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

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 _____

NAPIS

Lives Alone:
- ☐ Yes
- ☐ No

Is Rural
- ☐ Yes
- ☐ No

High Nutritional Risk:
- ☐ Yes
- ☐ No

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: _____
Address: _____
Phone: _____

From page 4
Nutrition Score: ☐
ADL Score: ☐
IADL Score: ☐

GOEA Score:

COA Membership Card
_____ Accepted
_____ Declined

Prelim Done _____ Initials ____

Client's Initials _____

Directions to Client's Home: _____

Other (Individual $15,060 **2024**)			
Monthly Poverty Guideline: 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:** $ _____	**Insurance:** **Medicaid:** ☐ Yes ☐ No **Medicaid Policy #:**
In Poverty: ☐ Yes ☐ No ☐ Don't Know	**Household Size:** # _____ Lives with: _____ _____	**Monthly Individual Income:** $ _____	**Medicare #:** **Medical Assistance ID #:**

Characteristics			
Abused/Neglected/Exploited: ☐ Yes ☐ No	**Duplicate Mail:** (Everyone in household gets same piece of mail) ☐ Yes ☐ No	**State Resident:** ☐ Yes ☐ No **Tribal:** ☐ Yes ☐ No	**Employment Status:** ☐ Declined to state ☐ Full Time ☐ None ☐ Part Time ☐ Retired ☐ Unemployed
Cognitive Impairment: ☐ Early Onset Dementia ☐ Mild ☐ Moderate ☐ None ☐ Severe	**Female Head of Household:** ☐ Yes ☐ No **Medicare Eligible:** ☐ Yes ☐ No	**Understands English:** ☐ Yes ☐ No **U.S. Citizen:** ☐ Yes ☐ No	**Receiving Social Security:** ☐ Yes ☐ No
Disabled ☐ Yes ☐ No **Frail** ☐ Yes ☐ No **Homebound** ☐ Yes ☐ No	**Language:** ☐ English ☐ Russian ☐ Spanish ☐ German ☐ French ☐ Other ☐ Italian	**Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/ Latino ☐ Unknown	**Race:** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White Hispanic ☐ White (Non-Minority Non-Hispanic) ☐ Other

Client's Initials _____

NSIP Meal Eligible: ☐ Yes ☐ No	**Eligibility Type:** ☐ Age 60 or over ☐ Disabled in Elderly Housing ☐ Disabled living with Elderly ☐ Food Handler ☐ Volunteer ☐ Spouse ☐ Tribal Specification ☐ Guest/Staff under sixty ☐ I & R Client ☐ Not Indicated/Other
	Email Address: _____

Client's Initials _____

1.A Intake		
(1) Where was the Client interviewed? ☐ Home ☐ Nursing Facility ☐ Hospital ☐ Other	**Describe where the Client was interviewed**	**(2) Did someone help the Client or answer questions for the Client?** ☐ Yes ☐ No
(3) Name of the person that helped the Client?		**(4) What is the helper's relationship to the Client?**
(5) What is the name of the person conducting this assessment?		**(6) Name of the agency where the Assessor works?**
(7) Was communication/language assistance needed for this assessment? ☐ Yes ☐ No		**(8) What type of communication/language assistance was needed for this assessment?**

1.B Legal Representative: (If not applicable, please go to the next page)	
Does the Client have a power of attorney? ☐ Yes ☐ No	**Does the Client have a Legal Guardian?** ☐ Yes ☐ No
What is the name of the Client's Power of Attorney?	**What is the name of the Client's Guardian?**
Phone number of Client's Power of Attorney. (H) _____ (C) _____	**Does the Client have a Living Will?** ☐ Yes ☐ No
	If the Client does not have a living will, was information provided about advanced directives? ☐ Yes ☐ No

1.C Assessment Information	
(1) **What is the Client's main problem or reason for referral (when not a standard choice)?**	**(2) Who was the Client referred by?** ☐ A=Self ☐ D=Agency ☐ B=Family ☐ E=Other ☐ C=Hospital
What is the name of the agency that referred the Client?	**Who referred the Client?**

(1) Indicate the type of residence that the Client currently resides

☐ A = House/Mobile Home
☐ B = Private apartment
☐ C = Private apartment in senior housing
☐ D = Residential care home
☐ E = Nursing home
☐ = Other

Client's Initials _____

(4) Select the Client's living arrangement.

- ☐ A=Lives Alone
- ☐ B=With Spouse/Partner
- ☐ C=Lives with Spouse and Child
- ☐ D=With Child/Children
- ☐ E=Information Unavailable
- ☐ F=With others

(5) What is the name of the Client's Spouse or Partner?

(6) Does the Client have any children nearby?

☐ Yes ☐ No

(7) Does the Client have contact with family often enough?

☐ Yes ☐ No

(8) Does the Client have contact with friends often enough?

☐ Yes ☐ No

(9) Is there a friend or relative that could take care of the Client for a few days?

☐ Yes ☐ No

(10) How does the Client rate his/her health?

- ☐ A = Excellent
- ☐ B = Good
- ☐ C = Fair
- ☐ D = Poor
- ☐ E = Information Unavailable

(11) In a typical week, during the last 30 days, how often did the Client go outside of their residence (no matter for how short of a period of time)?

- ☐ A = Two or more days a week
- ☐ B = One day a week or less

(12) Is the Client limited in what s/he can do because of the stroke/ neurological condition?

☐ Yes ☐ No

(13) How often does bad health, sickness, pain, or disability stop the Client from doing things s/he would like to do?

☐ A = Never ☐ C = Often
☐ B = Sometimes ☐ D = Always

(14) Indicate which of the following conditions/diagnoses the Client currently has.

- ☐ A = Heart problems
- ☐ B = Arthritis
- ☐ C = Diabetes
- ☐ D = Cancer
- ☐ E = Stroke/neurological problems
- ☐ F = Mental/emotional condition
- ☐ G=Breathing disorders
- ☐ H=Cataracts
- ☐ I=Urinary problems
- ☐ J = Ankle/leg swelling
- ☐ K = Cognitive impairment/dementia
- ☐ L = Other

(15) When the Client makes a decision about something, how does s/he do it?

- ☐ A=Independently and alone
- ☐ B=Independently after talking to family/friends
- ☐ C=Follow advice of family/friends
- ☐ D=Dependent
- ☐ E=Information unavailable

(16) What was the Client's response when asked, "What year is it?"

☐ A = Correct answer ☐ B = Incorrect answer

(17) What was the Client's response when asked, "What month is it?"

☐ A = Correct answer ☐ B = Incorrect answer

(18) What was Client's response when asked, "Where are you now?"

☐ A = Correct answer ☐ B = Incorrect answer

(19) Has the Client fallen in the past three months?

☐ Yes ☐ No

(20) Does the Client use a walker to get around?

☐ Yes ☐ No

(21) Does the Client use a wheelchair to get around?

☐ Yes ☐ No

Client's Initials _____

(22) Does the Client have problems with hearing that are not corrected with aids/devices? ☐ Yes ☐ No	**Describe the aids/devices used by the Client to correct hearing problems.**
(23) Are the Client's hearing aids/devices in working order? ☐ Yes ☐ No ☐ Don't Know	
(24) Does the Client have problems with vision that are not corrected with aids/devices? ☐ Yes ☐ No	**Describe the aids/devices used by the Client to correct vision problems.**
(25) Are the Client's vision aids/devices in working order? ☐ Yes ☐ No ☐ Don't Know	
(26) Does the Client have problems with speech that are not corrected with aids/devices? ☐ Yes ☐ No	**Describe the aids/devices used by the Client to correct speech problems.**
(27) Are the Client's speech aids/devices in working order? ☐ Yes ☐ No ☐ Don't Know	
(28) Does the Client often feel sad or blue? ☐ Yes ☐ No ☐ Don't Know	**(29) How many prescription medications does the Client take?**

(30) Is the Client participating in any of the following services or programs?

- ☐ A = Attendant Services Program (Not applicable to Louisiana
- ☐ B = Medicaid Waiver
- ☐ C = Homemaker Program
- ☐ D = Home Health Aide
- ☐ E = Nursing
- ☐ F = Speech Therapy
- ☐ G = Occupational Therapy
- ☐ H = Physical Therapy
- ☐ I = Home Delivered Meals
- ☐ J = Emergency Lifeline
- ☐ K = Senior Companion
- ☐ L = Weatherization
- ☐ M = Congregate Meals
- ☐ N = VCIL Peer Counseling **(Not Applicable to Louisiana)**
- ☐ O = Adult Day Services
- ☐ P = Job Counseling/Vocational Rehabilitation
- ☐ Q = Food Stamps
- ☐ R = Fuel Assistance
- ☐ S = Telephone Lifeline
- ☐ T = Medicaid
- ☐ U = SSI (Supplemental Security Income)
- ☐ V = V-Script **(Not Applicable to Louisiana)**
- ☐ W = QMB/SLMB (Medicare Savings Program: Qualified Medicare Beneficiary/Specified Low Income Medicare Beneficiary)
- ☐ X = Essential Person Program
- ☐ Y = ANFC **(Not Applicable to Louisiana)**
- ☐ Z = VHAP **(Not Applicable to Louisiana)**
- ☐ 0 = Other

(31) Does the Client want to apply for any of the following services or programs?

- ☐ A = Attendant Services Program (Not applicable to Louisiana
- ☐ B = Medicaid Waiver
- ☐ C = Homemaker Program
- ☐ D = Home Health Aide
- ☐ E = Nursing
- ☐ F = Speech Therapy
- ☐ G = Occupational Therapy
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- ☐ Z = VHAP **(Not Applicable to Louisiana)**
- ☐ 0 = Other

Client's Initials _____

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: ☐ HDM ☐ Homemakers ☐ PCA ☐ Congregate Meals ☐ Recreation ☐ Transportation ☐ Med Alert ☐ Other ☐ Material Aid	**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 fewer than two meals per day?	**3**	**0**
Does the Client eat fewer than five servings (1/2 cup each) of fruits and vegetables?	**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 have trouble eating well due to chewing/swallowing?	**2**	**0**
Does the Client sometimes not have enough money to buy food?	**4**	**0**
Does the Client eat alone most of the time?	**1**	**0**
Does the Client take three (3) or more different prescriptions or over-the-counter drugs per day?	**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**
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)

Client's Initials _____

ADL & IADL SCORE								
	Without Help (ADL 0-7) (IADL 0-10)			**If No, Do you have help?**		**If yes, Is it enough help?**		
Can you . . .	**Yes**	**No**		**Yes**	**No**	**Yes**	**No**	**Comments**
a) get around inside your home			ADL					
b) bathe			ADL					
c) dress			ADL					
d) get in and out of bed/chair			ADL					
e) use toilet			ADL					
f) eat			ADL					
g) groom yourself			ADL					
h) manage your money			IADL					
i) do laundry			IADL					
j) take care of shopping			IADL					
k) take your medication			IADL					
l) prepare your meals			IADL					
m) perform heavy home chores			IADL					
n) perform ordinary housework			IADL					
o) take our garbage			IADL					
p) use transportation			IADL					
q) use telephone			IADL					

TOTAL: ADL _____ **IADL** _____ **(**Record the **Total** number of "**NO Without Help**" for ADL and IADL score**)**

Client's Initials _____

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: _____

Client's Initials _____

GOEA SCORE SHEET

Client Name: _____ **ID #** _____ **Date:** _____

Nutritional Score (Page 4): _____ **Services Requested**: _____

	Question	Score
1.	Is this person low income? Yes = 1 No = 0	
2.	Is this person a minority? Yes = 1 No = 0	
3.	Is this person living alone? Yes = 1 No = 0	
4.	What is the person's ADL count from page 4 (Score 0-7)?	
5.	What is the person's IADL count from page 4 (Score 0-10)?	
6.	Is the person residing in a rural area? Yes = 1 No = 0	
7.	What age is the person? Below 75 = 0 75 – 84 = 1 85+ = 2	
8.	What level of support is currently available to this person? High = 0 Moderate = 1 Very little or none = 2	
9.	Is the person on a special diet? Yes = 1 No = 0	
10.	Is the person homebound? Yes = 1 No = 0	

[1]**Total**	

***[11]Assessor override*:**	**Eligibility for Priority status to override Total Score (Check all that apply – at least one must apply to be eligible)**
	Client is an older individual in greatest economic need
	Client is older individual in greatest social need

[1]The highest score is 27. Persons with the highest score on the waiting list should be served first.
[11]Assessor utilizing the override is required to maintain documentation on file.