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| * COMPLETE SECTIONS I, II and VII ONLY for codes **(180)-**Congregate Nutrition, **(181)**-Congregate Nutrition-NSIP, and **(182)**-Congregate Nutrition Supplemental Meals.
 |
| * COMPLETE SECTIONS I and VII ONLY for codes **(250)**-Transportation, **(033)**-Transportation (Medical) and (252) Transportation-Pilot Bus Pass Program.
 |
| * COMPLETE SECTIONS I, VI, and VII for Family Caregiver Support Program/Project C.A.R.E. **(all FCSP codes in series 820, 830, 840, 850 – EXCEPT codes 821, 822, 831, 841, 851, 861.** For Care Recipient complete SECTIONS III, IV and V**.**
 |
| * COMPLETE SECTIONS I, IV, and VII for codes **235, 236, 237, 238**-In-Home Aid Respite, **309**-Group Respite, **210**-Institutional Respite. Enter data for hands-on recipient, not the caregiver. If applicable, complete Sections V and VI.
 |
| * COMPLETE SECTIONS I, II, IV, VII for codes **020**-Home Delivered Meals, **021**-Home Delivered Meals-NSIP, **022**-Home Delivered Meals Supplemental, and **610**-Care Management. If applicable, complete Sections V and VI.
 |
| * COMPLETE SECTIONS I, IV, and VII for all other HCCBG services. If applicable, complete Sections V and VI.
 |
| **Service Codes:** Click or tap here to enter text. | **Region Code:** Click or tap here to enter text. | **Provider Code:** Click or tap here to enter text. |
| ***CLIENT STATUS: Check the Appropriate box(es) and enter the date.*** |
| [ ]  **New Registration** | DATE: Click or tap to enter a date. |
| [ ]  **Activation** | DATE: Click or tap to enter a date. |
| [ ]  **Waiting for Service** *[Complete Section I ONLY]* | DATE: Click or tap to enter a date. *(enter 3 service codes):* Click or tap here to enter text. |
| [ ]  **Change of Information** | DATE: Click or tap here to enter text. *(complete Section I when a change is needed for any client information)* |
| [ ]  **Inactive** – DATE: Click or tap to enter a date. *(check box below) (make inactive only if permanently leaving ARMS)**If client is a caregiver receiving FCSP/Project C.A.R.E. services and the client inactive reason relates more to CR status, check Care Recipient box.*Reason for making client inactive applies to: ☐ Client/Caregiver ☐ Care Recipient |
| [ ]  Moved to adult care home/assisted living[ ]  Alternative living arrangement[ ]  Death[ ]  Hospitalization (not expected to return) [ ]  Nursing home placement | [ ]  Moved out of service area[ ]  Improved function/Need eliminated[ ]  Service not needed/wanted[ ]  Illness (not expected to return)[ ]  Other (specify): Click or tap here to enter text. |
| **SECTION I: CLIENT/CAREGIVER INFORMATION (Required for *ALL* Clients/For FCSP the Caregiver is the Client)** |
| **Legal Name:** Last Click or tap here to enter text. | First Click or tap here to enter text. | M.I. Click or tap here to enter text. |
| Suffix Click or tap here to enter text. | **Last 4 Digits SSN:** Click or tap here to enter text. | **Phone:** Click or tap here to enter text.☐ No phone |
| **Address** Click or tap here to enter text.**County:** Click or tap here to enter text. | **Email** Click or tap here to enter text. | **DOB:** Click or tap here to enter text.[ ]  *Check if special eligibility* |
| **City:** Click or tap here to enter text. | **State:** Click or tap here to enter text. | **Zip:** Click or tap here to enter text. |
| **Sex***(check one)*[ ]  Female[ ]  Male | **At/Below Poverty Level?***(check one)*[ ]  Yes[ ]  No | **Marital Status** *(check one)*[ ]  Single [ ]  Divorced[ ]  Married [ ]  Widowed[ ]  Separated [ ]  Partnered[ ]  Client Refused [ ]  Unknown | **Household Status** *(check one)*[ ]  Lives alone [ ]  Lives with Other[ ]  Unknown [ ]  Client Refused[ ]  Lives in Long Term Care (LTC) facility [Legal Assistance is the only service to collect "Lives in Long Term Care (LTC) facility"] |
| **Race** (Check all that apply)[ ]  Black or African American [ ]  White [ ]  Asian or Asian American [ ]  Native Hawaiian or Pacific Islander[ ]  American Indian or Alaska Native[ ]  Refused/Unknown/Not Reported | **Ethnicity (Are you of Hispanic or Latino Origin?)**[ ]  Hispanic or Latino[ ]  Not Hispanic or Latino[ ]  Unreported/Missing/Client Refused |
| **Primary Language Spoken:** [ ] English [ ] Spanish[ ] Other Click or tap here to enter text. [*see languages in Client Registration Form (CRF) manual]* |
| **Name of Emergency Contact:** Click or tap here to enter text. [ ]  Refused to provideCell#: Click or tap here to enter text. Home#: Click or tap here to enter text. Day#: Click or tap here to enter text. |
| **Caregiver’s Overall Functional Status:** [ ]  Well [ ]  At risk [ ]  High risk***(When the CAREGIVER IS REGISTERED AS THE CLIENT, use this field for the CAREGIVER’S SELF-REPORTED functional status and complete Section IV for Care Recipient.) If SECTION IV is required, SKIP THIS QUESTION. ARMS will automatically calculate the Caregiver’s Overall Functional Status when SECTION IV is entered.*** |

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| **SECTION II: Required *ONLY* for clients of HCCBG Congregate Nutrition, Home-Delivered Meals, Congregate Nutrition Supplemental Meals, Home Delivered Meals Supplemental, NSIP (only meals), and Care Management services.** |
| **Nutrition Health Score** |
| **Assessment Date:** Click or tap to enter a date.  | **Response** | **Refuse** |
| 1. Do you have an illness or condition that made you change the kind and/or amount of food you eat?
 | [ ]  Yes [ ]  No |[ ]
| 1. How many meals do you eat per day?
 | Click or tap here to enter text. |[ ]
| 1. How many servings of fruit do you eat per day?
 | Click or tap here to enter text. |[ ]
| 1. How many servings of vegetables do you eat per day?
 | Click or tap here to enter text. |[ ]
| 1. How many servings of milk/dairy products do you consume per day?
 | Click or tap here to enter text. |[ ]
| 1. How many drinks of beer, liquor, or wine do you have every day or almost every day?
 | Click or tap here to enter text. |[ ]
| 1. Do you have tooth/mouth problems that make it hard for you to eat?
 | [ ]  Yes [ ]  No |[ ]
| 1. Do you always have enough money or food stamps to buy the food you need?
 | [ ]  Yes [ ]  No |[ ]
| 1. How many meals do you eat alone daily?
 | Click or tap here to enter text. |[ ]
| 1. How many prescribed drugs do you take per day?
 | Click or tap here to enter text. |[ ]
| 1. How many over-the-counter drugs do you take per day?
 | Click or tap here to enter text. |[ ]
| 1. Have you lost 10 or more pounds in the past 6 months without trying?
 | [ ]  Yes [ ]  No |[ ]
| 1. Have you gained 10 or pounds in the past 6 months without trying?
 | [ ]  Yes [ ]  No |[ ]
| 1. Are you physically able to shop for yourself?
 | [ ]  Yes [ ]  No |[ ]
| 1. Are you physically able to cook for yourself?
 | [ ]  Yes [ ]  No |[ ]
| 1. Are you physically able to feed yourself?
 | [ ]  Yes [ ]  No |[ ]

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| **SECTION III: Care Recipient Data (not caregiver) for Family Caregiver Support Program/ Project C.A.R.E. services.** |
| **CARE RECIPIENT #1 (Adult/Child) (For additional Care Recipients, attach an additional DAAS-101, Sections III, IV, and V.)** |
| **Name:** Last Click or tap here to enter text. | First Click or tap here to enter text. | M.I. Click or tap here to enter text. |
| **Suffix** Click or tap here to enter text. | **Last 4 Digits SSN/zeros:** Click or tap here to enter text. | **Phone:** Click or tap here to enter text.☐ No phone |
| **Address** Click or tap here to enter text. | **DOB:** Click or tap here to enter text. | **Sex:** [ ]  Male [ ]  Female [ ]  Other |
| **City:** Click or tap here to enter text. | **State:** Click or tap here to enter text. | **Zip:** Click or tap here to enter text. |
| Is Care Recipient a person with (a) severe disability(ies)? [ ] Yes [ ]  No |
| Does the Care Recipient live in same household as Caregiver? [ ]  Yes [ ]  No |
| **Marital Status:** [ ]  Single [ ]  Married [ ]  Separated [ ]  Divorced [ ]  Partnered [ ]  Refused [ ]  Widowed [ ]  Unknown |
| **SECTION IV: Client/Care Recipient Data (not caregiver)/ not required for Children Under 18 Receiving Care by FCSP.**  |
| Is the client/care recipient's daily life significantly affected due to memory loss or a cognitive impairment? [ ]  Yes [ ]  No |
| Has a doctor/healthcare professional diagnosed care recipient with Alzheimer's disease or a related dementia? [ ]  Yes [ ]  No |
| **IADLS** *(Client/CR can do without help; select Yes/No)* | **ADLS** *(Client/CR can do without help; select Yes/No)* |
|  | Yes | No |  | Yes | No |  | Yes | No |  | Yes | No |
| Food Preparation  | [ ]  | [ ]  | Use Telephone | [ ]  | [ ]  | Feeding | [ ]  | [ ]  | Toileting | [ ]  | [ ]  |
| Shopping | [ ]  | [ ]  | Housekeeping | [ ]  | [ ]  | Dressing | [ ]  | [ ]  | Transferring | [ ]  | [ ]  |
| Manage Medications | [ ]  | [ ]  | Laundry | [ ]  | [ ]  | Bathing | [ ]  | [ ]  | Continence | [ ]  | [ ]  |
| Manage Finances  | [ ]  | [ ]  | Use Transportation  | [ ]  | [ ]  | **TOTAL ADL SCORE:** Click or tap here to enter text. |
| **TOTAL IADL SCORE:** Click or tap here to enter text. |
| **Unpaid caregivers (include primary caregiver)** Click or tap here to enter text. ***[ONLY ANSWER for Respite, FCSP, and Project CARE services. Otherwise, enter “0” in ARMS and skip to Section VII on the DAAS-101.]*** |
| ***SECTION V: Complete for HCCBG respite, FCSP, and Project C.A.R.E. if “unpaid caregiver” = 1 or more in previous question.*** |
| How many hours of care does Care Recipient need? Click or tap here to enter text. [ ]  Day [ ]  Week |
| How many hours does Caregiver usually spend providing care for the Care Recipient? Click or tap here to enter text. [ ]  Day [ ]  Week |
| **Primary Caregiver Relationship to Care Recipient:** *(ONLY check one)* |
| [ ]  Wife[ ]  Husband[ ]  Parent  | [ ]  Sister[ ]  Brother[ ]  Grandparent | [ ]  Non-Relative[ ]  Other Relative[ ]  Son/Son-in-Law[ ]  Daughter/Daughter-in-Law | [ ]  Domestic partner, including civil union[ ]  Older Non-Relative (FCSP)[ ]  Other Older Relative (FCSP) |
| Is the primary caregiver a long-distance caregiver? [ ]  Yes [ ]  No **[If YES, please answer the next questions by listing the NC county or State.]** |
| [ ]  **Distance Caregiver** (list NC county Click or tap here to enter text.)[ ]  **Out of State** (list state Click or tap here to enter text.) |

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| **SECTION VI: Complete for *ALL* Caregivers** |
| **In general, would you say that the Caregiver’s health is:**  | Excellent(5)[ ]  | Very Good (4)[ ]  | Good (3)[ ]  | Fair (2)[ ]  | Poor (1)[ ]  |
| **How stressful for you is caregiving:**  | Extremely (5)[ ]  | Very (4)[ ]  | Moderately (3)[ ]  | Slightly (2)[ ]  | Not at all (1)[ ]  |
| **Primary Caregiver Employment Status:**[ ]  Full-time [ ]  Part-time [ ]  Quit due to caregiving [ ]  Is/was not working[ ]  Retired early due to caregiving [ ]  Retired [ ]  Lost job/dismissed due to caregiving[ ]  Refused [ ]  Other (please specify) Click or tap here to enter text. |
| **SECTION VII: Required for *ALL* Clients** |
| I, the client, understand the information contained on this form will be kept confidential unless disclosure is required by court order or for authorized federal, state or local program reporting and monitoring. I understand that any entitlement I may have to Social Security benefits or other federal or state sponsored benefits shall not be affected by the provision of the aforementioned information. My signature authorizes the providing agency to begin the service(s) requested. |
| **DATE:** Click or tap to enter a date. **CLIENT/CAREGIVER SIGNATURE:** Click or tap here to enter text.**DATE:** Click or tap to enter a date. **AGENCY EMPLOYEE SIGNATURE:** Click or tap here to enter text. |
| **Provider Use Only – initial below after re-assessment:**Registration Update: Click or tap to enter a date. Staff Initials Click or tap here to enter text.Registration Update: Click or tap to enter a date. Staff Initials Click or tap here to enter text.Registration Update: Click or tap to enter a date. Staff Initials Click or tap here to enter text. |
| **NOTES/COMMENTS:**Click or tap here to enter text. |