PSA:		Kansas Department for Aging and Disability Services	Disaster Red Flag	Electric
Assessor Name:				Physical Impairment
Assessor Phone:				Medication Assist
				Cognitive/MH Issues
				No Informal Support
				None

Abbreviated Uniform Assessment Instrument

Customer Legal Name & Address: Nickname _____

First _____ M.I. _____

Last _____

Residence Address _____

City _____

County _____ State _____ Zip _____

Primary Phone _____

Secondary _____

Directions _____

_____

Customer Social Security # _____

Customer KAMIS ID # _____

Does Customer live alone? Yes ____ No ____

Birth Date _____/ _____/_____
month day year

Age _____ Male ____ Female ____ Other ____

Marital Status: Single ____ Married ____
Widowed ____ Divorced ____

Veteran or Spouse of Veteran? Yes ___ No ___

Receive Veteran Benefits: Yes ___ No ___

Income below poverty level? Yes ____ No ____

Ethnicity:	Hispanic or Latino	
	Not Hispanic or Latino	
	Ethnicity Missing	

Race:	
White	
American Indian/Alaskan Native	
Asian	
Black or African American	
Native Hawaiian or Other Pacific Islander	

Emergency or alternate contact: Relationship _____

Name _____

Address _____

City _____

State _____ Zip _____

Primary Phone _____

Secondary _____

Primary Language	Speaks	Reads	Understands Orally
English			
German			
Spanish			
Sign			
Other:			

Does Customer have any difficulty :	
Communicating	
Understanding information	
Remembering information	

Is the Emergency or alternate contact a legally appointed Guardian? Yes ____ No ____

Activities of Daily Living	Difficulty	No Difficulty
Bathing		
Dressing		
Toileting		
Transferring		
Walking, Mobility		
Eating		

Instrumental Activities of Daily Living	Difficulty	No Difficulty
Meal Preparation		
Shopping		
Money Management		
Transportation		
Telephone		
Laundry, Housekeeping		
Medication Management, Treatment		

Are there concerns of possible Abuse, Neglect, and/or Exploitation? Yes ____ No ____

Does the customer have difficulty with chores i.e. mowing the lawn? Yes ____ No ____

Assessment Date:	Comments:

Customer Name _____ DOB: _____ Date _____

Ask the customer the following questions		
Nutrition Risk Screen	Comments	Score-if yes, circle
Do you eat less than 2 meals daily?		3
Do you eat less than 2 servings of fruits and vegetables daily?		1
Do you eat less than 2 servings of dairy products (milk, cheese, yogurt, etc.) daily?		1
Do you usually drink less than 6 glasses of water, milk, or juice daily?	# of glasses:	0
Do you drink 3 or more alcoholic beverages daily?		2
Do you take 3 or more different prescriptions and/or over-the-counter drugs daily?		1
Do you have problems with dentures, teeth, or mouth, which make it hard to eat?	Which:	2
Have you made changes in the kind and/or amount of food you eat because of an illness and/or condition?	What changes:	2
Are you physically not always able to grocery shop, cook, and/or feed yourself?	Which:	2
Do you eat alone most of the time?		1
Do you feel that you usually do not have enough money to buy the food you need?		4
Have you gained or lost more than 10 pounds in the last 6 months?	Pounds gained ____ lost ____	2
Customer does not meet any of the nutrition risk screen indicators.		0
	Add all the circled scores for a total Nutrition Risk Score	

Would you say that your appetite is:		Do any of the following cause you problems or affect your ability to eat:	
Good		Swallowing	
Fair		Taste	
Poor		Nausea, vomiting	
Comments: _____		Cutting up food	
		Opening containers (milk, plastic wrap, jars)	
		Certain foods, food allergy (specify):	
		No concerns	

Do you:	No	Yes	If yes, how often:
Skip meals and just snack, “piece”, through the day?			
Lack the energy or desire to fix a meal?			
Find you don’t know what to fix or can’t fix small portions?			
Forget to turn the stove off or burn food?			
Lack the desire to eat a meal?			
Eat restaurant or fast food?			
Leave home? If not, why?			

What do you eat in a typical day (ask about "breakfast", "lunch", "supper"), describe: _____

_____

_____

_____

Comments (include any special considerations for service delivery such as pets, or "go to back door"): _____

_____

_____

_____

Customer Name _____ DOB: _____ Date _____

Ask the customer:
Does anyone help you prepare food or bring food to you? Yes ☐ No ☐ If yes, answer the following:

Who	What	When

Ask the customer:
Are you following any modified diet(s)? Yes ☐ No ☐

Are any of the modified diets doctor prescribed? Yes ☐ No ☐

Check each modified diet followed:	x	x	Mark if doctor prescribed and indicate the name of the doctor:
Low sodium (salt)			
Diabetic			
Mechanical			
Renal			
Diverticulitis			
Vegetarian			
Pureed			
Ethnic/religious			
Other:			

Assessor: Is the customer:	Yes	No
Physically homebound		
Socially homebound		
Isolated		

Participant Status - Home-delivered Meals	
60+ eligible Person	
Spouse, regardless of age, of 60+ eligible Person	
Disabled Person, regardless of age, residing with 60+ eligible Person	
60+ non-spouse Caretaker (IIIB home-delivered meals only)	

Assessor: Do you recommend a referral to the Area Agency on Aging for in-home service?
No _____ Customer Refuses _____ Yes _____ Date of Referral _____

~~~~~~~~~~~~~~~~~~~~ BELOW FOR ABBREVIATED UAI FORM COMPLETION ~~~~~~~~~~~~~~~~~~~~

PSA	Service Code	Funding Source	Provider	Unit(s)	Per	Total Units Monthly	Cost of Unit	Start Date	End Date	Dis-charge Code

Release of Information: I consent to the release of the information on this page so I can receive services. I understand the information included in these pages 1-3 will be released to Kansas Department for Aging and Disability Services, the Area Agencies on Aging, and service providers as listed above to enable the delivery of services and program monitoring.

_____
Customer or Guardian Signature

_____ _____
Assessor Signature Date

Unmet Need Service Code, Availability Code, Monthly Number of Units

Service Code	Availability	Units