Iowa Department on Aging
510 E 12th Street, Ste. 2
Des Moines, IA 50319
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www.iowaaging.gov

*** Date (MM/DD/YYYY):** _____

Options Counseling Assessment Form

Prior to completing this form, please ensure the Aging & Disability Network Consumer Intake Form is complete and current. All fields on this form marked with an asterisk (*) are required fields; the form will not be considered complete unless all required fields are marked.

SECTION 1: GENERAL INFORMATION

*** Consumer name (as it appears on the Aging & Disability Network Consumer Intake Form):**			
FIRST NAME	MI	LAST NAME	
*** Type of assessment:**	☐ INITIAL ASSESSMENT	☐ REASSESSMENT	
*** Name of person completing this assessment:**			
FIRST NAME		LAST NAME	
AGENCY/ORGANIZATION		PHONE NUMBER	
Interpreter needed:	☐ YES	☐ NO	☐ UNKNOWN
Reason for interpreter:	☐ PRIMARY LANGUAGE	☐ PRIMARY LANGUAGE AT HOME	☐ SIGN LANGUAGE
Interpreter's availability:	☐ ALWAYS	☐ DAYTIME	☐ NIGHTS
	☐ SOMETIMES	☐ WEEKENDS	

SECTION 2: LIVING ARRANGEMENT

*** Current living arrangement:**	☐ LIVES ALONE	☐ WITH SPOUSE/PARTNER	☐ WITH SPOUSE & CHILD
	☐ WITH CHILD/CHILDREN	☐ WITH OTHERS	☐ INFORMATION UNAVAILABLE
*** Consumer other living arrangement:**	☐ ALONE	☐ SPOUSE	☐ NURSING FACILITY
	☐ CHILD	☐ HOMELESS	☐ N/A
	☐ FAMILY MEMBER	☐ ASSISTED LIVING	☐ OTHER
	☐ FRIEND	☐ ICF/IDD FACILITY	
	☐ ROOMMATE	☐ MENTAL HEALTH FACILITY	
*** Total number in household, including consumer:**			

SECTION 3: DENTAL STATUS

*** Consumer has a dentist:**	☐ YES	☐ NO	
*** Last time consumer saw a dentist:**	☐ MORE THAN 1 YEAR AGO	☐ WITHIN THE PAST YEAR	☐ WITHIN THE PAST 6 MONTHS
*** If the consumer has not seen a dentist, does he/she need assistance locating one?**	☐ YES	☐ NO	
*** Consumer has dental insurance:**	☐ YES	☐ NO	

SECTION 4: CONSUMER RESOURCES

Financial Resources

*** Current payment source(s) for services:**

- ☐ COMMUNITY OPTIONS/COMMUNITY INTEGRATION PROGRAM
- ☐ LONG-TERM CARE INSURANCE
- ☐ LOW-INCOME SUBSIDY
- ☐ MEDICAID
- ☐ MEDICALLY NEEDY
- ☐ MEDICARE ADVANTAGE
- ☐ MEDICARE PART A
- ☐ MEDICARE PART B
- ☐ MEDICARE PART D
- ☐ MEDICARE SAVINGS PROGRAM
- ☐ OTHER GOVERNMENT (e.g., CHAMPUS, VA, etc.)
- ☐ PRIVATE INSURANCE
- ☐ PRIVATE PAY
- ☐ QMB-LIMITED MEDICAID
- ☐ SELF-PAY
- ☐ SLMB-LIMITED MEDICAID
- ☐ SSI-RELATED MEDICAID
- ☐ WORKER'S COMPENSATION

*** Income source(s):**

- ☐ ANNUITIES
- ☐ DIVIDENDS/INTEREST
- ☐ MILITARY RETIREMENT
- ☐ OTHER NON-WORK INCOME
- ☐ PENSION/RETIREMENT BENEFITS
- ☐ PUBLIC ASSISTANCE/CASH ASSISTANCE
- ☐ PUBLIC ASSISTANCE-TANF
- ☐ RAILROAD RETIREMENT BENEFITS (RRB)
- ☐ SENIOR COMMUNITY SERVICE EMPLOYMENT
- ☐ SOCIAL SECURITY (SS)
- ☐ SOCIAL SECURITY DISABILITY INCOME (SSDI)
- ☐ SUPPLEMENTAL SOCIAL SECURITY (SSI)
- ☐ UNEMPLOYMENT BENEFITS
- ☐ VETERANS BENEFITS
- ☐ WORK INCOME
- ☐ WORKER'S COMPENSATION

Self-declared assets and resources:

CONSUMER HAS STOCK/BONDS/CDS? ☐ YES ☐ NO		MONTHLY INCOME FROM STOCK/BONDS/CDS $	
CONSUMER HAS INSURANCE SETTLEMENTS? ☐ YES ☐ NO		MONTHLY INCOME FROM INSURANCE SETTLEMENTS $	
CONSUMER HAS SAVINGS ACCOUNTS? ☐ YES ☐ NO		TOTAL BALANCE OF SAVINGS ACCOUNTS $	
CONSUMER HAS CHECKING ACCOUNTS? ☐ YES ☐ NO		TOTAL BALANCE OF CHECKING ACCOUNTS $	
CONSUMER HAS IRA/PENSION ACCOUNTS? ☐ YES ☐ NO		MONTHLY INCOME FROM IRA/PENSION ACCOUNTS $	
CONSUMER HAS VETERANS BENEFITS? ☐ YES ☐ NO		MONTHLY INCOME FROM VETERANS BENEFITS $	
CONSUMER HAS SOCIAL SECURITY/SSDI/SSI BENEFITS? ☐ YES ☐ NO		MONTHLY INCOME FROM SOCIAL SECURITY/SSDI/SSI BENEFITS $	
CONSUMER RECEIVES MONTHLY INCOME FROM FARM RENTAL? ☐ YES ☐ NO	FARM PROPERTY VALUE $	MONTHLY FARM RENTAL INCOME $	
CONSUMER HAS ANNUITY INCOME? ☐ YES ☐ NO		MONTHLY INCOME FROM ANNUITIES $	

SECTION 5: POWER OF ATTORNEY *(Data in this section not collected by the IDA)*

Consumer has a power of attorney:	☐ YES	☐ NO	☐ DON'T KNOW
Type of power of attorney:	☐ GENERAL ☐ LIMITED	☐ MEDICAL	☐ GENERAL & MEDICAL
Power of attorney information:			
FIRST NAME		LAST NAME	
PHONE NUMBER		POWER OF ATTORNEY EFFECTIVE DATE (MM/DD/YYYY)	