**GOVERNOR’S OFFICE OF ELDERLY AFFAIRS**

**Louisiana Independent Living Assessment (LILA)**

*Statewide Comprehensive Needs* ***Short*** *Assessment Form*

|  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **COVER SHEET** | | | | | | | | | | | | |
| **Assessment #1 Date:**  Is this a Reassessment?  Yes  No  **Assessment #2 Date:**  (Should be in a different color ink) | | | | **Veteran:** Yes No  **Veteran**  **Dependent:** Yes No | | | | | | | **Does the Client need assistance in the event of a disaster evacuation?**  Yes No | |
| **First Name:** | | | **Middle Name:** | | | | | | **Last Name:** | | | **Suffix:** |
| **Gender:**  Male Female  **Gender Identity:** Other:  **\_\_\_\_Non-Binary \_\_\_Transgender-Male \_\_\_\_Transgender-Female \_\_\_ Non-Disclosed** | | | **Maiden Name:** | | | | | | **Client AKA Name:** | | | |
| **Marital Status:**  Divorced  Legally Separated  Married  Single  Widowed | | | **Last 4 of Client’s SS #:**  \_\_\_\_\_\_\_\_\_\_\_ | | | | | | **Date of Birth: Age:**  / / | | | |
| **Client’s ID #** *(WellSky ID)*: | | | | | | **Home Phone:**  ( )  **Cell:**  ( ) | | | |
|  | | | | | |
| **Client’s Residence Address:**  Street  Town  State Zip Code | | | | | | **Client’s Mailing Address** *(if same as Residence, write SAME):*  Street  Town  State Zip Code | | | | | | |
| **Email Address:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | ***From page 4***  **Nutrition Score:** | | | | | | **COA Membership Card**  Accepted  Declined | | | | |
| **Other** (Individual $15,060 2024) | | | | | | | | | | | | |
| **Monthly Poverty Guideline per Person:**  1 - $1,255 or less 4 - $2,600 or less  2 - $1,703 or less 5 - $3,048 or less  3 - $2,151 or less 6 - $3,496 or less | | | | | **Monthly Household Income:**  $ | | **Monthly Individual Income:**  $ | | | **INSURANCE** | | |
| **Medicaid:**  Yes  No | | |
| **Medicaid Policy #:** | | |
| **In Poverty:**  Yes  No  Don’t Know | **Household Size:**    Lives with: | | | | **Medicare #:** | | |
| **Medical Assistance ID #:** | | |

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| **NAPIS** | | | | |
| **Ethnicity:**  Unknown  Hispanic/Latino  Not Hispanic/Latino | **High Nutritional Risk:**  Yes  No | | **NSIP Meal Eligible:**  Yes  No | |
| **Lives Alone:**  Yes  No | **Eligibility Type:**  Age 60 or over  Disabled in Elderly Housing  Disabled living with Elderly  Food Handler  Tribal Specification  Spouse  Volunteer | | Guest/Staff under sixty  I & R Client  Not Indicated / Other | |
| **Is Rural**  Yes  No |
| **Characteristics** | | | | |
| **Abuse/Neglected/Exploited:**  Yes  No | **Duplicate Mail:**  (Everyone in household gets same piece of mail)  Yes  No  **Female Head of Household:**  Yes  No  **Medicare Eligible:**  Yes  No | **State Resident:**  Yes  No  **Tribal:**  Yes  No  **Understand English:**  Yes  No  **U.S. Citizen:**  Yes  No | | **Employment Status:**  Declined to state  Full Time  None  Part Time  Retired  Unemployed |
| **Cognitive Impairment:**  Early Onset Dementia  Mild  Moderate  None  Severe  **Disabled:** Yes  No  **Frail:**  Yes  No  **Homebound:** Yes  No |
| **Receiving Social Security:**  Yes  No |
| **Language:**  English  Russian  Spanish  German  French  Italian  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Race:**  American Indian/ Native Alaskan  White (Non-Minority Non-Hispanic)  Asian  White-Hispanic  Black/African American  Other  Native Hawaiian/Other Pacific Islander | | | |

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| **Additional Contact Information**  Assessment Signature Page | | |
| **EMERGENCY CONTACT**  **Relative/ Friend:** (*other than Spouse/Partner* ***NOT*** *living in the household to contact in case of emergency)*  Name:  Town/State:  Phone:  Cell:  Relationship: | | **Primary Physician**  Name:  Affiliation:  Address:    Phone: |
| **Directions to Client’s Home:** | | |
| **Acknowledgement** | | |
| **Do you have prescription drug insurance?**  Yes  No    **Refer Client to SeniorRx for prescription assistance.** | **Client has been advised that he/she has an opportunity to make voluntary and anonymous donations for any service they may receive and has received a copy of the policy.**  Yes  No | |
| **The Client formally authorized release of information. Copy of signed and dated authorization is attached to this assessment.**  Yes  No | **ASSESSMENT #1** | |
| Where did assessment take place:  **Client Signature:**   **Date:**  Client Printed Name:  **Assessor Signature:**   **Date:**  Assessor Printed Name: | |
| **List services the Client would like to receive:**  Transportation  Congregate Meals  HPDP  Recreation  Utility Assistance  Material Aid  Wellness  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **ASSESSMENT #2 in a different color** | |
| Where did assessment take place:  **Client Signature:**   **Date:**  Client Printed Name:  **Assessor Signature:**   **Date:**  Assessor Printed Name: | |

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| **NUTRITIONAL HEALTH RISK**  (Circle your answers and add up your score) | | | | | | | **YES** | **NO** |
| Has the client made any changes in lifelong eating habits because of health problems? | | | | | | | **2** | **0** |
| Does the client eat less than two meals per day? | | | | | | | **3** | **0** |
| Does the client eat less than five servings (1/2 cup each) of fruits and vegetables per day? | | | | | | | **1** | **0** |
| Does the client eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day? | | | | | | | **1** | **0** |
| Does the client sometimes not have enough money to buy food? | | | | | | | **4** | **0** |
| Does the client have trouble eating well due to problems with chewing/swallowing? | | | | | | | **2** | **0** |
| Does the client eat alone most of the time? | | | | | | | **1** | **0** |
| Without wanting to, has the client lost or gained ten pounds in the past six months? | | | | | | | **2** | **0** |
| Is the client not always physically able to shop, cook, and/or feed themselves (or to get someone to do it for them)? | | | | | | | **2** | **0** |
| Does the client have three (3) or more drinks of beer, liquor, or wine almost every day? | | | | | | | **2** | **0** |
| Does the client take three (3) or more different prescriptions or over-the-counter drugs per day? | | | | | | | **1** | **0** |
| **TOTALS** | | | | | | |  |  |
| **Add YES + NO for your total nutrition score.** | | | | **COMBINED TOTAL** | | | \_\_\_\_\_\_\_\_ | |
| If score is |  | | | | | | | |
| 0 – 2 | GOOD! Recheck the Nutritional Score in 6 months. | | | | | | | |
| 3 – 5 | You are at moderate nutritional risk. See what can be done to improve your eating habits and lifestyles. Your area agency on aging, senior nutrition program, senior citizens center or health department can help. Recheck your Nutritional Score in 3 mo. | | | | | | | |
| 6 or more | You are at high nutritional risk. Bring a copy of this checklist the next time you see your doctor, dietitian, or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health. | | | | | | | |
| ***(Be sure to put score total on second page of Assessment)*** | | | | | | | | |
| **MEDICATION REVIEW** | | | | | | | | |
| 1. **MEDICATION USE:** *(Ask the Client if you can see the medications so that you can verify frequency, dosage, etc. Include over the counter drugs like aspirin, laxatives, and vitamins. Some medicines may be refrigerated.)* | | | | | | | | |
| 1. Are you taking any medicines? If so, could you show them to me so we can list their names and dosage? | | | | | | | | |
| **MEDICATION NAME** | | **PRIMARY DIAGNOSIS** | **DIRECTIONS/STRENGTH/**  **DOSAGE** | | **PRESCRIBING**  **DOCTOR & PHONE** | **MANUFACTURER**  **& COST** | | |
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| 1. Do you have problems or difficulty remembering to take your medications? a.  Yes b.  No   *(If necessary, prompt the Client by asking if s/he is concerned about forgetting. What steps does s/he take to remember?)* | | | | | | | | |
| 1. Please list your drug allergies: ­ | | | | | | | | |
| 1. Referral made: | | | | | | | | |