**Optional Questions**

* Optional Questions can be entered into SUDS (either on the Client Record or on an Assessment), but are not required by the State Unit on Aging as part of the Standard Assessments
* The Optional Questions are organized by their location in SUDS
* AAAs can choose whether and where to include Optional Questions on Assessments in their region
* You can add responses to be entered in SUDS as “Client Refused” and “Client Doesn’t Know” to any of the Optional Questions and the required questions on the SUA Standard Assessment Forms

**SUDS - Client Record**

Note – all these fields can be included in any combination on the assessment forms. Some fields from Communication and Service Needs are required on certain forms, but all fields are listed here for convenience.

| **Information:** |
| --- |

| **Title:** |  |
| --- | --- |
| **Suffix:** |  |

| **Phone & Email:** |
| --- |

| **Work Phone:** |  |
| --- | --- |

**Preferred Phone Number:** ☐ Home ☐ Cell ☐ Work

| **Mailing Address:** |
| --- |

☐ Do Not Mail

| **Optional Demographics:** | | | | |
| --- | --- | --- | --- | --- |
|  | **Total Monthly Income:** |  |  |

**Marital Status:**

☐ Single (never married) ☐ Domestic Partner/Committed Relationship/Common Law

☐ Married ☐ Divorced ☐ Separated ☐ Widow

**Veteran Status: are you a veteran?** ☐ Yes ☐ No☐ Not Applicable

| **Communication & Service Needs:** | | |
| --- | --- | --- |

**Limited English Proficiency:**

☐ Can't read English

☐ Can’t speak English

☐ Can't understand English

☐ Can't write in English

☐ N/A

**How did you hear about our services?**

| ☐ AAA Brochure | | ☐ AAA Newsletter | ☐ Channel 9 Senior Source |
| --- | --- | --- | --- |
| ☐ Congregate Meal Site | | ☐ From a Current Client | ☐ From a Friend/Relative |
| ☐ Senior Fair | | ☐ Walk-In | ☐ Web Site |
| ☐ Other: |  | | | |

**Pronouns:** ☐ He/Him/His ☐ She/Hers/Hers ☐ They/Them/Their ☐ Xe/Xem/Xyr

**Communication Needs:**

**SUDS – Contacts**

These questions appear on the Contacts screen in SUDS. You can add a contact to the Client from the right hand side of the Client Record page. You can use any combination of the questions below on your forms. You can also gather information for specific Contact Types (such as primary and secondary emergency contact, doctor, power of attorney). SUA Standard Assessment Forms ask for 1 emergency contact with basic information for the client.

| **Contacts:** |
| --- |

***Contact Information***

| **Salutation:** | |  |
| --- | --- | --- |
| **First Name:** | |  | |
| **Middle Name:** | |  | |
| **Last Name:** | |  | |
| **Suffix:** |  | |

***Phone & Email***

| **Phone:** |  |
| --- | --- |
| **Email:** |  |

***Additional Information***

**Emergency Contact:**

☐ Primary Emergency Contact

☐ Secondary Emergency Contact

☐ N/A

**Contact Type (select all that apply):**

☐ Attorney

☐ Clergy

☐ Doctor/Medical Provider

☐ Family Member

☐ Friend

☐ Legal Guardian

☐ Neighbor

☐ Other Agency

☐ Other Professional

☐ Power of Attorney

☐ Spouse/Partner

☐ Unspecified

| **Other Contact Type:** | |  |
| --- | --- | --- |
| **Agency:** |  | |

☐ **Voucher Services Provider** (This agency or person will serve as the client’s provider for a participant directed voucher)

**Can access client info:** ☐ Yes ☐ No ☐ N/A

**Can receive mail for client:** ☐ Yes ☐ No ☐ N/A

***Comments:***

| **Comments:** |  | |
| --- | --- | --- |
|  | |

***Address Information:***

| **Mailing Address** Line 1: | | | |  | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Line 2 (Apt/Unit/Floor #): | | | |  | | City: |  | | |
|  | Zip: |  | County: | | |  | | | State: |  |

**SUDS – Health and Home Conditions Assessment**

Note – Health and Home Conditions questions are optional for all assessment forms. You can use any combination of questions or wording, the questions below show how the fields are displayed in SUDS for optional data entry.

| **Health and Home Conditions** |
| --- |

***Homebound/Geographically Isolated***

**Is the client homebound or in a geographically isolated location?** ☐Yes ☐ No

***Health Conditions***

**Do you/does the client have any of the following conditions? Check all that apply:**

☐ Dementia or Alzheimer's

☐ DD / ID

☐ Autism

☐ Diabetes

☐ Epilepsy/Seizure disorder

☐ Intellectual Disability

☐ Mental Illness

☐ Memory Problems

☐ Mobility Impairment

☐ Hearing Impairment

☐ Visual impairment (cannot be corrected with glasses)

☐ Physical Disabilities

☐ Traumatic Brain Injury

**Does the client need supervision?** ☐Yes ☐ No

**Is the client medically dependent on any of the following:**

☐ Insulin

☐ Oxygen

☐ Dialysis

**Dentures:**

☐ Uses

☐ Needs Dentures or Needs Update

☐ Not Applicable

**Hearing Aids:**

☐ Uses

☐ Needs Dentures or Needs Update

☐ Not Applicable

**Glasses and Contacts:**

☐ Uses

☐ Needs Dentures or Needs Update

☐ Not Applicable

***Mobility Devices***

**Does the client use or need (but does not currently have) any mobility devices?**

☐ Yes ☐ No

*If yes, which mobility devices does the client currently use or need? Select all that apply:*

| **Cane** | ☐ Uses | ☐ Needs |
| --- | --- | --- |
| **Crutches** | ☐ Uses | ☐ Needs |
| **Walker** | ☐ Uses | ☐ Needs |
| **Wheelchair** | ☐ Uses | ☐ Needs |
| **Electric Scooter** | ☐ Uses | ☐ Needs |

**Other Mobility Device:**

|  |
| --- |

***Special Equipment***

**Does the client use or need (but does not currently have) any special equipment or assistive devices?**

☐ Yes ☐ No

*If yes, which special equipment/assistive device does the client currently use or need? Select all that apply:*

| **Medical phone alert** | ☐ Uses | ☐ Needs |
| --- | --- | --- |
| **Incontinence supplies** | ☐ Uses | ☐ Needs |
| **Bathing equipment** | ☐ Uses | ☐ Needs |
| **Transfer equipment** | ☐ Uses | ☐ Needs |
| **Adaptive eating equipment** | ☐ Uses | ☐ Needs |

**Other Special Equipment/Assistive Device:**

|  |
| --- |

***Home Conditions and Pets***

**Are any of the following safety, repair, or accessibility issues a concern in the client's residence? Select all that apply:**

| **Exterior:** | ☐ Road  ☐ Driveway  ☐ Yard  ☐ Ramp  ☐ Windows  ☐ Roof |
| --- | --- |
| **Interior:** | ☐ Doors  ☐ Stairs  ☐ Floor  ☐ Walls  ☐ Ceiling  ☐ Lights  ☐ Furniture  ☐ Rugs |
| **Restroom:** | ☐ Handrails  ☐ Tub  ☐ Shower  ☐ Toilet |
| **Utilities:** | ☐ Plumbing  ☐ Water  ☐ Electric  ☐ Gas |
| **Telephone:** | ☐ Broken  ☐ No phone  ☐ Disconnected/No service |
| **Temperature:** | ☐ Heating  ☐ Cooling |
| **Health and Safety:** | ☐ Odors  ☐ Insects  ☐ Rodents  ☐ Accumulating items or garbage  ☐ Floors or pathways cluttered  ☐ Smoke detector  ☐ Air quality |

**Does anyone smoke inside the client's home?** ☐ Yes ☐ No

**Are there any pets in the household?** ☐ Yes ☐ No

**If yes, please list pets:**

**Are any of your pets uncomfortable with visitors to the home?**

☐ Yes ☐ No ☐ Not Applicable

**Other Home Condition Concerns or Details:**

|  |
| --- |

**SUDS – Caregiver Assessment**

These questions appear on the Caregiver Assessment in SUDS. All of these questions besides the *Modified Caregiver Strain Index* appear on the SUA Standard Caregiver Respite/Supplemental Services/Case Management Assessment Form. They are optional inclusion on the Caregiver/Counseling/Training/Support Groups Assessment Form.

| **Caregiver Assessment** |
| --- |

***Caregiver Services***

**Which types of caregiver services are you interested in? Select all that apply:**

☐ Information about services

☐ Counseling

☐ Education/Training

☐ Support Groups

☐ Meals (delivered to your home or dining at a community site)

☐ Transportation

☐ Supplies to assist with caregiving duties (e.g. food, assistive devices)

☐ Respite Care (in-home or out-of-home supports/arrangements to provide caregivers temporary break from caregiving duties)

☐ Adult day care programs for care recipients

☐ Resources for grandparents raising grandchildren

| ☐ Other (please explain): |  |
| --- | --- |
|  | |

***Caregiver’s Duties & Employment Status***

**What type(s) of assistance do you provide to the care recipient? Select all that apply:**

| ☐ Hygiene (bathing, grooming, etc.) | | ☐ Transportation |
| --- | --- | --- |
| ☐ Dressing | | ☐ Errands/Shopping |
| ☐ Eating/Feeding | | ☐ Maintenance of Home/Yard |
| ☐ Meal Preparation | | ☐ Housekeeping and Laundry |
| ☐ Using the bathroom/incontinence | | ☐ Managing Finances/Paying Bills |
| ☐ Getting around the home | | ☐ Administering Medication |
| ☐ Getting in/out of beds and chairs | | ☐ Medical Treatment/Managing Condition(s) |
| ☐ Other (please explain): |  | | |
|  | | | |

**Are you getting help from anyone with your caregiver duties?**

☐ Yes - professional/paid (formal) help

☐ Yes - informal help

☐ Yes - both formal and informal help

☐ No

| **If yes, please explain:** |  |
| --- | --- |
|  | |

**What is your employment status?**

☐ Retired ☐ Employed full-time ☐ Employed part-time ☐ Unemployed ☐ On Leave

| ☐ Other (please explain): |  |
| --- | --- |

***Modified Caregiver Strain Index***

Here is a list of things that caregivers may find to be difficult. If an item applies to you, please indicate whether it applies on A Regular Basis or Sometimes. If an item does not apply to you, please mark the No column. Your situation may be slightly different, but the item could still apply.

| **Modified Caregiver Strain Index** | **Yes, on a regular basis (2 pts.)** | **Yes, sometimes (1 pt.)** | **No (0 pt.)** |
| --- | --- | --- | --- |
| **My sleep is disturbed.** For example: person I care for wanders at night; needs assistance; I can’t sleep | ☐ | ☐ | ☐ |
| **Caregiving is inconvenient.** For example: helping takes a lot of time; it’s a long drive over to help | ☐ | ☐ | ☐ |
| **Caregiving is a physical strain.** For example: lifting in or out of a chair/bed/toilet | ☐ | ☐ | ☐ |
| **Caregiving is confining.** For example: restricts my free time; I cannot go places I enjoy | ☐ | ☐ | ☐ |
| **There have been family adjustments.** For example: helping has disrupted my routine; there is no privacy; family arguments | ☐ | ☐ | ☐ |
| **There have been changes in personal plans.** For example: I could not go on vacation; I cannot participate in activities that I enjoy | ☐ | ☐ | ☐ |
| **There have been other demands on my time.** For example: other family members need me; work | ☐ | ☐ | ☐ |
| **There have been emotional adjustments.** For example: arguments with family about caregiving; anger; sadness | ☐ | ☐ | ☐ |
| **Some behavior is upsetting.** For example: person cared for has memory issues; outbursts | ☐ | ☐ | ☐ |
| **It is upsetting to find the person I care for has changed so much from their former self.** For example: the care recipient is a different person than they used to be; unable to do things | ☐ | ☐ | ☐ |
| **There have been work adjustments.** For example: I have to take time off for caregiving duties; adjusting schedules; unable to work | ☐ | ☐ | ☐ |
| **Caregiving is a financial strain.** For example: I use personal finances for caregiving; unsure about future financial situation | ☐ | ☐ | ☐ |
| **I feel completely overwhelmed.** For example: I worry about the person I care for; I have concerns for my future | ☐ | ☐ | ☐ |
| **Total Score:** |  | | |