

WV BOSS SAEF

Service Assessment and Evaluation Form

Service Referral

To what services or programs is the service recipient being referred?

- 1 - Group Client Support
- 1 - Individual Client Support
- 1 - Title III Transportation
- 1 - Title III-D Health Promotion
- 1 - Care Recipient (III-E Training, Respite, FAIR)
- 2 - Title III Assisted Transportation
- 2 - Title III Congregate Meals (C1)--Complete Nutritional Assessment - Level 3
- 2 - Title III Nutrition Counseling--Complete Nutritional Assessment - Level 3
- 3 - Lighthouse
- 3 - Title III Adult Day Care
- 3 - Title III Chore
- 3 - Title III Home Delivered Meals (C2)
- 3 - Title III Homemaker
- 3 - Title III Personal Care
- 1,2,4 - FAIR
- 1,2,4 - Title III-E Caregiver Training
- 1,2,4 - Title III-E Congregate Respite (Caregiver)
- 1,2,4 - Title III-E In-Home Respite (Caregiver)

Level 1

What is the service recipient's last name?

What is the service recipient's first name?

What is the service recipient's middle initial?

What is the service recipient's 'also known as' first name?

What is the service recipient's date of birth?

What is the service recipient's primary telephone number?

What is the date of the assessment?

Name of staff & organization completing the SAEF

Type of assessment

- 0 - Initial Assessment
- 1 - Annual Re-Assessment
- 2 - Change in Status Re-Assessment
- 3 - Waitlist

Select the requested action

- 0 - Inactivate the record
- 1 - New or modified record

Type of contact

- 0 - E-mail/fax/postal mail
- 1 - In-person (home visit)
- 2 - In-person (site)
- 3 - Telephone

Who is/are the service recipient's emergency contact(s)? (include name and phone number)

Level 2

Section 2 triggered based on services referred

If Section trigger is False, would you like to complete the questions in this section anyway? (If Section trigger is True, select Yes)

- 0 - Yes - Complete Level 2 Questions
- 1 - No

What is the service recipient's gender?

- 0 - Female
- 1 - Male

Select the service recipient's current living arrangement

- 0 - Lives alone
- 1 - Lives with others

Service recipient's residential street address

Residential city/town

Residential state

Residential zip code

Does the service recipient reside in a rural area?

0 - No

1 - Yes

Service recipient mailing street address or P.O. Box (if different than physical address)

Mailing city/town

Mailing state

Mailing zip code

Select the service recipient's ethnic race(s)

0 - American Indian/Alaskan Native

1 - Asian

2 - Black/African American

3 - Native Hawaiian/Other Pacific Islander

4 - White

5 - Other

What is the service recipient's ethnicity?

0 - Hispanic or Latino

1 - Not Hispanic or Latino

Is the service recipient's income level below the national poverty level? (For III-E/FAIR use care receiver's income)

0 - No

1 - Yes

Does the service recipient need hands on assistance with transportation?

0 - No

1 - Yes

Is the service recipient a veteran?

0 - No

1 - Yes

RISK INDICATORS**Bedbound**

Yes

No

Unable to vacate

Yes

No

Uses oxygen

Yes

No

On dialysis

Yes

No

Uses wheelchair

Yes

No

Terminal illness

Yes

No

No phone

Yes

No

Difficult access to home (i.e., remote, road conditions)

Yes

No

No air conditioning in home

Yes

No

No heat source in home

Yes

No

No family or informal support

Yes

No

Unable to prepare meals

Yes

No

Food insecurity

Yes

No

No transportation

Yes

No

Cognitive deficits (i.e., dementia, Alzheimer's, intellectual or developmental disability, TBI, or other organic dysfunction)

Yes

No

Deaf / hard of hearing

Yes

No

Blind / low vision

- Yes
- No

Uses walker

- Yes
- No

Language barriers

- Yes
- No

Is this individual on a list or registry maintained by your local emergency management entity, fire department, etc., for individuals at risk during an emergency event?

- Yes
- No
- Don't Know

Level 3

Section 3 triggered based on services referred

If Section trigger is False, would you like to complete the questions in this section anyway? (If Section trigger is True, select Yes)

- 0 - Yes - Complete Level 3 Questions
- 1 - No

Select the service recipient's current marital status

- 0 - Divorced
- 1 - Married
- 2 - Separated
- 3 - Single
- 4 - Widowed

Does the service recipient speak English?

- 0 - Yes
- 1 - No

Describe the service recipient's language limitations

- 0 - No Limitations
- 1 - Reading/writing limited
- 2 - Reads only
- 3 - Does not read

Service recipient's primary method of transportation

- 0 - Drives own car
- 1 - Caregiver
- 2 - Family/Friends
- 3 - Public Transportation
- 4 - Senior Center Transportation
- 5 - Other
- 6 - None

Does the service recipient demonstrate "greatest social need"?

- 0 - No
- 1 - Yes

NUTRITIONAL ASSESSMENT

I have an illness or condition that made me change the kind of food I eat

- 0 - No
- 1 - Yes

I eat fewer than 2 meals a day

- 0 - No
- 1 - Yes

I eat few fruits or vegetables, or milk products

- 0 - No
- 1 - Yes

I have 3 or more drinks of beer, liquor or wine almost every day

- 0 - No
- 1 - Yes

I have tooth or mouth problems that make it hard for me to eat

- 0 - No
- 1 - Yes

I don't always have enough money to buy the food I need

- 0 - No
- 1 - Yes

I eat alone most of the time

- 0 - No
- 1 - Yes

I take 3 or more different prescribed or over-the-counter drugs a day

- 0 - No
- 1 - Yes

Without wanting to, I have lost or gained 10 pounds in the last 6 months

- 0 - No
- 1 - Yes

I am not always physically able to shop, cook and/or feed myself

- 0 - No
- 1 - Yes

Refer for Nutrition Services

ACTIVITIES OF DAILY LIVING (ADLS)

Bathing

- 0 - No Assistance
- 1 - Some Assistance
- 2 - Much Assistance
- 3 - Unable to Perform

Dressing

- 0 - No Assistance
 - 1 - Some Assistance
 - 2 - Much Assistance
 - 3 - Unable to Perform
-

Eating

- 0 - No Assistance
 - 1 - Some Assistance
 - 2 - Much Assistance
 - 3 - Unable to Perform
-

Walking in home

- 0 - No Assistance
 - 1 - Some Assistance
 - 2 - Much Assistance
 - 3 - Unable to Perform
-

Transferring

- 0 - No Assistance
 - 1 - Some Assistance
 - 2 - Much Assistance
 - 3 - Unable to Perform
-

Toileting

- 0 - No Assistance
 - 1 - Some Assistance
 - 2 - Much Assistance
 - 3 - Unable to Perform
-

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS)**Transportation**

- 0 - No Assistance
 - 1 - Some Assistance
 - 2 - Much Assistance
 - 3 - Unable to Perform
-

Meal Preparation

- 0 - No Assistance
 - 1 - Some Assistance
 - 2 - Much Assistance
 - 3 - Unable to Perform
-

Shopping

- 0 - No Assistance
 - 1 - Some Assistance
 - 2 - Much Assistance
 - 3 - Unable to Perform
-

Light Housekeeping

- 0 - No Assistance
 - 1 - Some Assistance
 - 2 - Much Assistance
 - 3 - Unable to Perform
-

Managing Money

- 0 - No Assistance
 - 1 - Some Assistance
 - 2 - Much Assistance
 - 3 - Unable to Perform
-

Heavy Housework

- 0 - No Assistance
 - 1 - Some Assistance
 - 2 - Much Assistance
 - 3 - Unable to Perform
-

Telephone

- 0 - No Assistance
 - 1 - Some Assistance
 - 2 - Much Assistance
 - 3 - Unable to Perform
-

Managing Medications

- 0 - No Assistance
 - 1 - Some Assistance
 - 2 - Much Assistance
 - 3 - Unable to Perform
-

Level 4**Section 4 triggered based on services referred**

If Section trigger is False, would you like to complete the questions in this section anyway? (If Section trigger is True, select Yes)

- 0 - Yes - Complete Level 4 Questions
 - 1 - No
-

What is the name of the At Risk, Frail individual, or the individual with Dementia or Alzheimer's?

What is the date of birth of the At Risk, Frail individual, or the individual with Dementia or Alzheimer's?

What is the caregiver's relationship to the care receiver?

- 0 - Husband
 - 1 - Wife
 - 2 - Domestic Partner, including civil union
 - 3 - Son / Son-in-Law
 - 4 - Daughter / Daughter-in-Law
 - 5 - Brother
 - 6 - Sister
 - 7 - Other relative
 - 8 - Non-relative
-

Does the caregiver believe s/he is devoting enough time and attention to her/his own well-being?

- 0 - Always
- 1 - Frequently
- 2 - Sometimes
- 3 - Never

Does the caregiver feel stressed between caring for an individual and trying to meet other responsibilities?

- 0 - Always
- 1 - Frequently
- 2 - Sometimes
- 3 - Never

Select the following that are causing the caregiver stress

- 0 - Family relationships
- 1 - Care receiver behavior
- 2 - Caregiver's own health
- 3 - Financial problems
- 4 - Job/work issues
- 5 - Not enough time for self
- 6 - Not understanding how to care for an individual
- 7 - Social isolation
- 8 - Care receiver's declining health
- 9 - Other

Does the caregiver feel frustrated when s/he is around the individual?

- 0 - Always
- 1 - Frequently
- 2 - Sometimes
- 3 - Never

Does the caregiver have other people/programs to help provide care for the individual?

- 0 - Always
- 1 - Frequently
- 2 - Sometimes
- 3 - Never

Caregiver support needs

- 0 - Finding or working with doctors or specialists
 - 1 - Home safety and/or home modifications, or equipment
 - 2 - Caring for him/herself while caring for others
 - 3 - How to get other family members to help
 - 4 - Providing care to an aging individual
 - 5 - In-home support services
 - 6 - Legal and financial issues, advance directives
 - 7 - More information about individual's disease/condition
 - 8 - Short-term respite care in a facility
 - 9 - Support groups
 - 10 - Other
-

Scoring

SAEF Score

Risk Indicators Score

Nutrition Risk Score

ADL Score

IADL Score

Caregiver Score *(Not included in Total Score)*

Total Score

Assessment Completion

The form has been reviewed with the service recipient

- 0 - Yes
- 1 - No

Signature - Staffmember Completing SAEF

_____ Date

Service Recipient Signature (optional)

_____ Date