RHODE ISLAND DIVISION OF ELDERLY AFFAIRS
ELDER SERVICES SCREENING FORM

Date: _____ **Known to SAMS:** Select Item **Veteran:** Select Ite 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:** Married ☐ Widowed ☐ Single ☐ Divorced ☐

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:

_____

_____

_____

Please select all that apply:

Cane ☐ Walker ☐ Wheel chair ☐ Bed ridden ☐ Fall Risk ☐ Other: _____

ADL's Client needs assistance with:

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

IADL's Client needs assistance with:

- ☐ Housekeeping
- ☐ Meal Prep.
- ☐ Shopping
- ☐ Laundry
- ☐ Transportation

Can the client go out unaccompanied? Select Item

Can the client utilize public transportation? Select Item

Will the client accept personal care? Select Item

Client Diagnosis: _____

COMMENTS: _____

Outcome: DEA ☐ Referred to LTC ☐ No Service ☐ Other ☐ **Case Worker assigned to :** _____

Intake Worker: _____ Date: _____