Assessor:_____

Vendor: _____

Site:_____

► PERSONAL

Info Release Authorized: ☐ Yes ☐ No

Default Agency: North Central New Mexico Non-Metro

☐ PSA-2 ☐ PSA-3 ☐ PSA-4

***Date Registered**: _____

***First Name**: _____

Middle Initial: _____

***Last Name**: _____

Marital Status: ☐ Married; Spouse: _____

☐ Single ☐ Widowed ☐ Divorced ☐ Legally Seperated

***Gender**: ☐ F ☐ M ***Birth Date**: _____

***Last 4 SSN Digits**: 000/00/_____

***Home Phone**: (____) _____ - _____

► RESIDENTIAL ADDRESS

***Street 1**: _____

***County:** _____

*Town: _____

***State**: _____ ***Zip Code**: _____

► MAILING ADDRESS; Same as Residential ☐ Yes

***Street 1**: _____

***PO Box**: _____

***County:** _____

***Town:** _____

***State**: _____ ***Zip Code**: _____

► NAPIS

***Ethnicity**: ☐ Unknown ☐ Hispanic/Latino ☐ Not Hispanic/Latino

***Household Size**: ____ In Poverty? ☐ Yes ☐ No

Poverty based on household size

Download and print Poverty Guidelines from AAA Website

www.ncnmedd.com

► CARE ENROLLMENTS

☐ Senior Services Title III (B) & (C)

☐ Senior Program Evidence Based Title III (D)

☐ Family Caregiver Title III (E)

☐ All State Other Program

► *ETHNIC RACES

☐ American Indian/Native Alaskan

☐ Native Hawaiian/Other Pacific Islander

☐ Non-Minority (White, Non-Hispanic)

☐ White-Hispanic

☐ Asian

☐ Black/African American

☐ Missing

☐ _____

► III-E FAMILY CAREGIVER Respite Only:

Are you a Caregiver? ☐ Yes ☐ No

Who do you care for?_____

What is your relationship to the person you care for (Recipient)?

☐ Husband ☐ Wife ☐ Daughter/In-law ☐ Son/In-law

☐ Sibling ☐ Other Relative ☐ Parent

☐ Non-Relative ☐ Other: _____

Are you a IIIE Grand Parent Raising a Grandchild (Grandchildren)? ☐ Yes ☐ No

► CHARACTERISTICS

***Disabled:** ☐ Yes ☐ No ***Homebound:** ☐ Yes ☐ No

***Frail:** ☐ Yes ☐ No Seasonal: ☐ Yes ☐ No

Check if consumer is: ☐ Veteran ☐ Veteran Dependent

Receiving Medicaid?: ☐ Yes ☐ No Receiving Medicare?: ☐ Yes ☐ No

Primary Language: ☐ English ☐ Spanish ☐ French

Other Language: _____ (Entered in Consumer Notes.)

Understands English: ☐ Yes ☐ No

***Eligibility Type:** ☐ Age (60+) ☐ Spouse Age (60+)

Spouse: _____

SAMS ID Number:_____

☐ Disabled Living with Elderly Person ☐ Disabled In Elderly Housing w/senior prg. meal site

Name: _____

SAMS ID Number: _____

☐ Volunteer ☐ AAA-Approved Age Waiver dated: _____

► CONTACTS

1) Type: Emergency (other than spouse if married)

Name: _____

Relationship: _____

Phone: H=Home; M=Mobile; B=Business; A=Alternate

Phone: (_____) _____ - _____ ☐ H ☐ M ☐ B ☐ A

Phone: (_____) _____ - _____ ☐ H ☐ M ☐ B ☐ A

2) Type: ☐ Primary Physician ☐ Family/Relative ☐ Other

Name: _____

Relationship: _____

Phone: H=Home; M=Mobile; B=Business; A=Alternate

Phone: (_____) _____ - _____ ☐ H ☐ M ☐ B ☐ A

Phone: (_____) _____ - _____ ☐ H ☐ M ☐ B ☐ A

► SERVICES TO BE PROVIDED (as contracted with NM AAA)

Title III - B Services

☐ Adult Day Care _____ hours/week

☐ Assisted Transportation

☐ Case Management

☐ Homemaker _____ hours/week

☐ Chore _____ hours/week

☐ Transportation

Title III - C Services

☐ Congregate Meals

☐ Breakfast ☑ Lunch ☐ Evening

COVID HD Lunch

☐ Home Delivered Meals

☐ Breakfast ☐ Lunch ☐ Evening

☐ Weekend Breakfast ☐ Weekend

☐ Weekend Evening

Title III - D Evidence Based Services

☐ Enhanced Fitness

☐ MY CD

☐ Matter of Balance

Title III - E Family Caregiver Services

☐ Respite in ADC _____ hours/week

☐ In-Home Respite _____ hours/week

☐ GPRG

Consumer Registration Form (Advanced)

Printed 1/21/2016

Consumer Name: Jane Doe, ID: 925331234

All Bold and Highlighted fields are required

Personal

Prefix	
First Name	Jane
MI - Helpful information	L
Last Name	Doe
Suffix	
Maiden Name	
AKA Name	
Date Registered	08/08/2014
Details Last Reviewed	08/08/2014 Date Reassessment Was Conducted
Marital Status	
Gender	Female
Birth Date	9/25/1933
SSN	000-00-1234
Area Code	Enter Phone Number (If there is no phone indicate that here)
Home Phone	

Residential Address

Street 1	
Street 2	
County	
Town	
State	
ZIP Code	
Municipality	
Directions to Home	

Mailing Address

Street 1	
Street 2	
County	
Town	
State	

ZIP Code	88119

NAPIS

Ethnicity	Unknown
In Poverty	Don't Know
Lives Alone	Don't Know
High Nutritional Risk	Don't Know
Is Rural	Yes
Number of ADLs	**Number of IADLs**

Populates Automatically

Status

Active	Yes Ensure this is marked as Yes
Reason	
Status Date	08/08/2014 Date Reassessment Conducted

Insurance

Medicaid #	
Medicaid Policy #	
Medicare #	
Medical Assistance ID	

Defaults

Default Agency	North Central New Mexico Non- Metro PSA-2,3,4
Default Provider	Default Provider Name Here
Primary Care Manager	

Other

Monthly Household Income	
Household Size	
Monthly Individual Income	
Email Address	
Referred by	
Alternate ID1	
Alternate ID2	

Identify services that the consumer is receiving and mark out any services the consumer is no longer utilizing.

Notes Cong Meals, Trans (D.S.8.15.2014)

COVID HD Lunch and COVID Well Check Calls

Characteristics

Abused/Neglected/Exploited	No
Disabled	No
Duplicate Mail	No

Consumer Registration Form (Advanced)

Printed 1/21/2016

Continued for Consumer Name: Jane Doe, ID: 925331234

Female Head of Household	No
Frail	No
Home bound	No
Medicare Eligible	No
Receiving Social Security	No
State Resident	Yes
Tribal	No
Understands English	Yes
US Citizen	Yes
NSIP Meals Eligible	No
Eligibility Type	Age (60 or over)
Veteran	No
Veteran Dependent	No
Language	

Review/Update

Optional

Review/Update

Optional

Review/Update

This area will be blank unless there are contacts listed in SAMS

Enrollment (Care) - 1

Level of Care	Federal Funded Programs
Service Program	Senior Program-NAPIS Title III (B,C,D)
Care Program	Senior Program-NAPIS Title III (B,C,D)
Application Date	08/08/2014
Received Date	08/08/2014
Termination Date	
Status	Active
Reason	
Status Date	08/08/2014
Start Date	08/08/2014
End Date	

Check here if the client has formally authorized release of information.

Consumer: _____ Date:_____

☐ Initial Assessment ☐ Reassessment Where Interviewed: ☐ Senior Center ☐ Home ☐ Other

How does consumer rate his/her health? ☐ Excellent ☐ Fair ☐ Good ☐ Poor

► Nutritional Health Screening		
~ Adapted from the Determine Your Nutritional Health Checklist developed by the Nutrition Screening Initiative. ~ ► Within the last six (6) months, have any of these situations/conditions changed?	Yes	No
1) Have you made changes in eating habits because of heath problems such as diabetes, cholesterol, high blood pressure?	☐ 2	☐ 0
2) Do you eat fewer than 2 meals per day?	☐ 3	☐ 0
3) Do you eat fewer than 5 servings of 1/2 cup each of fruit or vegetables every day?	☐ 1	☐ 0
4) Do you have fewer than 2 servings of dairy products such as milk, yogurt, cheese, etc. everyday?	☐ 1	☐ 0
5) Do you have chewing/swallowing problems that make it difficult to eat? (includes loose/no dentures or medical condition)	☐ 2	☐ 0
6) Are there times when you do not have enough money to buy the food you need?	☐ 4	☐ 0
7) Do you eat alone most of the time?	☐ 1	☐ 0
8) Do you take 3 or more different prescribed or over-the-counter medications each day? (Includes: aspirin, laxatives, herbs, antacids, inhalers, etc…)	☐ 1	☐ 0
9) Have you lost or gained 10 pounds or more in the last 6 months without wanting to? Gained 10 lbs=yes; Lost 10 lbs=yes	☐ 2	☐ 0
10) Are you (or someone for you) physically unable to SHOP for food, COOK and/or FEED yourself?	☐ 2	☐ 0
11) Do you have 3 or more drinks of beer, wine or liquor almost every day?	☐ 2	☐ 0
Add the total value of all questions. (Note: If any question is left blank, SAMS is unable to determine the final score.) TOTAL:		

☐ Consumer refused to divulge 1 or more of the answers above. Refusal = No score which will affect justification for service. Consumer's Initials:

DISEASE
EATING POORLY
TOOTH LOSS/MOUTH PAIN
ECONOMIC HARDSHIP
REDUCED SOCIAL CONTACT
MULTIPLE MEDICINES
INVOLUNTARY WEIGHT LOSS/GAIN
NEEDS ASSISTANCE IN SELF CARE
ELDERS YEARS ABOVE AGE 80

Nutritional Health Score
0-2 Good 3-5 Moderate Risk 6 or more High Nutritional Risk

Service Needed
0-21 Congregate Meals and/or Congregete Weekend meals with justification
0-21 Frail and Homebound - Home Delivered (weekday-evening-weekend) if no other family or friend support is available)

Assessor-Please use the consumer notes page to describe a extenuating circumstance that may require a home-

► Activities of Daily Living (ADL) Assessment Ratings: Low = 0; Moderate Risk = 2; High Risk = 3; Highest Risk = 5	(Services Needed)	Not Dependant	Limited Assistance	Total Dependence
1) Did you need help to take a bath or shower this past week?	(Personal Care)	☐ 0	☐ 1	☐ 1
2) Did you need help to get dressed any day this last week?	(Personal Care)	☐ 0	☐ 1	☐ 1
3) Any day this last week have you needed assistance to use the toilet?	(Personal Care)	☐ 0	☐ 1	☐ 1
4) Did you need help any day this last week to get up from the bed, chair, couch, bathtub, etc. and to move to another location?	(Personal Care)	☐ 0	☐ 1	☐ 1
5) Any day this last week, did you need help to eat? (Includes cutting food and/or feeding themselves.)	(Homemaker)	☐ 0	☐ 1	☐ 1
6) Did you need any help this last week to walk inside your home? (Includes the use of cane, walker, etc.)	(Homemaker)	☐ 0	☐ 1	☐ 1
How many boxes were checked in the "Limited Assistance" and/or "Total Dependence" columns combined?		TOTAL:		

Consumer refused to divulge 1 or more of the answers above. Refusal to answer will effect justification for service. Consumer's Initials: _____

► Instrumental Activities of Daily Living (IADL) Assessment Ratings: Low = 0; Moderate Risk = 2; High Risk = 3; Highest Risk = 5	(Services Needed)	Not Dependant	Limited Assistance	Total Dependence
1) Did you need any help to prepare yourself a meal this last week?	(Meals, Homemaker)	☐ 0	☐ 1	☐ 1
2) Were you able to go shopping for food or household items this past week?	(Meals, Homemaker)	☐ 0	☐ 1	☐ 1
3) Have you been able to take your medicines this last week?	(Referral Needed)	☐ 0	☐ 1	☐ 1
4) Have you been able to pay your bills, make deposits and/or manage your bank accounts this last week?	(Referral Needed)	☐ 0	☐ 1	☐ 1
5) Did you need help using the telephone this last week?	(Homemaker)	☐ 0	☐ 1	☐ 1
6) Did you need help to do heavy housework this last week? (CHORE windows, refrigerators, moving furniture, etc.)	(Chore)	☐ 0	☐ 1	☐ 1
7) Have you been able to do light housework this past week? (HOMEMAKER vacuum, mop, dishes, dusting, etc.)	(Homemaker)	☐ 0	☐ 1	☐ 1
8) Have you been able to drive yourself to places you needed to go such as the store, doctor, pharmacy, etc?	(Homemaker)	☐ 0	☐ 1	☐ 1
How many boxes were checked in the "Limited Assistance" and/or "Total Dependence" columns combined?		TOTAL:		

Consumer refused to divulge 1 or more of the answers above. Refusal to answer will affect justification for service Consumer's Initials: _____

Family / Other support? ☐ Yes ☐ No (Please Describe the Type of Support Below)

If yes how much support is given each week? ☐ None (5) ☐ 24 hrs. or Less (4) ☐ 25 - 40 hrs. (3) ☐ 41 - 60 hrs. (2)

Are services paid from another program? ☐ Yes (0) ☐ No (5) (If Yes Please indicate the Agency Name and Describe Type of Services Below)

Jane Doe	Phone - COVID	3/21/21
Print Consumer's Name	Consumer's Signature	Date
Sally Sample	Sally Sample	3/21/21
Print Assessor's Name	Assessor's Signature	Date

~Consumer Notes~

How are the consumer's needs being met and/or addressed?

☐ Initial Assessment ☐ Reassessment

Vendor/Provider: _____

Site:_____

Date Conducted:_____

Consumer Name:_____

1. Use this page to make notations or explanations such as: eligibility through spouse (include eligible consumer's name and ID if available), eligibility if disabled (per policy); directions to home, unique circumstances, and any other notes relevant to receiving services.
2. Justification must be documented for any/all in-home services. Notes stated here should clearly match the ADL/IADL Assessment outcomes.
3. If the consumer receives either home delivered or congregate meals and scored three (3) or more on the Nutrition Assessment, document how their moderate or high nutrition risk is being addressed.
4. Be cautious of medically termed notes to ensure HIPAA laws are followed. Notes will be entered in SAMS Consumer Journal.

Tell us the consumer's needs and how they are being met/addressed:

Print Assessor's Name Assessor's Signature Date

Permanent Condition Waiver

This waiver will allow for a reassessment to be conducted 1x per year (annually) instead of every 6 months (bi-annually).

Tell us how the consumer qualifies for a Permanent Condition Waiver:

☐ Alzheimer's Disease ☐ Schizophrenia ☐ Limb Amputation ☐ Is Bed Ridden ☐ Is on Hospice

☐ Wheel Chair Confined ☐ Traumatic Brain Injury (TBI) ☐ Renal Failure ☐ Multiple Sclerosis ☐ Blindness

☐ Degenerative Disease Leading to physical incapacity ☐ Other Social or Intellectual Challenge ☐ Dementia or Other Cognitive Disorder

☐ Other (Explain)

Print Director's Name Director's Signature Date

In Home Services Rating Scale

Date of Assessment: _____

Consumer Name:_____

Consumer ID:_____

Consumer Telephone #_____

Program Name:_____

Other Contact Name:_____

Other Contact Telephone # _____

	Yes	No
Lives Alone	☐ 5	☐ 0
Frail	☐	☐
Isolated	☐ 5	☐ 0
Low-Income	☐ 5	☐ 0
Medicaid Eligible	☐ 0	☐ 5

See Definition Tab

Possible Interventions:

Referral made: ☐ Yes ☐ No

Follow-up date/outcome

Possible Interventions:

Referral made: ☐ Yes ☐ No

Follow-up date/outcome

Were the following Contacted: (check the box next to all that apply)

Contact Income Support

Social Security and/or Veterans Administration

To Determine Eligibity with: (check all that apply)

Food Stamps
Energy Assistance
Dentist
Veteran's Benefits
Housing Assistance
Medicaid
Medicare

Social Security and/or Veterans Administration

Rating Scale: See Definition Tab

Apply the score and place in the appropriate category	
ADL'S	
IADL'S	
NUTRITION	
Lives Alone	
Isolated	
Low-Income	
Paid Services from another program	
Medicaid Eligible	
Family/Other Support	
None	
Less than 24 hrs. wkly	
25-40 hrs wkly	
41-60 hrs. wkly	
TOTAL SCORE	

Reassessment Schedule based on Nutrition Score

1-2 Good	3-5 Moderate	6 or More High Nutritional Risk	
CM = 1 year Reassess In Home Services = 6 month Reassess	CM = 1 year Reassess In Home Services = 6 month Reassess	CM = 6 month Reassess In Home Services = 3 month Reassess unless Permanent Condition Wavier	

Highest Risk	High Risk	Moderate	Low
40 OR More	39-30	29-20	0
Homemaker Services per week			check hrs. that apply
5 ☐	4 ☐	3 ☐	2 ☐
Highest Risk	High Risk	Moderate	Low
40 OR More	39-30	29-20	19 or less
Chore Services per week			check hrs. that apply
5 ☐	4 ☐	3 ☐	2 ☐
Highest Risk	High Risk	Moderate	Low
40 OR More	39-30	29-20	19 or less
Home Delivered Meals Services per week			
Breakfast / Lunch/Evening /Wknd Breakfast / Wknd lunch / Wknd Evening ☐	Lunch/Evening & Wknd Lunch ☐	Lunch & Wknd Lunch ☐	Lunch ☐

Non-Metro AAA Data Center Reference Sheet

Initial Assessments /Short Forms Initial Assessments and/or Shorts Forms may be submitted to the data center on the same daily transmittal sheet. These are the forms used when the consumer is not already in the A & D Statewide Database Initial Assessments/ Short Forms are addressed immediately. This will enable the providers to enter service delivery units within 24 hrs. from submission.	**What to do:** If the consumer is not already in A & D • Prior to registering a consumer, users are to search the statewide database to determine if a consumer is already registered. • Complete the new forms and the Daily Transmittal • Scan the Completed Daily Transmittal along with all completed initial assessments or short forms listed. • Name the file using the correct file naming convention. • Upload the file to ShareFile using the link in our e-mails. "Click here to upload Transmittals."
Reassessments Reassessments should be submitted to data center on a daily transmittal sheet separately from both Initial Assessments and Short Forms. Reassessments are used for those consumers who have already been assessed and are in the statewide database. Utilizing the 2-page pre-filled print sheet from A & D.	**What to do:** If the consumer is already in A & D: • Print the 2-page prefilled reassessment pages from A & D. • Complete/Update the reassessments forms and the Daily Transmittal • Scan the Completed Daily Transmittal along with all completed/updated reassessments forms for the listed consumers • Name the file using the correct file naming convention. • Upload the file to ShareFile using the link in our e-mails. "Click here to upload Transmittal."
Change Forms Types of requested changes may include: Phone number, address; remove/add/change emergency contact; add a provider, possible merge (state correct ID), remove/add/change a service (in instances were a reassessment is not required.)	**What to do:** • Complete the Change Form. • Scan the completed form • Name the file using the correct file naming convention. • Upload the file to ShareFile using the link in our e-mails. "Click here to upload Transmittal."
Deactivation Forms Reasons for deactivation would include Deceased, Entered Institutional Care Facility, Moved Out of Area Within Sate, Moved Out of State or Other. (Please make sure to mark reason for deactivation.)	**What to do:** • Complete the Deactivation Form. • Scan the completed form • Name the file using the correct file naming convention. • Upload the file to ShareFile using the link in our e-mails. "Click here to upload Transmittal."

Non-Metro AAA Data Center Reference Sheet

Returned Daily Transmittal Daily transmittal is sent back and marked as Returned. Examples would include: • Missing Pages • Missing pertinent information • Wrong forms used • Services not Clarified • Not due for reassessment	**What to Do:** • Resubmit with the requested information • Complete the column to the left of the consumer's name that was identified as not complete. • Scan the completed file • Upload to ShareFile using the link in our e-mail. "Click here to upload Transmittal."
Validation Errors: **In-Home Services** Validation Error will be indicated by the consumer's name being highlighted in red when attempting to save service delivery. • Reassessment is not up to date • Not listed as provider • New sub-service identified - needs to be added to the consumer service plan.	**What to do:** • Complete the Validation Error log for consumers who should be current • Scan & e-mail the completed Validation Error log to the Data Center using the SAMS E-Mail Group: sams@ncnmedd.com **Please Note:** When submitting a validation error log for a consumer who has been recently reassessed, we ask that you wait and recheck at least 72 hrs. from the time the reassessment was submitted, before e-mailing the validation error log. In addition, please attempt to add the information to the roster, BEFORE sending in the validation error log.
Validation Errors: **Congregate Meals & Transportation** Consumer name not appearing on the roster indicates one of the following: • Reassessment is not up to date • Not listed as provider • New sub-service identified - needs to be added to the consumer service plan.	**What to do:** • Complete the Validation Error log • Scan & e-mail the completed Validation Error log to the Data Center using the SAMS E-Mail Group: sams@ncnmedd.com **Please Note:** Validation error log for consumers who has been recently reassessed, we ask that you wait and recheck at least 72 hrs. from the time the reassessment was submitted, before e- mailing the validation error log. In addition, please attempt to add the information to the roster, BEFORE sending in the validation error log.
Monthly Reports A & D Monthly Reports for reimbursement would include: • SAMS Verification Statement • AAA ASR (Agency Summary Report) • AAA NSIP Report (Nutrition Services Incentive Program) -if applicable • Unregistered Eligible Consumer Print Out (Service Delivery Print Out Sheet) – if applicable • Excel YTD Unregistered Eligible Consumers - if applicable	**What to do:** • Enter units into Roster from Sign-In Sheets on a daily or weekly basis • Verify rosters to ensure totals are correct • Verify ASR & NSIP reconcile (if applicable) • Complete Top portion of SAMS Verification Statement • Sign & Date all reports • Submit all the reports to the Data Center for review by e-mailing them to the SAMS E-Mail Group: sams@ncnmedd.com When Reports are verified signed and returned to you • Sign and date the middle section • Upload to the Monthly Expenditure folder. (This ensures that the process for reimbursement has been completed)