EISEP INTAKE SCREENING FORM

Clinton County Office for the Aging
135 Margaret Street, Plattsburgh NY 12901

Referral Date 1 _____________ Referral Date 2 _____________

Date: _____/_____/_____ Screener: ____

Referred by: ___________________DOB: Agency/Relationship: _______________________________________

Consumer's Name: ___________________________________ Date of Birth ____/____/____ Age_______________

Phone: ____ Address: ____

Email address:___________________________________ ____

Is Consumer:

_____Yes _____ No a minority

_____Yes _____ No living Alone

_____Yes _____ No using Lifeline

_____Yes _____ No a Veteran

_____Yes _____ No seen by a doctor at least yearly

Does consumer receive:

_____Yes _____ No HEAP

_____Yes _____ No SNAP

_____Yes _____ No HCR

_____Yes _____ No Home Delivered Meals

Doctor(s) Names and Phone Numbers: ____

Has consumer applied for or received Medicaid in the past 6 months? _____Yes _____ No

Total monthly income: ______________ Medicare Advantage Plan?________________ Part D Plan_______

Total resources: ___________________ Are you currently making a Medicaid spend down?______________

_____Yes _____ No Are there significant Medical Expenses? Explain____

_____Yes _____ No Does the consumer have a Medicare Supplemental policy?

Family/Neighbor Contact: ______________________________________ Phone: _________________________________

Address of Contact: ____

Email of contact: ____

Does the caregiver wish to be added to mailing/email list for caregiver support?_______________________________

Are there safety issues? _____Yes _____ No If yes, explain: ____

____

Medical Management by: _____ Client _____ Others Are medications well managed? _____Yes _____ No

What type of assistance is being sought? ____

____

Who is helping now and how are they helping (include private hire)?

____

____

____

Does the consumer need help with these IADL's?:

_____ transport _____ laundry _____ housekeeping _____ telephone

_____ shopping _____ handling finances _____ taking medications _____ cook/heat meals

Does the consumer need help with these ADL's?:

_____ bathing _____ walking _____ transferring _____ dressing

_____ toileting _____ eating _____ personal hygiene

Are there concerns with Memory or Mental Health? ____

____

____

Are there areas of strength or weaknesses identified for consumer and/or family? ____________________________

Does the consumer have:

_____ vision problems _____ respiratory problems _____ arthritis

_____ diabetes _____ heart disease _____ recent falls or fractures

_____ hearing loss _____ mobility problems _____ incontinence

Does applicant have:

_____ hearing aids _____ glasses _____ dentures _____ cane

_____ walker _____ wheel chair _____ bath bench _____ lift chair

_____ grab bars _____ hand held shower _____ ramp

Does consumer have any of the above devices but not use them? _____Yes _____ No

If not used, for what reasons (fit, usefulness, working condition, etc.)? ______________________

Pets in home? ____

Other:

____

____

____

____

____

____

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