GOVERNOR'S OFFICE OF ELDERLY AFFAIRS
Louisiana Independent Living Assessment (LILA)
*Statewide Comprehensive Needs **Short** Assessment Form*

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
2 - $1,703 or less
3 - $2,151 or less
4 - $2,600 or less
5 - $3,048 or less
6 - $3,496 or less

Monthly Household Income:
$ _____

Monthly Individual Income:
$ _____

In Poverty:
☐ Yes
☐ No
☐ Don't Know

Household Size:
_____
Lives with: _____
_____

INSURANCE

Medicaid:
☐ Yes ☐ No

Medicaid Policy #:

Medicare #:

Medical Assistance ID #:

Prelim Done _____ Initials ____

Client's Initials_____

NAPIS

Ethnicity:

- ☐ Unknown
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

High Nutritional Risk:

- ☐ Yes
- ☐ No

NSIP Meal Eligible:

- ☐ Yes
- ☐ No

Lives Alone:

- ☐ Yes
- ☐ No

Is Rural

- ☐ 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

Characteristics

Abuse/Neglected/Exploited:

- ☐ Yes
- ☐ No

Cognitive Impairment:

- ☐ Early Onset Dementia
- ☐ Mild
- ☐ Moderate
- ☐ None
- ☐ Severe

Disabled: ☐ Yes ☐ No

Frail: ☐ Yes ☐ No

Homebound: ☐ Yes ☐ No

Language:

- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Russian
- ☐ German
- ☐ Italian
- ☐ Other _____

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

Receiving Social Security:

- ☐ Yes
- ☐ No

Race:

- ☐ American Indian/ Native Alaskan
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White (Non-Minority Non-Hispanic)
- ☐ White-Hispanic
- ☐ Other

Assessment Signature Page

Additional Contact Information

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: _____

Client's Initials_____

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

A. 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

2. 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?)
3. Please list your drug allergies: _____
4. Referral made: _____