

Appendix J: Participant Survey

Please use this document to report information about consumers as they apply for services under the project. Please complete one form for each new consumer.

Consumer Contact Information

1) Center:

2) Consumer's Nickname: Salutation: (Mr., Ms., Sr., etc.)

3) First Name: MI: Last Name:

4) Date of Application: (M/d/yy)

5) Name of Nursing Facility:

(If name of facility has changed, write "Name Change" after inserting current name.)

Facility Code:

Reference: See Nursing Facilities for Data Entry for a list of nursing homes and

6) Current Mailing/Home Address #1:

Room Number: *(Include only if consumer is residing in a nursing home)*

Current Mailing Address #2: *(Include Apt. # or PO Box here if consumer is in community)*

Town:

State: CT

Zip Code:

7) Consumer Telephone: Consumer TDD? (Check if yes)

Consumer E-Mail:

8) Alternate Contact Name:

Contact Telephone: Alternate TDD? (Check if yes)

Contact E-Mail:

1 = Conservator 2 = Guardian 3 = Parent 4 = None

9) **Legal Representative:**

First Name: **Last Name:**

Address:

City: **State:** CT **ZIP:**

Legal Rep. Limitations:

10) **Meets grant requirements?** (Check if yes)

11) **Reason not participating:**

12) **Date Accepted for Services:** (M/d/yy)

Consumer Demographics

1) **Social Security Number:** (Please **do not** include hyphens "-")

2) **Medicaid Number:**

3) **Date of Birth:** (M/d/yy)

4) **Gender:**

M = Male F = Female

5) **Veteran?** (Check if yes)

6) **Spouse of Veteran?** (Check if yes)

7) **How did the consumer learn about the project?**

8) **Date the consumer learned about the project:** (M/d/yy)

9) Date consumer contacted ILC: (M/d/yy)

10) Date consumer applied to the project: (M/d/yy)

11) Date consumer was admitted to the project: (M/d/yy)

12) Ethnic background of consumer:

Ethnic background other:

Reference: See Page 2, Item (1) of Instructions for **Ethnic Codes**

13) Disability categories: (For multiple disabilities, check Multiple AND all that apply.)

<i>Disability Category</i>	<i>Check only if YES</i>
Cognitive	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>
Physical	<input type="checkbox"/>
Visual	<input type="checkbox"/>
Hearing	<input type="checkbox"/>
Multiple	<input type="checkbox"/>
Declined	<input type="checkbox"/>

14) Which specific disabilities represent the primary, secondary and tertiary disabilities of the consumer? (For instances where secondary and/or tertiary disabilities are not present, please enter Code Number 23 for "none")

Primary Disability:

Primary Disability Other:

Secondary Disability:

Secondary Disability Other:

Tertiary Disability:

Tertiary Disability Other:

Reference: See Page 2, Item (2) of Instructions for **Specific Disability Codes**

15) Community where the consumer would like to transition:

Preferred community:

Reference: See Page 3, Item (3) of Instructions for **Education Codes**

16) Consumer's level of education:

Comments/notes about education level:

17) Consumer's employment history:

How many years (in total) did the consumer work since turning age 18?

Years worked:

Reference: See Page 3, Item (4) of Instructions for **Work History Codes**

What was the consumer's highest level of earnings in any one year from wages, salary or profit from a business?

Level of earnings:

Reference: See Page 3, Item (4) of Instructions for **Earning Codes**

18) Nursing facility history at time of consumer's admission to project:

- Was the consumer discharged from a hospital to the nursing facility?
 (Check if yes)

If yes, what was the name of the hospital?

- Date consumer was admitted to nursing facility: (M/d/yy)
→(If the consumer has been in a number of nursing facilities consecutively, enter date admitted to the first facility.)

- Reason consumer was admitted:

- What is the level of care for the consumer in the facility?

Skilled (CCNH) or Intermediate

- What was the consumer's last address of record? (Town only)

- **Where did the consumer reside before admission to this facility?**

Reference: See Page 3, Item (5) of Instructions for **Former Residence Codes**

- **What was the consumer’s living situation before admission?**

Reference: See Page 4, Item (6) of Instructions for **Living Situation Codes**

- **If the consumer lived with other people, were the people serving as caregivers to the consumer?** **(Check if yes)**
- **How many times (if any) was the consumer discharged to the community?**
- **If the consumer was discharged from a facility, what factor(s) led to readmission to a nursing facility?**

Consumer Daily Living Needs

- 1) **How does the individual’s disability affect them functionally in terms of living independently?**

- 2) **Activities of Daily Living**

Needs Hands on Assistance (Check if yes)	Needs Cueing or Guidance (Check if yes)	Activity
<input type="checkbox"/>	<input type="checkbox"/>	Bathing
<input type="checkbox"/>	<input type="checkbox"/>	Dressing
<input type="checkbox"/>	<input type="checkbox"/>	Transferring
<input type="checkbox"/>	<input type="checkbox"/>	Eating
<input type="checkbox"/>	<input type="checkbox"/>	Bowel/Bladder Care

3) Instrumental Activities of Daily Living

Needs Hands on Assistance (Check if yes)	Needs Cueing or Guidance (Check if yes)	Activity
<input type="checkbox"/>	<input type="checkbox"/>	Housework
<input type="checkbox"/>	<input type="checkbox"/>	Finances
<input type="checkbox"/>	<input type="checkbox"/>	Transportation
<input type="checkbox"/>	<input type="checkbox"/>	Shopping
<input type="checkbox"/>	<input type="checkbox"/>	Management of Support Services
<input type="checkbox"/>	<input type="checkbox"/>	Other IADL

Description of "Other" Instrumental Activity:

4) Are there other supports needed by the consumer? (Check if yes)

Description of other supports needed:

Consumer Placement History

References:
 See Page 4, Item (7) of Instructions for **Reason for Admission Codes**
 See Page 3, Item (5) of Instructions for **Former Residence Codes**
 See Page 4, Item (6) of Instructions for **Living Situation Codes**
 See Page 4, Item (8) of Instructions for **Reasons for Discharge**
 See Page 5, Item (9) of Instructions for **Discharge Destination Codes**

	Current Facility ∨	Next Previous ∨	Next Previous ∨	Next Previous ∨
Type of Placement				
Date Admitted (M/d/yy)				
Reason for Admission				
Former Residence				
Former Living Situation				
Discharge Date (M/d/yy)				
Reason for Discharge				
Discharge Destination				

Description of Other Living Situation:

Consumer Resource Needs and Utilization

1) Status of Resources Needed

References:
See Page 5, Item (10) of Instructions for **Support Services Needed Codes**
See Page 5, Item (11) of Instructions for **Support Status**

For each support needed, start at the top of the first available column (start at left) and fill down.

Support Needed					
Support Status					
Estimated Date Needed (m/d/yy)					
Total Estimated Cost					
Primary Payer					
Amount Requested					
Amount Paid					
Secondary Payer					
Amount Requested					
Amount Paid					

Description of other supports needed: