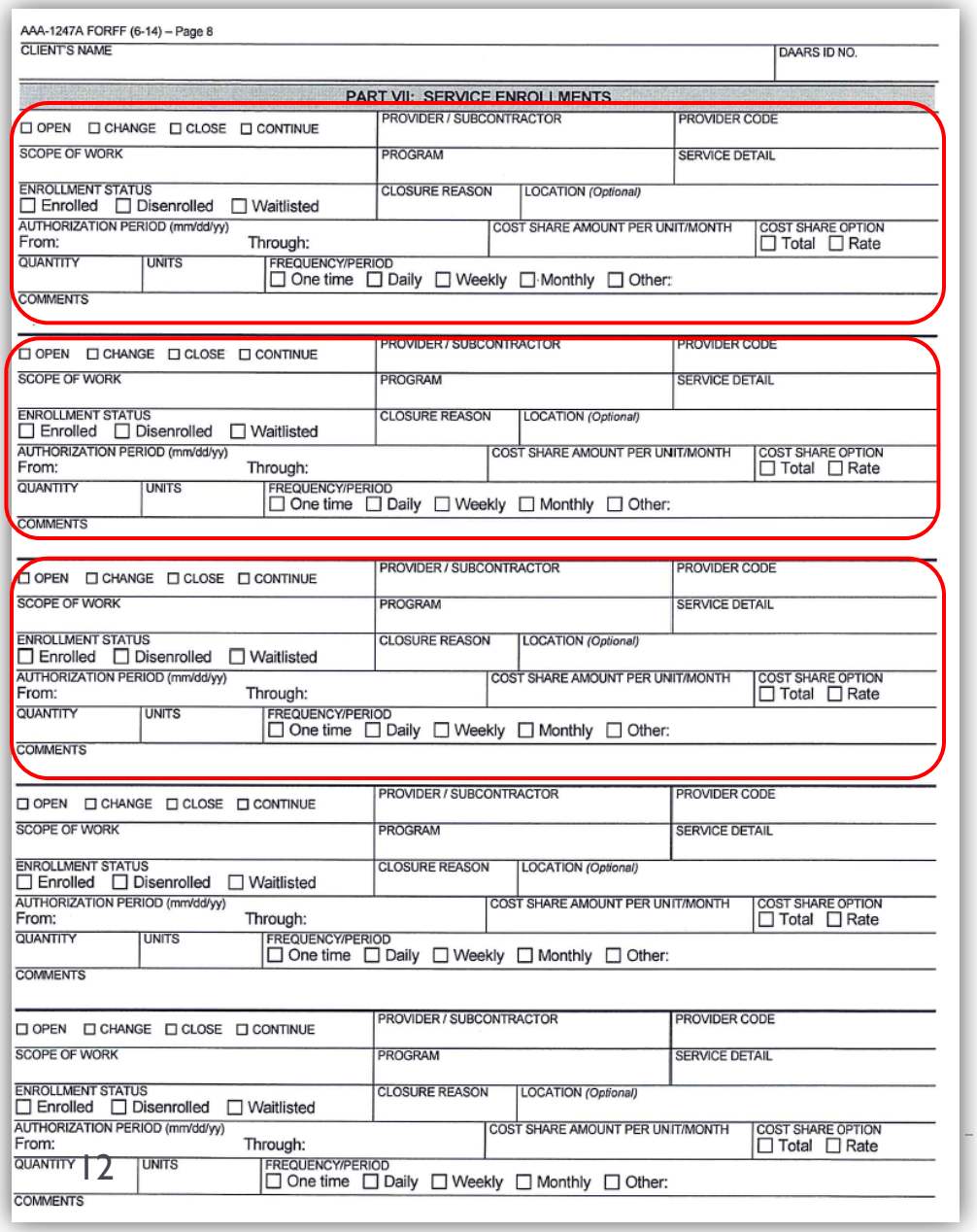
This section intentionally blank. It is not required for the SFID.

<u>Part E: Evacuation Needs Assessment</u>

- If client lives alone, then strongly encouraged to complete this section
- Automatically completed in DAARS
- This section can be used for emergency preparedness
- Partnering with other tribal departments to assist elders in case of emergency

- Part Five: Additional Functional Assessment – Not Required
- Part Six: Unmet Needs – Not Required

SFID Overview – Page #8



AAA-1247A FORFF (6-14) – Page 8

CLIENT'S NAME | DAARS ID NO.

PART VII: SERVICE ENROLLMENTS

☐ OPEN ☐ CHANGE ☐ CLOSE ☐ CONTINUE | PROVIDER / SUBCONTRACTOR | PROVIDER CODE

SCOPE OF WORK | PROGRAM | SERVICE DETAIL

ENROLLMENT STATUS ☐ Enrolled ☐ Disenrolled ☐ Waitlisted | CLOSURE REASON | LOCATION *(Optional)*

AUTHORIZATION PERIOD (mm/dd/yy) From: Through: | COST SHARE AMOUNT PER UNIT/MONTH | COST SHARE OPTION ☐ Total ☐ Rate

QUANTITY | UNITS | FREQUENCY/PERIOD ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:

COMMENTS

(repeated)

(repeated)

(repeated)

(repeated)

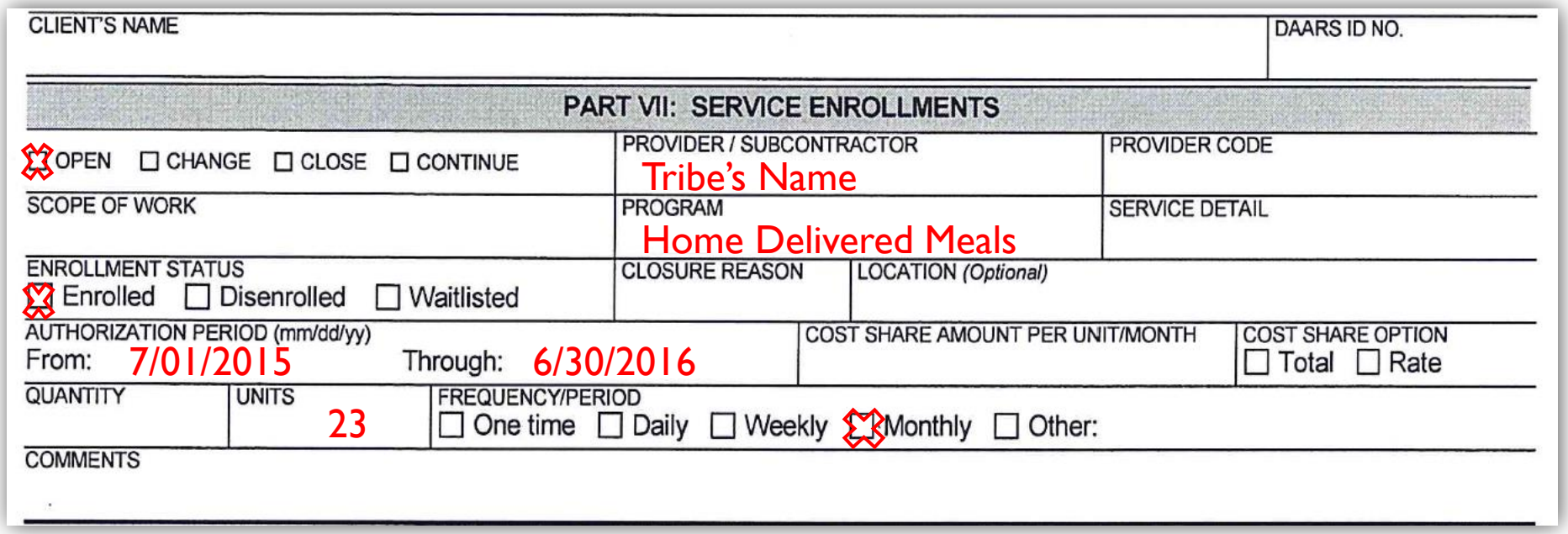
12

Part 7: Service Enrollments

- Provider - Tribe
- Program – Congregate Meals, Home Delivered Meals, etc.
- Enrollment Status – "Enrolled"
- Authorization Period
  - Fiscal Year: 7/1/15 – 6/30/16
- Units
  - 23 units = max days in month
- Frequency Period
  - Monthly

Note: If client has more than one service, i.e. Congregate Meals, Housekeeping, etc. then complete a difference service enrollment for each service.

SFID Form – Service Enrollment Example



CLIENT'S NAME | DAARS ID NO.

PART VII: SERVICE ENROLLMENTS

☒ OPEN ☐ CHANGE ☐ CLOSE ☐ CONTINUE

PROVIDER / SUBCONTRACTOR: Tribe's Name

PROVIDER CODE

SCOPE OF WORK

PROGRAM: Home Delivered Meals

SERVICE DETAIL

ENROLLMENT STATUS: ☒ Enrolled ☐ Disenrolled ☐ Waitlisted

CLOSURE REASON

LOCATION *(Optional)*

AUTHORIZATION PERIOD (mm/dd/yy) From: 7/01/2015 Through: 6/30/2016

COST SHARE AMOUNT PER UNIT/MONTH

COST SHARE OPTION ☐ Total ☐ Rate

QUANTITY

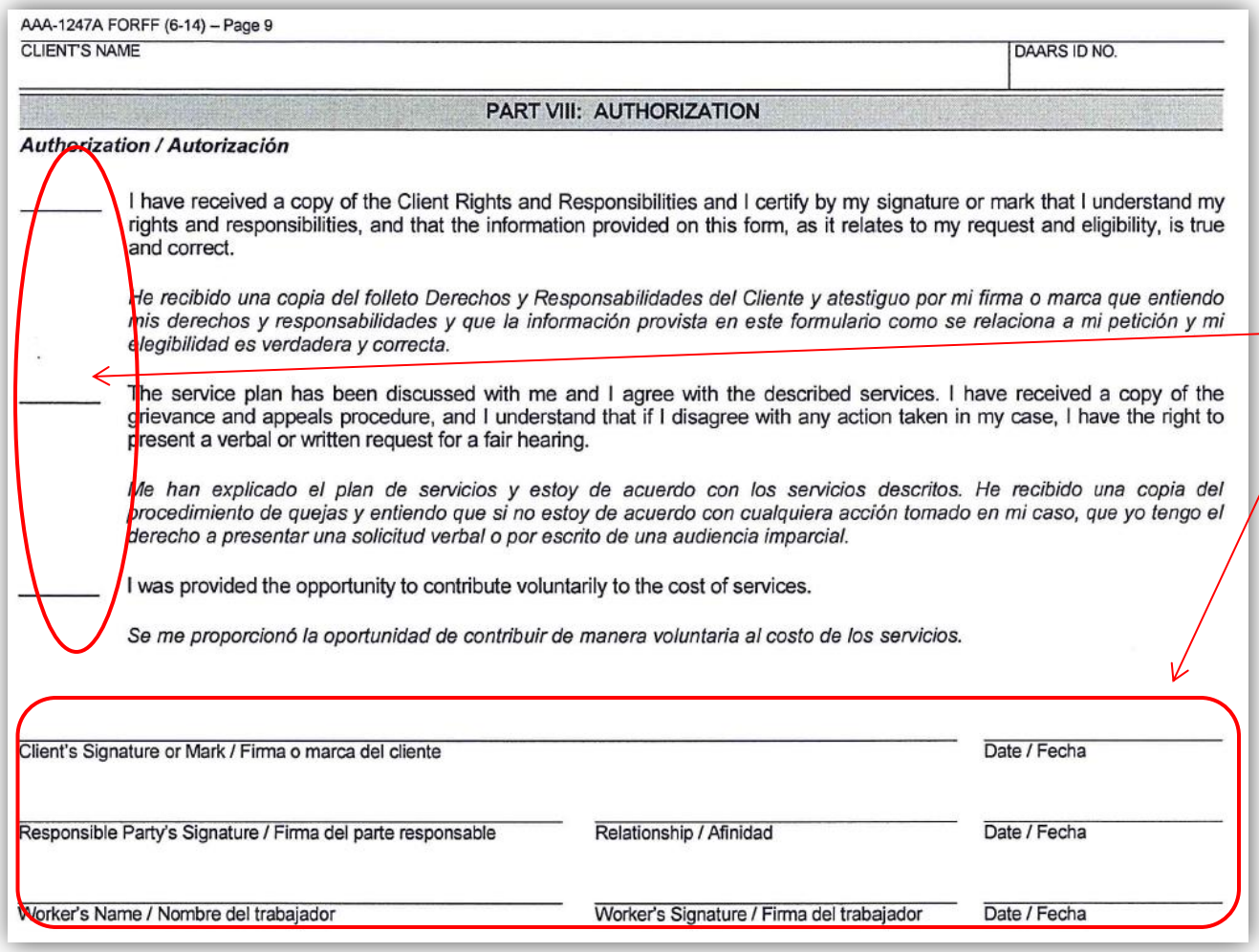
UNITS: 23

FREQUENCY/PERIOD ☐ One time ☐ Daily ☐ Weekly ☒ Monthly ☐ Other:

COMMENTS

Reminder: If client is enrolled in more than one service, then complete a service enrollment for each service.

SFID Overview – Page #9 (Last Page)



AAA-1247A FORFF (6-14) – Page 9

CLIENT'S NAME | DAARS ID NO.

PART VIII: AUTHORIZATION

Authorization / Autorización

_____ I have received a copy of the Client Rights and Responsibilities and I certify by my signature or mark that I understand my rights and responsibilities, and that the information provided on this form, as it relates to my request and eligibility, is true and correct.

He recibido una copia del folleto Derechos y Responsabilidades del Cliente y atestiguo por mi firma o marca que entiendo mis derechos y responsabilidades y que la información provista en este formulario como se relaciona a mi petición y mi elegibilidad es verdadera y correcta.

_____ The service plan has been discussed with me and I agree with the described services. I have received a copy of the grievance and appeals procedure, and I understand that if I disagree with any action taken in my case, I have the right to present a verbal or written request for a fair hearing.

Me han explicado el plan de servicios y estoy de acuerdo con los servicios descritos. He recibido una copia del procedimiento de quejas y entiendo que si no estoy de acuerdo con cualquiera acción tomado en mi caso, que yo tengo el derecho a presentar una solicitud verbal o por escrito de una audiencia imparcial.

_____ I was provided the opportunity to contribute voluntarily to the cost of services.

Se me proporcionó la oportunidad de contribuir de manera voluntaria al costo de los servicios.

Client's Signature or Mark / Firma o marca del cliente — Date / Fecha

Responsible Party's Signature / Firma del parte responsable — Relationship / Afinidad — Date / Fecha

Worker's Name / Nombre del trabajador — Worker's Signature / Firma del trabajador — Date / Fecha

<u>Required Items:</u>

- Client's initials
- Client's Name
- Client's signature
- Worker's Name
- Worker's Signature

Contact Information

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