Division of Aging and Adult Services Manual

Client Registration Form (DAAS 101) Instructions

Effective Date: July 1, 2006
Last Update: August 16, 2006

Client Registration Form (DAAS 101) Instructions

A. Purpose

The purpose of the Client Registration Form (DAAS 101) is to collect and record client registration data and changes in client information and service status that will be entered into the Division of Aging and Adult Services' Aging Reporting Management System (ARMS). Complete and accurate client information will provide valuable reports, reimbursement information, and outcome measures at the state and local level.

B. General Instructions

1. The Client Registration Form (DAAS 101) is to be completed by all service providers for *each* client who receives certain services funded by the Division of Aging and Adult Services (DAAS) under the Home and Community Care Block Grant (HCCBG) and the Family Caregiver Support Program (FCSP). Departments of Social Services who provide in-home aide, adult day care, adult day health care, or housing and home improvement with HCCBG funding are to complete DAAS 101 *and* the DSS 5027. Departments of Social Services should continue to follow current procedures for the DSS 5027.

2. The DAAS 101 must be completed at the time of the client's first contact with the provider agency with the intent to receive services. Service requests that have a waiting list must complete Section I only.

3. Information in the client record must be updated at least every 12 months, except for home-delivered meal clients who are updated every six months. When there are changes to record, a blank DAAS 101 should be completed. If there are no changes, space is provided at the end of the form to document the date that the information was reviewed with the client.

4. Providers are responsible for keying their own data through direct access to the ARMS via the Internet. The DAAS 101 is keyed directly on-line in the ARMS. The Division of Aging and Adult Services will receive all client data by 5:00 p.m. on or before the 11th calendar day of each month. The ARMS Client Database will be updated on the 12th calendar day of each month. The ARMS deadline schedule is posted at http://www.dhhs.state.nc.us/aging/arms/armspage.htm

5. Once a client is entered into the system by means of a Client Registration Form, any provider may report changes or units of service for the client. There is only one client record per client, regardless of the number of providers serving a client.

C. Specific Instructions for Client Registration Form Completion

SECTION I: (REQUIRED ENTRY) This section of the Client Registration Form is required for all clients receiving a unit-based service or services through the Family Caregiver Support Program. Check the applicable category or categories listed and write the service code in the "Service Codes" column. Follow the corresponding directions for the appropriate service.

1. For clients who are being registered to receive HCCBG congregate nutrition, congregate supplemental meals, and NSIP-only congregate meals, complete **Sections I, II and VII** of the Client Registration Form.

2. For clients who are being registered to receive HCCBG general or medical transportation, complete **Sections I and VII** of the Client Registration Form.

3. For clients who are being registered to receive any Family Caregiver Support Program (FCSP) service and/or HCCBG respite services (in-home aide respite, group respite, or institutional respite), complete **Sections I, VI, and VII** on the caregiver and complete **Sections III, IV, and V** on the care recipient.

   For FCSP Grandparents Raising Grandchildren Services, completion of **Sections I and VII** only for the caregiver and **Section III #16-18** only for the care recipient (minor child) are required.

4. For clients who are being registered to receive care management, home- delivered meals, NSIP-only home-delivered meals, and/or home-delivered supplemental meals, complete **Section I, II, IV, V** (if appropriate)**, VI** (if appropriate)**, and VII** of the Client Registration Form.

5. For clients who are being registered to receive any other service not mentioned above, complete **Sections I, IV, V** (if appropriate)**, VI** (if appropriate)**, and VII** of the Client Registration Form.

REGION CODE - Enter the appropriate one-digit alpha or numeric character (A-R, 1, 2, 3, 4, 5, 6, 7, 8, 9, and 0).

PROVIDER CODE - Enter the appropriate region code letter followed by a three-digit provider code for the provider completing the registration. (Example: A099)

1) Client Status (Check the appropriate box)

- **New Registration/Activate** – Select this option if this is the first time (to your knowledge) the client is being registered for service(s) with your agency. If "New Registration/Activate" is checked, all appropriate data fields (see instructions for

Section I above) must be completed. Enter the **Date** the client is being registered, not the date of data entry.

- **Waiting for Service** – Select this option to indicate if the client being registered is waiting for service(s). Enter up to three (3) service codes for the specific service(s) the client is waiting to receive. Enter the **Date** the client is being registered as "Waiting for Service". Complete Section I only of the DAAS 101 when a client is being registered as waiting for service.

- **Inactive** – "Inactive" status means that it is the understanding of the provider that the client is *permanently,* not temporarily, terminating from **all services**. If necessary, an inactive client may be returned to active enrollment using the "New "Registration/Activate" status code.

There are two selections that must be completed on this item (1) to whom does the reason for termination apply, and (2) what is the reason for termination.

(1) <u>To whom does the reason for termination apply:</u>

<u>Applies to Client/Caregiver</u>

- Select when the reason for inactivity relates to the person who is registered in **Section I.**

OR

<u>Applies to care recipient</u>

- Select when the reason for inactivation relates to the care recipient registered in **Section III**.

To illustrate, the following examples are provided:

Example 1: Mrs. Jones receives respite in-home aide service to help with the care of her husband and is registered in ARMS as the client/caregiver. Mr. Jones is placed in a nursing home, and Mrs. Jones terminates services.

- Check the box beside "**applies to care recipient**", AND
- Check the box beside "nursing home placement".

Example 2: Mr. Johnson has been attending a monthly caregiver support group through the Family Caregiver Support Program and is registered in ARMS as a client/caregiver. Mr. Johnson is moving to another state and terminates services.

- Check the box beside "**applies to client/caregiver**", AND
- Check the box beside "moved".

Example 3: Mr. Smith receives home-delivered meals. He is registered in ARMS as the client/caregiver. He decides that he is now well enough to make his own lunch, so he cancels the service.

- Check the box beside "**applies to client/caregiver**", AND
- Check the box beside "improved function/need eliminated".

Example 4: Mr. Davis receives home-delivered meals. He is registered in ARMS as the client. His daughter, who has been providing other supports for him, and is *not* registered in ARMS as a client/caregiver, moves out of town and places Mr. Davis in a nursing home.

- Check the box beside **"applies to client/caregiver"**, AND
- Check the box beside "nursing home placement".

(2) What is the reason for termination? Select the appropriate box (one only) to indicate the reason the client is being placed on an "Inactive" status.

❒ *"Adult care home/assisted living"* means the client has moved to one of these types of facilities and no longer needs services.

❒ *"Alternative living arrangement"* means the client has made other living arrangements, such as living with a family member, and no longer needs services.

❒ "*Death"* means client is deceased.

❒ "*Hospitalization"* means client has been hospitalized and is not expected to return to active status.

❒ "*Nursing home placement"* means client has been placed in a skilled nursing facility and no longer needs services.

❒ "*Moved"* means client has moved out of the provider's service area.

❒ "*Improved function/need eliminated"* means client's status has improved, eliminating the need for services.

❒ "*Service not needed/wanted"* means client no longer needs or wants service(s) for reasons other than those above.

❒ "*Other"* – For clients identified as "Inactive" for a reason other than the options listed above, write the reason in the blank provided.

The **Date** entered is the date that the client experienced the reason for the change in status, *not* the date of data entry.

- **Change** – Select this client status option when making a routine change to any item, including changes to information as the result of an update of the client information

  OR

  Select this option when an existing client needs to be activated for a new service and additional information must be obtained on the client.

  When reporting a change, fill out a new form (use a blank DAAS 101) and complete the following required fields: **Section I**, questions #2, #4, #5, and any additional items related to the specific change being reported. Enter the **Date** the client's status

changed.

2) **Name** - Enter the client's name. Middle initial may be entered if known but is not required. First and last names are **REQUIRED ENTRIES**. Enter last name first.

3) **Mailing address** –
   - Enter the physical address on *Line 1*. If physical address and mailing address are the same, leave Line 2 blank.
   - If *mailing* address is different from *physical* address, use address *Line 2* to enter the *mailing* address.
   - If mail is sent *in care of* another individual, enter that individual's name on *Line 1*.
   - See the Mailing Address Appendix for correct abbreviations. Use correct abbreviations in all situations in order to conserve space and assure consistency.

     EXAMPLES:
     Line 1 – 325 Central Ave.
     Line 2 – P.O. Box 456

     Line 1 – c/o Ralph Smith
     Line 2 - 234 Grant Ave.

     Line 1 – 111 Main St.
     Line 2- {blank}

   Enter the City, State, and first five (5) digits of the Zip Code. **(REQUIRED ENTRY).** If the four-digit extension is available for the zip code you may enter as part of the zip code, but it is not required.

   County - **(REQUIRED ENTRY).** Enter the name of the client's county of residence.

4) **Last four digits of Social Security Number** - Enter the last four digits of the client's nine-digit Social Security Number. Senate Bill 1048 prohibits use of complete Social Security Numbers. A client cannot be denied service because he/she does not have or refuses to provide the last four digits of his/her Social Security Number. However, the system REQUIRES a unique identifier be provided for each client to record units of service provided and generate reimbursement. If a client does not have a Social Security Number, he/she should be encouraged to obtain one from the local Social Security office.

   Assigning a Number – Clients who do not provide the last four digits of their Social Security Number are to be assigned a four-digit number consisting of the client's birth month and day. For example, a client born on July 15 would be assigned the number "0 7 1 5".

5) **Date of Birth** – **(REQUIRED ENTRY**). Enter the client's numeric date of birth. Precede one-digit months and days with a zero (0) and enter the four (4) digits of the

calendar year in which the client was born.

For example, 01 01 1940

Special Eligibility - A client is determined to be a special eligibility client if they will be receiving specified nutrition services (service codes 180, 181,182, 020, 021, 022) when the following conditions exist:

a. An adult under 60 years of age may receive congregate meals, home-delivered meals, and/or transportation to a congregate meal site if their spouse is age 60 or older *and* receiving the same service;
b. An adult under 60 years of age may receive a home-delivered meal if disabled and living in the same household as a relative who is 60 years of age or older *and* receiving the service;
c. A person with disabilities under 60 years of age may receive congregate meals if residing in a congregate housing facility which serves as a congregate nutrition site for older adults;
d. A volunteer under age 60 providing service during meal hours may be offered a meal.

6) **Phone Number** - Enter the client's telephone number or a number where he/she can be reached. Area codes are essential. If the client does not have a telephone, check the box indicating "No phone".

7) **Sex – (REQUIRED ENTRY)**. Check the appropriate box indicating the client's sex.

8) **At/below Poverty Level – (REQUIRED ENTRY)**. Check "Yes" if the client has an income at or below 100% of the poverty level. Check "No" if the client is above 100% of the poverty level.

The poverty rates change on an annual basis and are published by the U.S, Department of Health and Human Services. The following table will assist in determining the appropriate response.

Number in Household	100% Poverty*
1	$ 9,800
2	$ 13,200
3	$ 16,600
4	$ 20,000

* Note: The poverty rates listed above were effective January 2006.
For current poverty rates see http://aspe.hhs.gov/poverty/

9) **Marital Status – (REQUIRED ENTRY).** Check one box to indicate the marital status of the client as “single (never married)”; “married”; “single (divorced/widowed)”, or “refused to answer”. (Clients who identify as “single” should choose either

"divorced/widowed" or "never married" as appropriate.)

10) **Household size – (REQUIRED ENTRY).** Select the size of the client's household as:
    - lives alone (in their own home or a private residence);
    - 2 in home (in their own home or a private residence);
    - 3 or more in home (in their own home or a private residence);
    - group or shared home (lives in adult care home, assisted living unit or group home); or
    - client refused to answer.

11) **Race** - Ask the client "What is your race?" Check each race with which the client identifies. Ask the client if there is one race with which he or she most closely identifies.

12) **Hispanic/Latino (Ethnicity)** – Check "YES" if the client reports being a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture of origin, regardless of race. Check "NO" if they do not.

13) **Primary language spoken** - Write the primary language the client says he/she speaks at home. Select from the language options listed below:

Language Name	Language Name
Arabic	Laotian
Cambodian	Miao
Chinese	Mon-Khmer
English	Other
French Creole	Portuguese Creole
French	Persian
German	Portuguese
Greek	Polish
Guiarati	Russian
Hindi	Serbo-Croatian
Hmong	Spanish
Hungarian	Tagalog
Italian	Thai
Japanese	Urdu
Korean	Vietnamese

14) **Overall Functional Status** – If Section IV is required, this question should be omitted because ARMS will automatically calculate the Overall Functional Status once Section IV is entered. The Overall Functional Status field is used as a mechanism to categorize clients for reporting purposes and includes an evaluation of activities of daily living and instrumental activities of daily living as determined by the client or caregiver. Designating an overall functional status does not represent a functional assessment of the client. If Section IV is not completed, accept client self-report as one of the following: Well; At-Risk; or High Risk (Frail). See questions #21 and #22 for

definitions of Instrumental Activities of Daily Living (IADL) impairments and Activities of Daily Living (ADL) impairments. For clarification, each category is defined as follows:

Well

- Client has no (0) IADL impairments AND
- No (0) ADL impairments AND
- Is *not* cognitively impaired (see question #20)
  - Persons free of significant functional impairment and are physically able to manage routine daily tasks independently.
  - This includes persons who use assistive devices such as wheelchairs, canes, or walkers, provided the client feels that they manage adequately on their own.

At Risk

- Client has 1 - 2 IADL impairments; AND/OR
- Client has 1 - 2 ADL impairments: OR
- Client is cognitively impaired (see questions #20) and has less than 3 IADL impairments.

High Risk (Frail)

- Client has 3 or more ADL impairments; OR
- Client is cognitively impaired (see question #20) and has at least 3 IADL impairments.

SECTION II: Completion of this section is required ONLY for clients who are being registered for HCCBG congregate nutrition, home-delivered meals, congregate or home-delivered supplemental meals, NSIP-only meals, and/or care management.

15) **Nutritional health score**: The following questions require the client to respond with either a "yes" or "no" *or* with a specific number (1, 2, 3, 4, etc.). Check the box in the last column should client refuse to answer a question.

Note: Clarification of “serving size” is found in DAAS Nutrition Service Standards.

SECTION III: This section is required ONLY for care recipients (not the caregiver) whose caregivers are to receive Home and Community Care Block Grant (HCCBG) respite care (in-home aide respite, group respite, or institutional respite) or the services funded by the Family Caregiver Support Program (FCSP). When registering an unpaid caregiver for service(s), enter **caregiver** information into **Section I** and enter information on the **care recipient** into **Section III.** For care recipients (minor children) registering for FCSP Grandparent Raising Grandchildren, **complete # 16-18 only**.

CARE RECIPIENT # 1: **(REQUIRED ENTRY).** This section of the form is designed to obtain information on at least one (1) care recipient. If the registered caregiver is caring for more than one (1) care recipient, attach additional forms, as needed, one for each care recipient. The web-based ARMS will allow for multiple entries of care recipient

information.

16) **Name** - Enter the care recipient's name. Middle initial may be entered, if known, but is not required. First and last names are **REQUIRED ENTRIES**. Enter last name first.

Mailing address –

- Enter the physical address on *Line 1*. If physical address and mailing address are the same, leave Line 2 blank.
- If *mailing* address is different from *physical* address, use address *Line 2* to enter the *mailing* address.
- If mail is sent *in care of* another individual, enter that individual's name on *Line 1*.
- See the Mailing Address Appendix for correct abbreviations. Use correct abbreviations in all situations in order to conserve space and assure consistency.

EXAMPLES:
Line 1 – 325 Central Ave.
Line 2 – P.O. Box 456

Line 1 – c/o Ralph Smith
Line 2 - 234 Grant Ave.

Line 1 – 111 Main St.
Line 2- {blank}

Enter the City, State, and first five (5) digits of the Zip Code. **(REQUIRED ENTRY).** If the four-digit extension is available for the zip code you may enter as part of the zip code, but it is not required.

County - **(REQUIRED ENTRY).** Enter the name of the client's county of residence.

Date of Birth - Enter date of birth of the care recipient as mm/dd/yyyy.

Last four digits of Social Security Number - Enter the last four digits of the care recipient's nine-digit Social Security Number. Senate Bill 1048 prohibits use of complete Social Security Numbers. A client cannot be denied service because he/she does not have or refuses to provide the last four digits of his/her Social Security Number. However, the system REQUIRES a unique identifier be provided for each client to record units of service provided and generate reimbursement. If a client does not have a Social Security Number, he/she should be encouraged to obtain one from the local Social Security office.

Assigning a Number – Clients who do not provide the last four digits of their Social Security Number are to be assigned a four-digit number consisting of the client's birth month and day. For example, a client born on July 15 would be assigned the number "0 7 1 5".

17) **Is care recipient a minor child with mental retardation or developmental disability?** Check "YES" only if service is for FCSP Grandparent Raising Grandchildren (or blood relative) raising child age 18 or under who is mentally retarded or developmentally disabled.

18) **Does the care recipient live in the same household as caregiver**? Indicate "yes or no" if the care recipient resides in the same household as their caregiver.

19) **Care recipient marital status**: Check one box to indicate the marital status of the adult care recipient as "single (never married)"; "single (divorced/widowed)", "married"; or "refused to answer". (Care recipients who identify as "single" should choose either "divorced/widowed" or "never married" as appropriate.)

SECTION IV: This section is to be completed for all clients/care recipients *except* congregate nutrition, congregate nutrition supplemental meals, congregate -NSIP- only, transportation, or minor relative children under the Family Caregiver Support Program.

20) **Does the care recipient have significant memory loss or confusion?** This item requires "yes" or "no" response. The response is not a clinical diagnosis, but a way to identify possible cognitive impairment of individuals receiving services.

a. **Answer YES if** the person or agency making the referral for the service (e.g., family member, caregiver, social worker, physician, etc.) indicates that the client has a significant impairment in short and/or long-term memory, thinking, judgment or decision-making affecting daily activities. The impairment may or may not have been diagnosed by a medical professional.

OR

If it appears that the client, based on the service provider's professional staff assessment, has significant impairments in short and/or long-term memory, thinking, judgment or decision-making.

OR

b. **Answer NO if** there is no indication of a significant memory problem from the referral source, the family, or the provider's professional assessment.

Possible warning signs of significant cognitive impairment
• **Memory loss.** Forgetting recently learned information is one of the most common early signs of dementia. • **Difficulty performing familiar tasks.** People with dementia often find it hard to plan or complete everyday tasks. Individuals may lose track of the steps

involved in preparing a meal, placing a telephone call or shopping, managing medications, etc.

- **Problems with language.** People with Alzheimer's disease often forget simple words or substitute unusual words, making their speech or writing hard to understand.
- **Disorientation to time and place.** People with Alzheimer's disease can become lost in their own neighborhood, forget where they are and how they got there, and not know how to get back home.
- **Poor or decreased judgment.** Those with Alzheimer's or other types of dementia may dress inappropriately, wearing several layers on a warm day or little clothing in the cold. They may show poor judgment, like giving away large sums of money to telemarketers.
- **Problems with abstract thinking.** Someone with Alzheimer's disease or other types of dementia may have unusual difficulty performing complex mental tasks, like forgetting what numbers are for and how they should be used.
- **Misplacing things.** A person with Alzheimer's disease or other types of dementia may put things in unusual places.
- **Changes in mood or behavior.** Someone with Alzheimer's disease may show rapid mood swings - from calm to tears to anger - for no apparent reason. People with other types of dementia may experience mood problems as well.
- **Changes in personality.** The personalities of people with dementia can change dramatically. They may become extremely confused, suspicious, fearful or dependent on a family member.

21) **Number of instrumental activities of daily living (IADL) impairments.** *(Note: The IADL categories have been revised effective 7-1-2006 to reflect the categories required for federal reporting.)*

IADLS are required for the following services: in-home aide (including respite), senior companion, skilled home health care, home-delivered meals, home- delivered supplemental meals, home-delivered NSIP-only meals, group respite, institutional respite, adult day services (adult day care, adult day health), care management, housing and home improvement, and the Family Caregiver Support Program (except for Grandparents Raising Grandchildren Services).

a. Check "yes" or "no" in the boxes corresponding to each IADL (items a – h) to indicate if the client (care recipient) can carry out the tasks listed without help.

Instructions on the assessment of IADLs

Instructions on the assessment of IADLs are adapted from Lawton and Brody's work on assessment of older adults. Documentation following client's assessment should clarify the extent or the nature of the inability to perform the IADL.

Instrumental Activities of Daily Living	Independent Independent means without supervision, direction, or active personal assistance, except as specifically noted below. This is based on actual status, not ability. Persons who refuse to perform a function are considered as not performing the function even though they may be able to.	Dependent Dependent means with supervision, direction, or assistance from another person.
a. Prepare meals	Plans, prepares, and serves adequate meals without help.	Needs assistance.
b. Shop for personal items	Can shop for all personal needs without help of another person	Needs to be accompanied on any shopping trip or does not shop.
c. Manage own medications	Can take medications in correct dosage at correct time.	Another person must assist with reminders or preparing medication.
d. Manage own money	Manages financial matters independently (writes checks, pays personal bills, collects and keeps track of finances).	Unable to handle money or financial transactions.
e. Use telephone	Can look up and dial phone numbers.	Cannot use telephone unassisted.
f. Do heavy housework	Can perform heavier tasks unassisted (e.g., vacuuming and scrubbing floors, cleaning bathrooms, etc.).	Unable to perform heavy household tasks.
g. Do light cleaning	Can wash dishes, make beds, dust, empty trash, and do other light tasks. Maintains cleanliness in the home.	Needs assistance for all housekeeping tasks.
h. Transportation ability	Can travel independently with own vehicle or can arrange and negotiate public transportation without help.	Needs help of another to travel or does not travel at all.

b. This section records the way client has his/her needs met.
   - "Unpaid" care is defined as informal assistance by a family member or friend.
   - "Paid" care is defined as formal care where the aide is paid, but not necessarily by the client. This could include Medicaid, Social Services Block Grant, Home and Community Care Block Grant, or it could be paid by another person.

   For those clients who answer "no", indicate if:
   - The client (care recipient) **cannot do and has someone unpaid** who assists, OR
   - The client (care recipient) **cannot do and has someone paid** who assists, OR
   - The client (care recipient) **cannot do and has both paid and unpaid**

assistance, OR

- The client has **no one** who assists.

In the space provided, add the number of "no" responses to determine the number of IADL impairments. Once this information is entered into the ARMS, the client's functional status will automatically be calculated.

22) Number of ADL (activities of daily living) impairments. *(Note-The ADL categories have been revised effective 7-1-2006 to reflect the categories required for federal reporting.)*

ADLs are required for the following services: in-home aide (including respite), senior companion, skilled home health care, home-delivered meals, home-delivered supplemental meals, home-delivered NSIP-only meals, group respite, institutional respite, adult day services (adult day care, adult day health), care management, and the Family Caregiver Support Program (except for Grandparents Raising Grandchildren Services).

a. Check "yes" or "no" in boxes corresponding to each ADL (items a – f) to indicate if the client (care recipient) can carry out the following tasks without help. Instructions on the assessment of ADLs are taken from the Katz Index of Independence in Activities of Daily Living, a widely accepted instrument used to assess the ability of older adults to perform six functions. The Katz Index was adapted to meet the requirements of the Administration on Aging's National Aging Program Information System (NAPIS).

Activity of Daily Living	**Independent** Independent means without supervision, direction, or active personal assistance, except as specifically noted below. This is based on actual status, not ability. Persons who refuse to perform a function are considered as not performing the function even though they may be able to.	**Dependent** Dependent means with supervision, direction, personal assistance, or total care.
a. Eat	Gets food from plate into mouth without help. Food preparation, including precutting meat, buttering bread, etc., may be done by another person.	Needs partial or total help with feeding, does not eat at all, or is fed through an IV.
b. Get dressed	Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	Needs help dressing self partially or totally.
c. Bathe self	Bathes self completely or needs help in bathing only a single part of the body, such as the back or disabled extremity.	Needs help bathing more than one part of the body, needs help getting in or out of the tub or shower, or

		requires total bathing assistance.
d. Use the toilet	Goes to toilet, gets on and off, arranges clothes, cleans self without help.	Needs help transferring to toilet; uses bedpan or commode and/or needs help cleaning self.
e. Transfer into/out of bed/chair	Moves in and out of bed or chair unassisted. May use mechanical supports.	Needs help in moving from bed to chair or requires a complete transfer.
f. Ambulate	Walks or moves about the house without the help of another person. May use assistive device independently to move about.	Needs hand-on support or total assistance from another person to move about.

b. For those clients who answer "no", indicate if:
- The client (care recipient) **cannot do and has someone unpaid** who assists. OR
- The client (care recipient) **cannot do and has someone paid** who assists, OR
- The client (care recipient) **cannot do and has both paid and unpaid** assistance, OR
- The client has **no one** who assists.

In the space provided, add the number of "no" responses to determine the number of ADL impairments. Once this information is entered into the ARMS, the client's functional status will automatically be calculated.

23) **How many unpaid caregivers [are] involved in [providing] care including primary caregiver?** If ADL/IADL responses in question 21 or 22 indicate that "*client has someone unpaid who assists"*, there must be at least a "1" entered in this box.

NOTE: **Primary caregiver is:**
- The caregiver registering for service for FCSP (non-Grandparents Raising Grandchildren) and HCCBG Respite.
- The unpaid person who provides most of the care for a non-respite or FCSP client.

SECTION V: This section is required for the clients who are being registered to receive Family Caregiver Support Program and/or HCCBG Respite services (In-Home Aide Respite, Group Respite, or Institutional Respite) and any client answering question #23 with a "1" or more. Again, the clients/caregivers registering for service are considered the Primary Caregiver for purposes of reporting.

Non-respite and non-FCSP services may not have their caregiver available at the time of registration to complete **Sections V and VI.** These caregiver sections may be added as a "change" when this information is obtained. Caregiver information on non-respite and non-FCSP should be answered by the client's primary caregiver.

24) **How many hours per day of help, care, or supervision does the care recipient need?**
a. Enter the number of hours per day needed, OR
b. Enter the number of hours needed per week if client does not need help every day.

25) **How many hours per day of help, care, or supervision does primary caregiver provide?**
a. Enter the number of hours per day provided, OR
b. Enter the number of hours provided per week if caregiver does not provide assistance every day.

26) **Primary caregiver's relationship to care recipient**: Check the box by the correct relationship. **The primary caregiver is the care recipient's:** husband, wife, mother, father, daughter/daughter-in-law, son/son-in-law, sister, brother, grandson/grandson-in-law, granddaughter/granddaughter-in-law, niece, nephew, grandmother, grandfather, aunt, uncle, other relative, **or** non-relative.

SECTION VI: Questions 27-30 should be answered by the primary unpaid caregiver only.

NOTE: **Primary caregiver is:**
- The **caregiver registering for service** for FCSP (non-Grandparents-Raising-Grandchildren) and HCCBG Respite.
- The unpaid person who **provides most of the care for a non-respite or non-FCSP client.**

27) **Ask primary caregiver: How would you rate your health on a scale of 1 (poor) to 5 (excellent)?** Check the box under one number corresponding to caregiver's self-reported health from 1 (poor) to 5 (excellent).

28) **Ask primary caregiver: How stressful for you is caregiving on a scale of 1 (not at all/very low) to 5 (very high)?** Check the box under one number corresponding to caregiver's self-reported stress level from 1 (not at all/very low) to 5 (very high). Question should be asked the way it is written.

29) **Ask primary caregiver: What is the status of your (paid) employment? Are you/did you…** (check one). This will probably require more than one question. Choices are: Full-time; part-time; quit due to caregiving; is not/was not working; retired early due to caregiving; retired/full benefits; ad lost job/dismissed due to caregiving Suggestion is to ask: "**Do you work**?"

a. If yes, ask if full-time or part-time.
b. If no, ask if **he/she was working** when they began taking care of their (spouse, mother, etc).
    i. If no, check "is not/was not working".
    ii. If yes, ask "Why are you no longer working?"
    iii. Ask appropriate questions to find caregiver's status (early retirement due to caregiving, quit due to caregiving, has full retirement, is not/was not working, lost job or was dismissed due to caregiving issues).

30) **Is the primary caregiver a long distance caregiver?** This is a self-reported "YES' or "NO" answer with no specific travel time or mileage definition.

SECTION VII (Signatures are **REQUIRED** for all service recipients on the original form only.)

31) **Signature and dating of the form by the client** assures confidentiality of the information in cases except for federal, state, and local data reporting and monitoring. For details of the confidentiality policy, see Section 6 of the HCCBG Procedures Manual at http://www.dhhs.state.nc.us/aging/manual/hccbg/bgsect6.pdf. A client signature is required at the ORIGINAL completion of the Client Registration Form. Signatures are not required on additional forms as future updates are completed.

32) **Signature and dating by authorized agency/provider representative** is required on each new form completed for all services and updates.

33) **Emergency Contact Person** - Indicate the name and day/evening telephone numbers of an individual who may be reached in the event of an emergency. Providers have the option to indicate if the emergency contact information was refused.

Provider Use Only: Registration information updates - Three registration update spaces are available for the provider to document the date that information in the form was reviewed with the client. It is the responsibility of providers to maintain current and accurate information on each client in the ARMS. Each client record must be updated as client changes warrant or at least every 12 months, except for home-delivered meal clients who are updated every six months.

Appendix A
Mailing Address Appendix

ADDRESS LINES 1 and 2

Alley	ALY	Grove	GRV
Apartment	APT	Heights	HTS
Avenue	AVE	Highway	HWY
Beach	BCH	In Care Of	C/O
Block	BLK	Lane	LN
Boulevard	Blvd	Lot	Lt
Box	BOX	Mobile Home Park	MHP
Brook	BRK	Mobile Home Village	MHV
Building	BLDG	North	N
Cape	CPE	Northwest, etc.	NW, etc.
Center	CTR	Parkway	PKY
Circle	CIR	Place	PL
City	CTY	Point	PT
Corner(s)	COR(s)	Post Office	PO
Court	CT	Road	RD
Creek	CRK	South	S
Drive	DR	Terrace	TER
East	E	Trailer Park	TRLR PK
Extension	EXT	West	W
General Delivery	GEN DEL		

NOTE: ENTER NUMERIC STREET NAMES WITH A NUMBER AND THE TWO LETTER ENDING. FOR EXAMPLE: 2^{ND}, 3^{RD}, 4^{TH}, ETC.

STATE

Georgia	GA
North Carolina	NC
South Carolina	SC
Tennessee	TN
Virginia	VA

Appendix B

{Insert Blank Client Registration Form DAAS 101}