RHODE ISLAND DIVISION OF ELDERLY AFFAIRS
ELDER SERVICES SCREENING FORM

Date: ____________ **Known to SAMS:** Y/N **Veteran:** Y/N Gender: ____________

Applicant Name: ______________________ **DOB:** ____________

Address: ______________________________________

Phone: ____________ Apt./Floor City/Town State Zip

SSN: ________

Current Living Arrangment:

Alone	w/others	pet	other	Spouse

Primary Language: ____________

Marital Status:

M	W	S	D

Monthly Income: ____________ **Source of Income:** ____________ **Assets:** ____________

Pension ____________ **SSI** ____________ **Other** ____________

Type of Insurance: ____________ Referral Source: ____________

Type of Services Requested:

DEA-AL	DEA-Home Care	Co-Pay	Other:

Contact Person: ____________ **Phone#** ____________

Primary Person to contact:

Client	Contact	Other

Primary Care Provider Contact Information:

____

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____

Please select all that apply:

Cane	Walker	Wheel chair	Bed ridden	Fall Risk	Other:

ADL's Client needs assistance with:

	Mobility		Eating
	Dressing		Personal Hygiene
	Bathing		Medication Mgmt.
	Toileting		*Other*

IADL's Client needs assistance with:

	Housekeeping
	Meal Prep.
	Shopping
	Laundry
	Transportation

Can the client go out unaccompanied? Y/N

Can the client utilize public transportation? Y/N

Will the client accept personal care? Y/N

Client Diagnosis: ____________

COMMENTS: ______________________________________

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Outcome:

DEA	Referred to LTC	No Service	Other

Case Worker assigned to : ____________

Intake Worker: ____________ Date: ____________

mr12/2015