DIVISION OF AGING AND ADULT SERVICES

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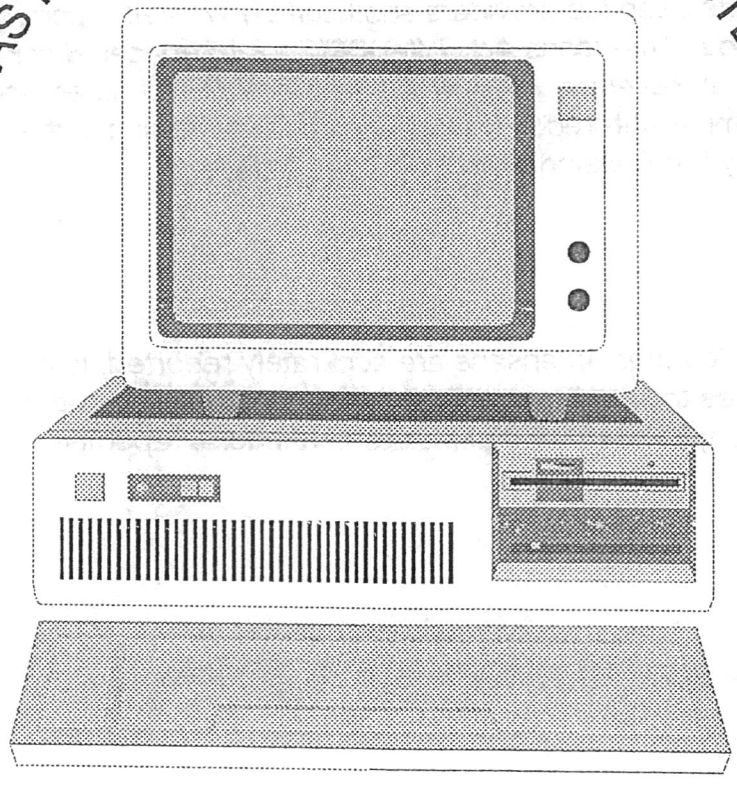
SHARON PRIEST
SECRETARY OF STATE
STATE OF ARKANSAS
BY

ARKANSAS INFORMATION REPORTING SYSTEM (AIRS)



AREA AGENCIES ON AGING

DRAFT

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF AGING AND ADULT SERVICES

Policy 208.00	Reporting	Effective: July 1, 1996

Policy Statement:

The Division of Aging and Adult Services (DAAS), the area agencies on aging (AAA), and the contracted service providers shall comply with all reporting requirements of the Older Americans Act, Title XX (Social Services Block Grant or SSBG), State General Revenue, Discretionary Grants and all other funding sources. Failure to comply with reporting requirements may result in the withholding of grants by the Division Director.

Purpose:

To ensure that services to older Arkansans are accurately reported, to make it possible to relate services to specific populations and identify areas where older individuals may be underserved and to fulfill state and federal reporting requirements.

Scope:

Applies to DAAS, the AAAs and the contracted service providers.

General Authority:

The Older Americans Act of 1965 as amended.
Arkansas Code Ann. 25-10-101 et. seq.
Social Services Block Grant

Taxonomy

Service and Unit Descriptions

Adult Day Care: A group program designed to provide care and supervision to meet the needs of 4 or more functionally impaired adults for periods of less than 24 hours, but more than 2 hours per day in a place other than in the adult's own home. Meals, transportation and recreational activities are also provided.

Unit definition: 1 hour

Medicaid service and unit definition -same

Chore Service: This is a household service which may include running errands, preparing food, simple household tasks, heavy cleaning or yard and walk maintenance which the client is unable to perform alone and which do not require the services of a trained homemaker or other specialist. This cannot include medically oriented personal care tasks.

Unit definition: 1 hour

Medicaid service and unit definition: Provides heavy cleaning and/or yard and sidewalk maintenance only in extreme, specific and individual circumstances when lack of these services would make the home uninhabitable. This service does not include routine lawn and yard maintenance.

Unit definition: 1 hour

Client Representation: Client Representation is an activity under which a client's needs are assessed and services to meet those needs are either provided directly by the Client Representative or arranged for in an organized and consistent manner. Client Representation includes, but is not limited to, such activities as outreach; referral for legal assistance; providing information about and determining eligibility for public benefits such as QMB and SMB; assisting with completion of applications and paperwork; attending meetings on behalf of clients; and providing information and assistance. Clients receiving both Medicaid Targeted Case Management and Client Representation will not receive duplicate services.

Unit definition: 1 client per annual reporting period

Employment Services: This service provides an organized program of counseling, assessment, training and placement in employment, either subsidized or unsubsidized. Clients must be 55 or older.

Unit definition: 1 person

ARKANSAS INFORMATION REPORTING SYSTEM (AIRS)

AAA Reporting Requirements

›e Report	Frequency	Due Date (NLT)	Submit To	cc	Form	Comments
›enditure/Request for Cash	Monthly	12th Working Day	DAS - Fin. Supp. System	DAAS		
; III Preliminary Year End	Annual	Feb 15	DAS - Fin. Supp. System	DAAS		Carryover should be shown on revised NGAs submitted to DAAS
te Fund and Title V Federal liminary Year End	Annual	Aug 15	DAS - Fin. Supp. System	DAAS		There is no carryover on State funds.
; V Final	Annual	Oct 1	DAS - Fin. Supp. System	DAAS		All excess Title V Federal funds plus interest returned to the state
; V Federal & te Match; Title III	Quarterly	18th of month following the quarter	DAS - Fin. Supp. System	DAAS		All monthly expenses of quarter if not reported
; III Final Expenditures	Annual	Jun 1	DAS - Fin. Supp. System	DAAS		Due 30 days after audit date. Carry-over should be shown on revised NGA submitted to DAAS
›gServices Report	Quarterly	Nov 1; Feb 1; May 1;	DAAS (Attn: Ed Merck)		AAS 9578	All services in Area Plan by units and unduplicated count.
›g Services Report	Annual	Sep 1	DAAS(Attn: Ed Merck)		AAS 9579	Same as quarterly plus demographics and expenditures.
›h Contribution Report	Annual	Sep 1	DAAS (Attn: Ed Merck)		AAS 9576	
›arette Tax Expenditure ›ort	Annual	Sep 1	DAAS (Attn: Debbie Tillery)		AAS 9574	Report period is SFY
›tipurpose Senior ›ter Inventory Report	Annual	Sep 1	DAAS (Attn:Debbie Tillery)		AAS 9577	
.D.A. Report for Meals Count	Monthly	18th	DAAS(Attn: Brenda Barfield)		AAS 9547	Adjustments by the state to USDA are to be made within 90 days.
›a Plans (Excluding Waivers)	Annual	June 1	DAAS (Attn: Suzanne Crisp)			
›budsman Facilities ›rmation	Quarterly	Jan 10; Apr 10; Jul 10; Oct 10	DAAS: (Attn: Raymon Harvey)		AAS 9537	
›budsman Quarterly ›ort Information	Quarterly	Jan 10; Apr 10; Jul 10; Oct 10;	DAAS (Attn: Raymon Harvey)		AAS 9538	
›contractor Assessment ›ort	Quarterly	Apr 15; Jul 15; Oct 15; Jan 15	DAAS(Attn: Wetzel LaGrone)		AAS 9575	
›er Worker (Title V) Progress ›ort	Quarterly	Apr 15; Jul 15; Oct 15; Jan 15;	DAAS(Attn: Terry Keefe)		ETA 5140	
›te Older Worker ›ort	Quarterly	Apr 15; Jul 15; Oct 15; Jan 15	DAAS(Attn: Terry Keefe)		AAS 9573	
›vey of Volunteers in ›g Services	Annual	Feb 1 following end of calendar yr	DAAS(Attn: Betty French)		AAS 9580	

›; - Division of Admin Services - DHS

AGING SERVICES REPORT (Quarterly)

AAA:

Quarter Ending:

Services	Unduplicated Persons Served	Total Service Units	Service Unit Definition
Adult Day Care			1 Hour
Chore			1 Hour
Client Representation			1 Client
Congregate Meals			1 Meal
Employment			1 Person
Health Promotion			1 Session
Home Delivered Meals			1 Meal
Homemaker			1 Hour
Information and Assistance			1 Contact
Legal Assistance			15 Minutes
Material Aid			1 Distribution
Personal Care			1 Hour
Repairs/Modification			1 Job
Socialization			1 Session
Special Events			1 Session
Supervised Living			1 Day
Telephone Reassurance			1 Call

Services	Unduplicated Persons Served	Total Service Units	Service Unit Definition
Transportation			1 One Way Trip

(Report the number of persons served and units of service provided during this quarter. Submit to DAAS by Feb. 1, May 1, and Nov. 1.)

AAS 9578 (Jul 96)

Title of Form: Aging Services Report (Quarterly)

Form Number: AAS 9578 (Jul 96)

Purpose: Area Agencies on Aging use the form to report the number of persons served and the number of service units provided during the quarter. This report is not a cumulative report. It only reflects a snapshot of the activities during the quarter for which it is filed.

Definitions: Services —See the taxonomy of services for the definition of each service.

Unduplicated Persons Served —Number of persons served during the quarter for a specific service. The count of unduplicated clients for services requiring client registration should be very accurate. These services are: personal care, homemaker, chore, home delivered meals, adult day care, client representation and congregate meals. The count for other services may be estimates.

Total Service Units —Number of units of service provided during the quarter for a specific service.

Procedures: 1. Enter the number of persons served and the number of service units provided for each service listed in the Area Plan.

2. Submit the completed form to DAAS no later than February 1, May 1 and November 1. (An Aging Services Report for the year will be submitted by August 1.)

Disposition: Data from the completed forms will be consolidated by the DAAS Administrative Section and provided to the Director, Assistant Directors and program managers..

Instructions for Aging Services Report (Annual)

Completion of Section I: Estimated Unduplicated Count of Clients Served

Section I provides a summary profile of the clients served, through programs funded, in whole or part, by the Older Americans Act and by other funding sources. **This report does not include programs funded by Medicaid.** There are two parts to Section I: A) Unduplicated Client Count by Type of Service; and B) Unduplicated Client Count By Characteristic.

Section I.A. Unduplicated Client Count By Type of Service

Enter summary counts of the unduplicated persons served through programs supported in whole or part by Older Americans Act Title III funds, by other funding, and a total of the two. To increase the reliability and validity of these unduplicated counts, three separate counts should be furnished: 1) unduplicated counts of persons receiving services where client registration is required; 2) an estimate of unduplicated clients receiving non-registered services; and 3) an estimate of the total clients receiving services, which takes into account the two counts/estimates of clients served which are entered on lines 1 and 2.

Line 1 -- Enter the unduplicated count of persons served for the Cluster 1 and 2 services listed in Section II.A. It is expected the count of unduplicated clients for the seven services requiring client registration will be very accurate. The count entered in line 1 should correspond with the unduplicated client count across the registered services.

Line 2 -- Enter an estimation of unduplicated persons served through transportation, legal assistance, and information and assistance plus all other services which are supported in whole or part by OAA Title III funds. In the second column, enter an estimation of the unduplicated persons served in non-registered services funded through other sources.

Line 3 -- Enter an estimation of unduplicated persons served in the area through OAA supported programs in the first column, and through programs supported by other funding sources in the second column. These estimates should take into account clients who use multiple services. There will likely be an overlap of clients included in lines 1 and 2. A single client may receive a registered service and also be assisted through unregistered services. As a result, line 3 is not simply a sum of lines 1 and 2.

Totals -- Total the two entries on each line.

Section I.B. Summary Estimate by Selected Client Characteristics

Show the characteristics of the persons served by programs supported by Title III and by programs supported by other funds. Enter a summary total for all services on each line. The definitions of the client descriptors used in this section are in Appendix I. The breakdown by registered services and other services is not scheduled to be implemented as a requirement until FY97.

Completion of Section II: Utilization Profile

Service utilization is examined in several ways. The focus is on units of service and clients served. Two different sections are included in the utilization profile.

Section II.A. Service Utilization Profile, Listed Services

Some of the data elements in Section II.A. are not required in FY96. They are shaded on the forms. Specific guidelines are:

1) Provide utilization data for any of the listed services provided in the area. Indicate those for which OAA Title III and Title VII funds were used to support the provision of services.

2) Include performance data related for the service "as a whole", even if the OAA Title III and VII funding is one of several funding sources used to support the service. For example, document all service units provided and clients served by a service provider, even if the OAA funds only 25% of the

total cost of the service. Treat OAA Title V and Title VI funding as other sources of funding. Also consider USDA meal reimbursement as other sources of funding.

The services listed in Section II.A. are organized into 3 clusters. *(See the Taxonomy of Services for service definitions.)* Each cluster has distinctive reporting requirements.

Cluster 1: Registered Services Requiring Detailed Client Profile

Registration will be required for all six services in cluster 1 **beginning in FY97**. For each service, provide the following:

Total Number of Providers -- Enter a count of the number of providers who provide each listed service. If the AAA provides the service directly, include the AAA in the count of providers. Also provide the unduplicated number of providers across all listed services, taking into account that provider organizations are likely to provide multiple services.

Number of Minority Providers -- Of the total providers listed in the first column, identify how many are minority organizations. *(See Appendix I for a definition of a minority provider.)*

AAAs Direct Services Provision -- Indicate if the AAA provides each listed service directly, using AAA paid and/or volunteer personnel.

Total Unduplicated Persons Served -- Provide an unduplicated count of persons served in the area. The total count should include all persons served during the year, regardless of how many services/units individual clients receive.

Beginning in FY97, provide an unduplicated count of persons served across the registered services. The count of unduplicated persons served should be based upon the use of a master client registry of persons served through the registered services in each area. AAAs may voluntarily report this total in FY96 as line 1 in Section I.A. See the box below the Cluster 2 services in Section II.A. The registry will be maintained by the AAA.

New Persons Served This Year -- By service, identify how many persons were newly registered for the service during the course of the year. Count any client who has never been previously registered as a client for the service, either in the current fiscal year or a prior fiscal year by any provider funded with Older American Act funds. Also, provide an unduplicated count of persons served, across the registered services.

Total Service Units -- Enter a total count of service units provided during the year. If there are multiple service providers for the same service, the total is a sum of the service units provided by all providers to all clients. Report all service units, even if the OAA funding and related match funds are not the exclusive source of funding for the provider.

(Note: In the case of meals, enter the number of USDA eligible meals. Include meals provided to volunteers. In the appropriate block (waiting lists), enter the number as of June 30 of the report year of persons eligible to receive home delivered meals but not yet receiving them because of the provider's inability to provide them at the present time.)

Cluster 2. Registered Services Requiring Summary Client Profile

For congregate meals services , follow the same directions provided for Cluster 1 services.

Cluster 3. Non-Registered Services

A more limited set of data is reported for Cluster 3 services: 1) an unduplicated count of providers; 2) a count of minority providers; 3) the number of AAAs directly providing the service; 4) an unduplicated count of persons served; and, 5) a count of service units. For these services, it is difficult to require client registration. As a result, the provision of client specific information is not required.

Section II. B. Service Utilization Profile, Other Services

For those other services in your area plan, a more limited set of data is reported. List each service and indicate if the service is supported by OAA

funds. Report: 1) the number of unduplicated persons served; 2) total service units; and 3) the service unit by which service is measured.

Section II. C. Service Utilization Profile, Detailed Client Profile for Registered Services (1 - 6)

For the six services in Cluster 1, a detailed profile of client characteristics is required beginning in FY97. The profile of clients is a breakdown of the unduplicated count of persons served (by service) by client characteristics. The six services requiring a detailed client profile are:

- Personal Care
- Homemaker
- Chore
- Home Delivered Meals
- Adult Day Care
- Client Representation

Required data elements include:

- Minority status, by individual minority group
- Age group
- ADL/IADL status
- Sex
- Rural
- Live alone
- Poverty status

To complete Section II. C., the following guidelines apply:

1) Complete this section for <u>each of the six services</u> requiring a detailed client profile.

2) For each Cluster 1 service, indicate if the service is supported by OAA funds. Then identify how many persons in each of five racial/ethnic groups were served:

- African American
- Hispanic
- American Indian/Native Alaskan
- Asian/Pacific Islander
- Non-Minority
- Race/ethnicity missing from records

A separate profile will be developed for each racial/ethnic group <u>whose members were served</u>.

3) Provide a count of total clients and total clients in poverty for each minority group.

4) Within the Total Clients category and Total Clients in Poverty category for each racial/ethnic group, provide a breakdown by age and ADL status; then document how many persons in each age/ADL sub-group have no IADLs, 1 IADL, 2 IADLs, etc., how many persons were female or male, how many live in rural areas and how many live alone.

(Note: Any persons served by the program that are under age 60 should be reported in the "Age 64 and Under" group. Persons served under age 60 applies only to congregate and home delivered meals clients who are spouses of an eligible client, disabled persons who reside in housing facilities occupied primarily by older individuals at which congregate nutrition services are provided and individuals with disabilities who reside at home with and accompany older individuals who are eligible under Title III of the Act. Do not include volunteers receiving meals in the count of clients.)

Reminder: A separate record is prepared for each minority group served for each of the six services.

5) Document missing data. Indicate for each client data element how many client records, by minority group, do not contain a valid response for the data element, either because of data collection problems or the client refused to provide the required information. Counts for missing data are specific to Total Clients and Total Clients in Poverty.

Section II. D. Service Utilization Profile, Summary Client Profile for Other Registered Services

A summary client profile is required for congregate meals services beginning in FY97.

The client characteristics to be documented for these services include:

- Minority status
- Age group
- Sex
- Rural
- Live alone
- Poverty status

The following guidelines should be used for completion of this section:

1) For congregate meals, indicate if the service is supported by OAA funds. Then identify by individual racial/ethnic group, the total number of persons served by each of four age groups. For each age group total, indicate how many of the total clients are female or male, live in rural areas and how many live alone.

2) Provide a comparable profile as developed for Total Clients for Clients In Poverty.

3) Document missing data. Follow the same procedures as describe for Section II. D. above.

Completion of Section III. Profile Of Community Focal Points and Senior Centers

This section is used to document the status of focal point designations and the use of senior centers by the National Network on Aging. The data elements are self-explanatory.

Completion of Section IV. Staffing Profile

Guidelines for completion of the profile are:

Follow these steps:

1. Categorize all paid AAA staff by the categories listed on lines 1-3. The definitions for each personnel category are provided in Appendix I.

2. Develop the staffing profile based on a snapshot taken on a given day during the fiscal year designated by DAAS.

3. Determine the total number of full time equivalents (FTEs) for each position category. The number of FTEs should reflect filled or staffed positions at the time of the survey. Do not include authorized but unfilled positions.

4. For each personnel category, identify how many FTEs are filled by minority staff. Enter this number in the column titled Number of Minority FTEs.

5. Identify, by personnel category, how many FTEs are paid for, in full or in part, using OAA funds.

(Note: this section includes a count of the volunteers who assist the area agency in carrying out its responsibilities either in direct service provision or any of its planning, development, administration, access/care coordination roles. Include volunteers in the count of Total AAA staff on line 5.)

Appendix I. Definitions

The following definitions should be used when completing the Aging Services Report.

A. Client Descriptors

1. *Minority Status* -- Minority older persons are confined to the following designations:

African American, Not of Hispanic Origin -- A person having origins in any of the black racial groups of Africa.

Hispanic Origin -- A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.

American Indian or Alaskan Native -- A person having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

Asian American/Pacific Islander -- A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands, Samoa and the Hawaiian Islands.

Non-Minority -- Any person who is not considered a minority.

2. *Impairments in Activities of Daily Living* -- AoA will introduce a definition for ADL impairments for FY97 which reflects testing in FY96 by AoA. The definition of ADL impairment to be used, unless changed as a result of testing, is: the inability to perform one or more of the following six activities of daily living without assistance, stand-by assistance, supervision or cues; eating, dressing, bathing, toileting, transferring in and out of bed/chair, and walking.

3. *Impairments in Instrumental Activities of Daily Living* -- AoA will introduce a definition for IADL impairments for FY97. The definition to be used, unless changed as a result of testing is: the inability to perform one or more of the following eight instrumental activities of daily living without personal or stand-by assistance, supervision or cues; preparing meals, shopping for personal items, medication management, managing money, using telephone, doing heavy housework, and transportation ability. Transportation ability refers to the individual's ability to make use of available transportation.

4. *Poverty* -- Persons considered to be in poverty are those whose income is at or below the offical poverty guideline (as issued each year by the Division of Aging and Adult Services).

5. *Living alone* -- A one person household (using the Census definition of household) where the householder lives by his or herself in an owned or rented place of residence in a non-institutional setting, including board and care facilities, assisted living units and group homes.

B. Service Definitions

Standardized names, definitions and service units are provided in the Taxonomy of Services.

C. Other Definitions

A variety of other terms are used in the report. Definitions for these terms are as follows:

Agency Executive/Management Staff -- Personnel such as the AAA director or other senior management positions which provide overall leadership and direction for the Area Agency on Aging; i.e., assistant directors or major division or unit directors.

Other Paid Professional Staff -- Personnel who are considered professional staff who are not responsible for overall agency management or direction

setting but carry out key responsibilities or tasks associated with the AAA in the following areas:

Planning -- Includes such responsibilities as needs assessment, plan development, budgeting/resource analysis, inventory, standards development and policy analysis.

Development -- Includes such responsibilities as public education, resource development, training and education, research and development and legislative activities.

Administration -- Includes such responsibilities as bidding, contract negotiation, reporting, reimbursement, accounting, auditing, monitoring, and quality assurance.

Access/Care Coordination -- Includes such responsibilities as outreach, screening, assessment, case management, client representation, information and assistance.

Service Delivery -- Includes those activities associated with the direct provision of a service which meets the needs of an individual older person and/or caregiver.

Clerical/Support Staff -- All paid personnel who provide support to the management and professional staff.

Minority Provider -- A not for profit organization whose controlling board is comprised of at least 51% minority individuals **or** a business concern that is at least 51 percent owned by one or more individuals who are either an African American, Hispanic origin, American Indian/Native Alaskan, Asian American/Pacific Islander minority **or** a publicly owned business having at least 51 percent of its stock owned by one or more minority individuals and having its management and daily business controlled by one or more minority individuals.

New Persons Served -- Any client who has never been previously registered as a client for the service, either in the current fiscal year or a prior fiscal year by any provider funded with Older American Act funds.

Rural -- Any area that is not defined as urban. Urban areas comprise (1) urbanized areas (a central place and it's adjacent densely settled territories with a combined minimum population of 50,000) and (2) an incorporated place or a census designated place with 20,000 or more inhabitants. The Division of Aging and Adult Services will provide a listing of urban places.

Appendix II. Forms

Page

1. Section I. Estimated Unduplicated Counts of Clients Served
2. Section II. Service Utilization Profile; A. Listed Services
3. Section II. Service Utilization Profile; B. Other Services
4. Section II. Service Utilization Profile; C. Detailed Client Profile for Registered Services (1 - 6)
5. Section II. Service Utilization Profile; D. Summary Client Profile for Other Registered Services (Congregate Meals)
6. Section III. Profile of Community Focal Points and Senior Centers
7. Section IV. Staffing Profile

AAA:

Fiscal Year:

A. Unduplicated Client Count By Type of Service	Funded by Title III Total	Other Funding Total	Total
1. Unduplicated Persons Served in Registered Services *			
2. Unduplicated Count of Persons Served in Other Services			
3. Total Unduplicated Count of Persons Served **			

B. Unduplicated Client Count By Characteristic	Title III Services			Other Than Title III Services			Total
	Clients For Registered Services	Clients For Other Services	Clients For All Services	Clients For Registered Services	Clients For Other Services	Clients For All Services	Clients For All Services
1. Clients By Minority Status:							
African American							
Hispanic Origin							
American Indian/Native Alaskan							
Asian American/Pacific Islander							
Non-Minority							
2. Rural Clients							
3. Clients In Poverty							
4. Clients In Poverty/Minority							

* Registered services include personal care, homemaker, chore, home delivered meals, adult day care/health, client representation, and congregate meals.

** A summary total of the estimated unduplicated client count, considering all services.

A. Listed Services

AAA:

Fiscal Year:

For Selected Services	Supported by Title III/VII Funds: Yes	Supported by Title III/VII Funds: No	Total Number Of Providers	Number Of Minority Providers	(Yes/No) AAA Direct Svc Provision	Total Unduplicated Persons Served	New Persons Served This Year	# of Persons Served - At High Nutrition Risk	Total Service Units
Cluster 1. Registered Services									
1. Personal Care									
2. Homemaker									
3. Chore									
4. Home Delivered Meals **									
5. Adult Day Care/Health									
6. Client Representation									
Cluster 2. Registered Services									
7. Congregate Meals									
Total Unduplicated Registered Clients ⟶						*			
Cluster 3. Non-Registered Services									
8. Transportation									
9. Legal Assistance									
10. Info. and Assistance									
Undupl. Count of Providers ⟶									

* Note: The total undupl. persons served should match the total reported in I.A.1.

** Number of Persons on Waiting List	

AAA:

Fiscal Year:

Services	Supported by OAA Funds		Total Persons Served	Total Service Units	Service Unit Definition
	Yes	No			
Employment					1 Person
Health Promotion					1 Session
Material Aid					1 Distribution
Repair/Modif/Maint					1 Job
Respite					1 Hour
Socialization					1 Session
Special Events					1 Session
Supervised Living					1 Day
Telephone Reassurance					1 Call

C. Detailed Client Profile for Registered Services (1 -6)

AAA:

FOR SERVICE: _____

Supported by OAA Funds: _____ Yes _____ No

FOR: _____ African American _____ American Indian/Native Alaskan
_____ Hispanic _____ Asian/Pacific Islander
_____ Non-Minority _____ Race/Ethnicity Missing

Fiscal Year:

	Total Age 64 and Under				Total Age 65 -74				Total Age 75 -84				Total Age 85+			
	0 ADL	1 ADL	2 ADLs	3+ ADLs	0 ADL	1 ADL	2 ADLs	3+ ADLs	0 ADL	1 ADL	2 ADLs	3+ ADLs	0 ADL	1 ADL	2 ADLs	3+ ADLs
Total Clients																
No IADL																
With 1 IADL																
With 2 IADLs																
With 3+ IADLs																
Female																
Male																
Rural																
Live Alone																

	Total Age 64 and Under				Total Age 65 -74				Total Age 75 -84				Total Age 85+			
	0 ADL	1 ADL	2 ADLs	3+ ADLs	0 ADL	1 ADL	2 ADLs	3+ ADLs	0 ADL	1 ADL	2 ADLs	3+ ADLs	0 ADL	1 ADL	2 ADLs	3+ ADLs
Poverty Clients																
No IADL																
With 1 IADL																
With 2 IADLs																
With 3+ IADLs																
Female																
Male																
Rural																
Live Alone																

Missing Information By Data Element *	Total Clients	Poverty Clients
Income		
Age		
ADL Status		
IADL Status		
Sex		
Rural Status		
Live Alone Status		

Total Clients Served (For the Racial/Ethnic Group)	

* Provide counts of clients whose records do not contain the data elements requested, because the data are missing or the client refused to furnish the information.

D. Summary Client Profile for er Registered Services (Congregate Meals)

AAA:

FOR SERVICE: Congregate Meals
Supported by OAA Funds: _____ Yes _____ No

FOR: _____ African American _____ American Indian/Native Alaskan
_____ Hispanic _____ Asian/Pacific Islander
_____ Non-Minority _____ Race/Ethnicity Missing

Fiscal Year:

TOTAL CLIENTS	Age 64 and Under	Age 65 -74	Age 75 -84	Age 85+
Total				
Female				
Male				
Rural				
Live Alone				

CLIENTS IN POVERTY	Age 64 and Under	Age 65 -74	Age 75 -84	Age 85+
Total				
Female				
Male				
Rural				
Live Alone				

Total Clients Served (For the Racial/Ethnic Group)	

Missing Information By Data Element *	Total Clients	Clients In Poverty
Income		
Age		
Sex		
Rural Status		
Live Alone Status		

* Provide counts of clients whose records do not contain the data elements requested, either because the data are missing or the client refused to provide the information.

AND SENIOR CENTERS

AAA:	Fiscal Year:

	Number
1. Total Number of Focal Points Designated Under Section 306(a)(3) of the Act in Operation in the Past Year	
2. Of the Total Number of Focal Points in 1., the Number That Were Senior Centers.	
3. Total Number of Senior Centers in the Area in the Past Fiscal Year.	
4. Total Number of Senior Centers in 3., That Received Funds During the Past Fiscal Year.	

AAA:	Fiscal Year:

AAA Personnel Categories	Number Of FTEs	# Of Minority FTEs	# Of FTEs Paid With OAA Funds
1. Agency Executive/ Management Staff			
2. Other Paid Professional Staff (By Functional Responsibility)			
A. Planning			
B. Development			
C. Administration			
D. Service Delivery			
E. Access/Care Coordination			
F. Other			
3. Clerical/Support Staff			
4. Volunteers			
5. Total AAA Staff			

AAA _____
REPORTING PERIOD (SFY) _____
DATE OF REPORT _____

CASH CONTRIBUTION REPORT

CONGREGATE MEALS/ SOCIALIZATION	HOME-DELIVERED MEALS	TRANSPOR-TATION	PERSONAL CARE	HOMEMAKER	OTHER

ADULT DAY CARE/HEALTH	CLIENT REPRESENTATION	LEGAL ASSISTANCE	INFORMATION AND ASSISTANCE	CHORE

TOTAL REGION CONTRIBUTIONS

AAS 9576 (Jul 96)

DIVISION OF AGING AND ADULT SERVICES
CASH CONTRIBUTION REPORT

PURPOSE: The Cash Contribution Report is used to report income generated by a particular program in the form of client contributions, voluntary donations, fees for services to non-clients (e.g. meals purchased by guests), etc. by an Area Agency on Aging.

Due Date: The report is due August 1 of each year.

To Complete Form:

1. Show the Area Agency making the report, the State Fiscal Year covered by the report, and the date of the report in the space provided in the upper left corner.

2. Show the amount of contributions for the specific services listed separately on the form. In the space labeled "Other" show the amount of cash contributions not otherwise listed.

3. In the space provided, show total cash contributions for the year.

REPORTING PERIOD (SFY) _____

DATE OF REPORT _____

CIGARETTE TAX EXPENDITURE REPORT

TRANSPORTATION

Units _____

Clients _____

Capitalized Expend.	Quantity	Description	Expenditure
Vehicles: & Equip.			

Total Capitalized Expenditures

Service Costs

Total Cost of Program

HOME-DELIVERED MEALS

Units _____

Clients _____

Quantity	Description	Expenditure

Total Capitalized Expenditures

Service Costs

Total Cost of Program

Explain line item " other costs" on your Cash Request and accessories and equipment not capitalized.

Quantity	Description	Expenditure

Quantity	Description	Expenditure

AAS 9574 (Jul 96)

DIVISION OF AGING AND ADULT SERVICES
ANNUAL CIGARETTE TAX EXPENDITURE REPORT

PURPOSE: The annual Cigarette Tax Expenditure Report is to be used to list vehicles and other equipment purchased during the State Fiscal Year which are capitalized and to list and describe those expenditures charged to "Other Cost" on the Monthly Actual Expenditure report.

Due Date: The report is due August 1 of each year.

To Complete Form:

1. Show the Area Agency on Aging making the report, the state fiscal year covered by the report, and the date of the report in the space provided in the upper left corner.

2. Show the number of units and clients for both Transportation and Home Delivered Meals provided by the Cigarette Tax.

3. List the Number, a description and value of capitalized vehicles and equipment charged to the Transportation program in the designated section of the form and for the Home Delivered Meals program in the space provided.

4. Show the total value of capitalized vehicles and equipment both for Transportation and Home Delivered Meals in the spaces provided.

5. Show the amount of all other cost charged to the respective programs on the line called "Service Costs"

6. Show the total cost of the respective programs on the line labeled "Total Cost of Program". These two totals combined should equal the total amount of Cigarette Tax that has been expended during the year.

7. The bottom section of the form is to list items that have been charged to the line labeled "Other Cost" on the Monthly Expenditure Report. This would include cost such as insurance, professional fees, major equipment repair, etc.

8. NOTE: Total program costs should equal total costs on expenditure report.

AAA_____
Reporting Period (SFY)_____
Date of Report_____

MULTIPURPOSE SENIOR CENTER INVENTORY REPORT

I. Older Americans Act funds were used to acquire or construct a Multipurpose Senior Center in the area agency on aging planning and service area. Complete the following:

1. Name and address of grantee

2. Name and address of center

3. Operational status
   a._____Still in use b._____Closed c._____Sold

4. Date of award_____

5. New Construction YES_____ or Acquisition YES_____

6. Proportion of award to total acquisition or construction cost.

   Amount of award $_____divided by Total Cost
$_____=_____%

7. COMMENTS:

==========

II. OAA funds **were not used** to acquire or construct a Multipurpose Senior Center in this AAA's planning and service area _____.

==========

III.

_____ _____
Signature of AAA Executive Director Date

DIVISION OF AGING AND ADULT SERVICES
MULTIPURPOSE SENIOR CENTER INVENTORY REPORT

PURPOSE: The annual Multipurpose Senior Center Inventory Report is used to document the use of Older Americans Act funds awarded for acquisition and construction of senior centers and maintain a current inventory in compliance with statutory limitations. The report information is required by the Administration on Aging as directed in PI-90-04 and RIM 93-31.

DUE DATE: The report is due to DAAS on September 1 of each year and should include information from the previous state fiscal year.

TO COMPLETE FORM:

In the upper left corner, show the Area Agency on Aging making the report, the state fiscal year covered by the report, and the date of the report.

Section I.

1. List the name and address of the grantee agency that received the funds.

2. List the name and address of the senior center that was acquired or constructed using the awarded funds.

3. Identify the operational status by checking the appropriate blank.

4. List the date the funds were awarded to the grantee.

5. Identify whether the funds were awarded for construction or acquisition.

6. Show the proportion of the award to the total cost using the formula shown.

7. List any comments that pertain to the award. For example "This is revised or additional information from a previous report" or "Center is under construction, primary funding is provided by Federal Housing Administration, and it is titled to XYZ agency."

Section II.

Complete this section only if no funds have been awarded for this purpose and there are no buildings subject to the statutory limitations of 10 years for acquisition and 20 years for construction.

Section III.

Include the signature of the Executive Director of the Area Agency on Aging and the date signed.

MONTHLY REPORT FOR MEAL COUNTS

AAA No.:	Name:

YEAR	MO.	TYPE OF RPT. ORIG.	TYPE OF RPT. REV. #	NUMBER OF MEALS SERVED CONGREGATE	NUMBER OF MEALS SERVED DELIVERED	NUMBER OF MEALS SERVED TOTAL	COMMENTS YES	COMMENTS NO
1996	JUL							
1996	AUG							
1996	SEP							
1996	OCT							
1996	NOV							
1996	DEC							
1997	JAN							
1997	FEB							
1997	MAR							
1997	APR							
1997	MAY							
1997	JUN							
1997	JUL							
1997	AUG							
1997	SEP							
1997	OCT							
1997	NOV							
1997	DEC							
1998	JAN							
1998	FEB							
1998	MAR							
1998	APR							
1998	MAY							
1998	JUN							
1998	JUL							
1998	AUG							
1998	SEP							
	1997 STATE FISCAL YTD							
	1997 FEDERAL FISCAL YTD							
	1997 CALENDAR YTD							

MONTH	COMMENTS
	SIGNATURE: DATE:

DIVISION OF AGING AND ADULT SERVICES
MONTHLY REPORT FOR MEAL COUNTS

PURPOSE: The Monthly Report for Meal Counts is used to report the number of meals eligible for USDA reimbursement which are served in a congregate setting and the number of meals which are delivered to the homes of participants for each month.

Due Date: The report is due to DAAS by the 18th of the month following serve of the meal.

To Complete Form:	(This form is furnished on disk as a Lotus 1-2-3 file. Update the form on disk each month. Forward the disk to DAAS with a printed, signed copy. The disk will be returned to you. All totals indicated below will be automatically computed in the spreadsheet file.)
AAA No.:	Provide the number of the Area Agency on Aging.
Name:	Provide the name of the Area Agency on Aging.
Type of Rpt.:	Place an "X" in the "ORIG." column to indicate if the report is the original. If a major revision to a previous report is necessary, indicate in the "REV.#" column the number of times numbers were revised for the month indicated. (Revisions must be made within 90 days of the end of the quarter. Minor revisions may be incorporated into the original monthly report, with a note made in the COMMENTS section detailing the revision.)
No. of Meals Served:	Enter the number meals eligible for USDA reimbursement served during the month in a congregate setting. Meals served to staff and guests under 60, or other meals whose cost is paid by another source, may NOT be reported for USDA assistance. Enter the number of meals eligible for USDA reimbursement which were delivered to the homes of homebound Older Arkansans. Meals served to Medicaid Waiver clients, staff and guests under 60, or other meals whose cost is paid by another source, may NOT be reported to USDA for assistance. Enter the Total USDA eligible meals served in congregate and home delivered settings. (Automated Total field.)
Comments:	Place an "X" in the Yes column if comments are included. Include the Comments at the bottom of the page. Note any minor adjustments incorporated into the totals. (Example: HDM Total includes an adjustment to May total of 15 less meals -- necessary because a service to billing audit revealed an error in a provider's count.) Note any other circumstances which have affected the total (for example; Computer system was down, totals were estimated).
State Fiscal YTD	Enter columnar totals for the current State Fiscal Year. (Automated field.)
Federal Fiscal YTD	Enter columnar totals for the current Federal Fiscal Year. (Automated field.)
Calendar YTD	Enter columnar totals for the current Calendar Year. (Automated field.)
Signature:	Enter the signature of the person submitting the report.
Date:	Enter the date the report is submitted.

SUBCONTRACTOR ASSESSMENT REPORT

AAA:_____ Reporting Period: _____

Submitted By: _____ Date Submitted _____

Date of Assessment	Subcontractor	Type of Assessment/Summary of Findings

DIVISION OF AGING AND ADULT SERVICES
SUBCONTRACTOR ASSESSMENT REPORT FORM

PURPOSE: This form will be used to report the quarterly AAA assessments of subcontractors.

Due Dates: The report is due quarterly on April 15, July 15; October 15 and January 15.

To Complete Form:

1. AAA: Enter name of the AAA submitting the report.

2. Submitted By: Enter the name and telephone number of the person submitting the report.

3. Reporting period: Enter the dates covered by the assessment.

4. Date submitted: enter the date submitted to Financial Management, DAAS.

5. Date of Assessment: Enter date of subcontractor's assessment.

6. Subcontractor: Enter name of subcontractor assessed.

7. Type of Assessment/Summary of Findings: List the type of assessment (i.e. transportation, client eligibility etc.) and provide a brief summary of the findings.

Quarterly Progress Report

U.S. Department of Labor

Employment and Training Administration
Senior Community Service Employment Program

Project Sponsor	Report Period Ending (Month & Year)	OMB Approval No. 1205-0040 Expiration Date: 07/31/91
City and State		Type of Report (Check One) ☐ Interim ☐ Final
Agreement Number	Subproject No.	Project Period From / To
No. Enrollment Positions Established:		Unsubsidized Placement Goal:

A. ENROLLMENT LEVELS (Number of Enrollees)

1. Carried over from previous project	3. Placed in unsubsidized employment this project	5. Current enrollment (End of Period)
2. Started under this project	4. Other terminations this project	6. Enrollment vacancies (End of Period)

B. JOB INVENTORY

Services to General Community	No. Jobs	Services to Elderly Community	No. Jobs
1. Education		11. Project Administration	
2. Health and Hospitals		12. Health and Home Care	
3. Housing/Home Rehabilitation		13. Housing/Home Rehabilitation	
4. Employment Assistance		14. Employment Assistance	
5. Recreation, Parks, and Forests		15. Recreation/Senior Centers	
6. Environmental Quality		16. Nutrition Programs	
7. Public Works and Transportation		17. Transportation	
8. Social Services		18. Outreach/Referral	
9. Other		19. Other	
10. TOTAL (1 - 9)		20. TOTAL (11 - 19)	

C. ENROLLEE CHARACTERISTICS

Characteristics		Starts (Cum.)	Cur. Enrol.	Characteristics		Starts (Cum.)	Cur. Enroll.
Sex	Male			Ethnic Group	White (not Hispanic)		
	Female				Black (not Hispanic)		
Education	8th & Under				Hispanic		
	9th - 11th				American Indian/ or Alaskan Native		
	HighSchool Grad or Equivalent				Asian or Pacific Islander		
	1 - 3 years of College			Age	55 - 59		
	4 yrs. College or more				60 - 64		
Family Income at/below Poverty Level					65 - 69		
Veteran					70 - 74		
Handicapped					75 and Over		
D. AVERAGE HOURLY WAGE/CURRENT ENROLLMENT							

E. NARRATIVE REPORT ATTACHED: YES ☐ NO ☐

Signature / Date

Public reporting burden for this collection of information is estimated to average 8 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Information Management, Department of Labor, Room N-1301, 200 Constitution Avenue, N.W., Washington, DC 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1205-0040), Washington, DC 20503.

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM (SCSEP)
QUARTERLY REPORT INSTRUCTIONS

ITEM NAME	INSTRUCTION
Number Enrollment Positions Established	Enter the number of enrollment positions established under the project as indicated in the project agreement or the most recent approved modification thereto.
Report Period Ending	Enter the month and year Of the Federal fiscal quarter for which data is being submitted.
Interim/Final Report	Check appropriate box.
Project period	Enter the inclusive dates (month, day, year) of the project period as stated in the project agreement.
Unsubsidized Placement Goal	Enter the unsubsidized placement goal as stated in the project agreement.

SECTION A: Enrollment Levels

LINE NAME	INSTRUCTION
1 Carried over from previous project	This applies only to projects conducted under renewed agreements. Enter the number of persons enrolled at the start of the new period whose enrollment was carried over from the previous project period. This figure should remain consistent on all quarterly reports submitted under a project agreement (unless it is necessary to correct an error).
2 Started under this project	Enter the cumulative number of persons who have become enrolled in the project from the beginning of the project period through the last day of the reporting period. These persons include those who re-enrolled after having been terminated from the project. DO NOT include persons carried over from the previous project.
3 Placed in unsubsidized employment this project	Enter the cumulative number of enrollees who were placed in unsubsidized jobs and were, therefore, terminated from enrollment in the project. Include only those placements which occurred from the beginning of the project period through the last day of the reporting period.
4 Other terminations this project	Enter the cumulative number of enrollees whose enrollment was terminated during the period for any reason other than placement into unsubsidized employment.

5	Current enrollment (end of period)	Enter the total number of persons actually enrolled in the project as of the end of the last day of the reporting period. This figure must equal the sum of entries made in B.10 and B.20 below.
6	Enrollment Vacancies (end of period)	Enter the number of unoccupied enrollment positions under the project as of the last day of the project period. This is determined by subtracting the number of persons currently enrolled from the number of enrollment positions established. If a negative figure results, enter zero.

NOTE: If Section A has been completed correctly, this mathematical procedure will have been followed:

(+) Carried over from previous project. (A. 1)

(+) Started under this project. (A.2)

(-) Placed in unsubsidized employment this project. (A.3)

(-) Other terminations this project. (A.4)

(=) Current enrollment end of period) (A.5)

SECTION B: Job Inventory

Section B is used to indicate the ways enrollee manpower serves the community or communities in which the project operates. The section has two parts. The first part (items 1 through 9) is headed "Services to General Community". This part is used to indicate enrollee work assignments which benefit the general community. The second part (items 11 through 19) is headed "Services to Elderly Community." This part is used to indicate enrollee work assignments which solely or primarily benefit the elderly in the community. The two parts are mutually exclusive. That is, an enrollee work assignment or job position which is included in the first part must not be double counted by being included in the second part and vice versa.

For each community service area listed, enter the number of enrollee job positions actually occupied as of the end of the last day of the reporting period. Each enrollee job must be reflected in only one community service area. Double counting is not permitted. For community service areas preprinted on the form in which no enrollee is employed enter "-0-". Enter the total number of enrollee job positions in "Services to General Community" (i.e., the sum of the figures entered in items 1-9) in item 10. Enter the total number of enrollee job positions in "Services to Elderly Community" (i.e., the sum of the figures entered in items 11-19) in item 20. The combined (i.e., the figure entered in item 10 added to the entry in item 20) must equal the figure entered in item 5.A (Current Enrollment) above. All current enrollees must be accounted for in Section B.

The basic principle for categorizing an enrollee job position is to determine the nature of the service in which the enrollee plays a part, even in a supporting role. An enrollee may play a supporting role, as opposed to a direct role, in the delivery of a community service. In cases where an enrollee plays a supporting

role, the job performed by the enrollee should be attributed to the community service area supported by the enrollee's work. (Ex: if an enrollee works in a school cafeteria, the job should be reflected in item B.1 (Education); or if an enrollee works as a janitor in a senior center, the job should be reflected in item B.15 (Recreation/Senior Centers).

NOTE; item B.11 (Project Administration) refers only to assignments involving the administration of the SCSEP project. It does not refer to administrative work assignments in other projects .

SECTION C: Enrollee Characteristics

Section C is used to indicate the characteristics of persons (1) who became enrolled in the project during the reporting period and (2) who are actually enrolled in the project as of the last day of the reporting period. A separate breakout is required for both groups. The first group (i.e., those persons who become enrolled in the project during the reporting period) is to be accounted for in the column headed "Starts (Cum.)". The second group (i.e. those persons who are actually enrolled in the project as of the last day of the reporting period) is to be accounted for in the column headed "Cur Enroll.". In cases where no person in the group demonstrates a characteristic preprinted on the form, enter "-0-" in that block.

CHARACTERISTIC	INSTRUCTION
Sex	Enter the number of males and the number of females who became enrolled in the project during the reporting period, in the column headed "Starts (Cum.)". The sum of these two entries should equal the figure entered in item A.2 (started under this project). For persons who are actually enrolled in the project as of the last day of the reporting period, enter the number who are male and the number who are female in the column headed "Cur. Enrll.". The sum of these two entries should equal the figure entered in item A.5 (Current enrollment).
Education	Enter in the appropriate columns the number of person who have completed the grades or years of schooling indicated. Persons who have a GED and who have advanced no further should be counted as "High School Grad. or Equivalent". The sum of the entries in each column should equal the respective entries made for items A.2 and A.5
Family Level at/or below OMB Poverty Level	Enter in the appropriate columns the number of persons who are from a family which has an income at/or below the OMB poverty level.
Veteran	Enter in the appropriate columns the number of persons who served on duty for more than 180 days in the active military, navy or air force who were discharged, separated or released there from with other than a dishonorable discharge or were discharged or released from active duty for a service connected disability.

Race/Ethnic Group	Enter in the appropriate columns the number of persons who are members of the groups listed. For this report, Yaquis, Lumbees, Eskimos, Aleuts, and members of their groups are to be reflected as "American Indian or Alaskan Native" Persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race are to be grouped as "Hispanic." Filipino, Hawaiian, Chinese, Japanese etc., shall be grouped in the "Asian or Pacific Islander" category. The sum of entries in each column should equal the respective entries made for items A.2 and A.5 above.
	Enter in the appropriate columns the number of persons in the age groups listed. The sum of entries in each column should equal the respective entries made for items A.2 and A.5 above.

SECTION D: Average Hourly Wage/Current Enrollment

Enter the average hourly wage received by the person actually enrolled in the project as of the last day of the reporting period. To calculate this figure add the hourly wage rate of each enrollee who is reflected in the entry made for item A.5 (Current Enrollment - End of Period) and divide the sum by the number of enrollees.

SECTION E: Narrative Report (Attachment)

The purpose of the narrative report is to give the project sponsor an opportunity to expand on any noteworthy achievements of the project or any problem area encountered by the project. The report, which does not have to take any specific format, should be presented as concisely as possible and should be limited to items of major interest or importance.

Signature and date: Each report must be signed and dated by an authorized official of the sponsoring organization.

OLDER WORKER COMMUNITY SERVICE PROGRAM QUARTERLY REPORT

Number & Name of Region:_____
Date Quarter Ended:_____

Personnel Status

Participants terminated this quarter_____
Participants enrolled this quarter_____
Total number participants end of quarter____
Average Hourly Salary_____

Age Group Male Female Total	Ethnic Group Total
55-64	White
65-74	Black
75-84	Hispanic
85-over	Asian
	American Indian

Program Service Total	Distribution by County Total
Environmental	
Aging	
Social	
Health	
Education	
Recreation	
Natural Resources	
Beautification	
Other	

COMMENTS

_____
_____
_____
_____
_____
_____

OLDER WORKER COMMUNITY SERVICE PROGRAM
QUARTERLY REPORT INSTRUCTIONS

PURPOSE: This form is used by the AAA's to report the personnel status of the State Older Worker Community service program.

Due dates: The report is due quarterly on April 15; July 15; October 15; and January 15.

To complete the form:

1. Provide the name and number of the region submitting the report.
2. Provide the date the report quarter ended.
3. Provide the number of participants that were terminated for any reason, during the report quarter.
4. Provide the number of new participants enrolled during the report quarter.
5. Provide the total number of participants enrolled at the end of the report quarter.
6. Provide the average wage of all participants enrolled, as of the last day of the report period.
7. Provide the number of the male and female participants enrolled, by age group, as well as the total number of the male and female participants enrolled at the end of the report period.
8. Provide the total number of participants enrolled by ethnic group at the end of the report period.
9. Provide the total number of participants enrolled, by the program service field in which they are employed, at the end of the report period.
10. Provide the counties in which participants are employed, as well as the total number of participants employed in each county, at the end of the report period.
11. Provide narrative comments that are relevant. *Example. We have several inquires per month about enrolling in the older worker program, but we presently do not have any slots available in our area.*

199___ SURVEY OF VOLUNTEERS IN AGING SERVICES

Area Agency _____

FUND RAISING/OTHER	# Volunteers	# Hours
Cookbooks		
Dances		
Family Councils		
Health/Information Fairs		
Miles for Meals		
Ms. Senior Arkansas		
Project Care		
Recipe Contest		
Sr.Center Activities.		
Senior Olympics		
Silver Haired Legislators		
Speakers Bureau		
Support Groups		
Other Sp.Projects (list)		
TOTAL		

PROFESSIONAL/TECHNICAL		
Newsletter		
Sr Olympic Officials		
Volunteer.Attorneys		
Other		
TOTAL		

EDUCATION/TRAINING		
Literacy Projects		
Nutrition presenters		
Staff Trainers		
Student Placement/Univ.		
Other(Fin.Plan.,etc)		
TOTAL		

GROUPS/ORGANIZATIONS		
Church Projects		
Delta Srvc/Ntl/Comm Srvc		
Service League Projects		
Other (UCRC,etc)		
TOTAL		

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SOCIAL/COMMUNITY	# Volunteers	# Hours
Adult Day Care Activities		
Counseling(Peer,MMAP,Tax)		
Foster Grandparents		
Friendly Visitors		
Home Delivered Meals		
Hospice		
Intergenerational Projects		
Retirement/Financial Plan		
Senior Companions		
Transportation Program		
Telephone Reassurance		
Volunteer Ombudsman		
TOTAL		

BOARDS/COMMITTEES		
AAA Exec. Boards		
AAA Advisory Boards		
Project Advisory Councils		
TOTAL		

ALL CATEGORIES		
TOTALS		

This report was completed by _____ _____
Name Telephone

Do you have a designated volunteer coordinator? Y or N

If yes, please list name and telephone _____ _____
Name Telephone

If you have questions, please call, 501-682-8150

Please return this form by February 1 to:

Division of Aging and Adult Services
P.O. Box 1437, Slot 1412
Little Rock, AR 72203-1437

ATTN: Information & Assistance Specialist

DIVISION OF AGING AND ADULT SERVICES
SURVEY OF VOLUNTEERS IN AGING SERVICES

PURPOSE: This form will be used by AAAs to report the annual number of volunteers and the hours of volunteer services provided to older Arkansans in programs and activities operated and/or sponsored by area agencies and their contracted service providers. Information from the report will be consolidated and reported in the UALR Economic Impact of Volunteers study.

Due Dates: The report is due annually by February 1 of the year following the calendar year.

To Complete the Form:

1. AAA: Enter name of the AAA submitting the report.

2. Enter the number of volunteers and the number of hours served in each sub-category. (ie; Miles for Meals, etc.)

3, Total the number of volunteers and number of hours in each major category (ie: Fund Raising/Other, etc.))

4. Total the number of volunteers and number of hours from each major category on the ALL CATEGORIES line.

5. Enter the name and telephone number of the person compiling the report.

6. Respond Yes or No by circling Y or N to the question "Do you have a designated Volunteer Coordinator?"

7. If the answer to #6 is Yes, please submit the name and telephone number of the Volunteer Coordinator.

8. For uniform reporting, it is recommended that the AAA ask service providers and AAA program staff to use the form for their reporting to the AAA compiler.

CLIENT INTAKE FORM

WORKER #

SOCIAL SECURITY NUMBER

New Existing

INTAKE DATE / / INITIAL CONTACT DATE / /

REFERRAL SOURCE A. SELF B. DHS OFFICE C. FRIEND/FAMILY D. AAA/PROVIDER
E. DAAS F. AGENCY G. PUBLIC HEALTH H. MED/HOSPITAL
I. PUBLIC HOUSING J. NURSING HOME V. OTHER/CHURCH Z. UNKNOWN

LAST NAME FIRST MIDDLE

ADDRESS 1 ADDRESS 2

CITY STATE ZIP CODE

TELEPHONE

SYSTEM STATUS
DATE / /
REASON CODE

COUNTY CODE REGION CODE

GEOGRAPHIC DESIGN. A. RURAL B. URBAN Z. UNKNOWN

PROVIDER(S)

BIRTHDATE / / AGE NUTRITIONAL SCORE

IF UNDER 60, REASON FOR SERVICE
X. N/A (CLIENT OVER 60)
A. SPOUSE
B. MEAL VOLUNTEER
C. HANDICAPPED/DISABL. LIVES W/ELDER HOUSING
D. HANDICAPPED/DISABL. LIVES W/CLIENT
E. APS
V. OTHER

SEX A. FEMALE B. MALE Z. UNKNOWN

RACE A. WHITE B. BLACK C. HISPANIC D. AM. INDIAN
E. ASIAN V. OTHER Z. UNKNOWN

PRIMARY LANGUAGE A. ENGLISH B. SPANISH C. VIETNAMESE D. FRENCH
E. SIGN V. OTHER Z. UNKNOWN

MARITAL STATUS A. MARRIED B. NEVER MARRIED C. WIDOWED
D. SEPARATED/DIVORCED Z. UNKNOWN

EDUCATION A. 8TH GR. OR LESS B. 9TH-12TH GR. C. H.S. DIPLOMA/GED
D. 1-3 YRS. COLLEGE E. 4 OR MORE YRS. COLLEGE W. REFUSED
Z. UNKNOWN

BENEFITS A. SOC. SEC. B. MEDICAID C. MEDICARE D. FOODSTAMPS
E. RENTAL ASSIST F. SSI G. VA BENS. H. OVB
I. ELDERCHOICES V. OTHER W. REFUSED Y. NONE Z. UNKNOWN

VETERAN A. YES B. NO Z. UNKNOWN VET ID#

NUMBER IN FAMILY NUMBER IN HOUSEHOLD

MONTHLY CLIENT INCOME MONTHLY FAMILY INCOME

SOURCES OF INCOME A. SOC. SEC. B. S.S.I. C. V.A. D. EARNED V. OTHER

HOUSING TYPE A. HOUSE/OWN B. HOUSE/RENT C. APT./DUPLEX D. RES. CARE FACILITY
E. NURS. HOME F. ELDERLY HOUSING V. OTHER Y. NONE
Z. UNKNOWN

RETIREMENT COMMUNITY A. YES B. NO X. N/A

HOUSEHOLD COMPOSITION A. LIVES ALONE B. SPOUSE C. FAM/FRIEND D. LIVES W/ HELP
E. BOARDER V. OTHER X. N/A Z. UNKNOWN

ADL/IADL FUNC. LIMITS
A. WALKING B. HOUSEWORK C. HEAVY CLEAN (YARD)
D. GETTING PLACES E. READING F. WRITING
G. COOKING H. LAUNDRY I. BUSINESS AFFAIRS
J. SHOPPING K. BATHE/GROOM L. BOWEL/BLADDER
M. DRESS/GROOMING N. TAKING MEDS O. USING TELEPHONE
P. USING TOILET Q. FEEDING SELF V. OTHER
Y. NONE Z. UNKNOWN

WHO HELPS A. FAMILY B. FRIEND/NEIGHBOR C. TO HELP
D. HAS HELP BUT UNSURE WHO X. N/A Y. NONE Z. UNKNOWN

PRIMARY TRANSPORTATION A. OWNS CAR B. FRIEND/NEIGHBOR C. PUBLIC TRANSPORT.
D. SENIOR TRANSPORT. E. FAMILY V. OTHER
Y. NONE Z. UNKNOWN

PROSTHETIC DEVICES A. WALKER/CANE B. WHEELCHAIR C. HEARING AID
D. GLASSES E. DENTURES F. ART. LIMB
V. OTHER Y. NONE Z. UNKNOWN

MEDICARE MEDICAID OTHER

PHYSICIAN PHONE

EMERGENCY CONTACT PHONE

CLIENT/RELATIVE DATE INTERVIEWER DATE

CLIENT INTAKE FORM

WHEN TO USE THIS FORM:

The Client Intake Form must be completed for every person who will receive any type of individualized service from the AAA or subcontractor. Do not complete this form if the client will be participating only in "group activities" such as support groups of brief contracts for which no client file is used.

A revised Client Intake Form must be submitted if there is a change, correction, or addition to information previously submitted. When submitting revisions or updates or client information, if there is a change on an item which allows multiple responses then all correct responses must be entered for that item, not just those which changed. For example: the benefits item, if the client was receiving only Medicaid but now also receives Food Stamps, show both Medicaid and Food Stamps on the new Client Intake Form you submit.

II. INSTRUCTIONS AND DEFINITIONS

This section contains the instructions/explanations for completing each item and some possible responses.

When completing the Form, firmly **PRINT** the response in the blank. For multiple choice items, print only the letter of the response/responses which apply. If the correct response is "Other," print what that "other" means beside or beneath the item, not in the response blank.

To assure clear copies, use a ball point pen in blue or black ink only.

1. WORKER NUMBER _____
Enter the worker number of the person doing the interview.

2. CLIENT IS _____ NEW _____ EXISTING
NEW - Mark "new" to enter a new client into the MIS. EXISTING - Mark "existing" if the client is already entered in the MIS and information needs to be updated. For example, use this option if the social security number was not known when the client first applied for the service.

NOTE: If you are completing a form to show a change, you must:
- enter SSN of the client,
- mark "existing,"
- print the current date in Today's Date Line
- print client's name, and Provider number
- enter the new or changed data in the appropriate items.

3. SOCIAL SECURITY NUMBER: _____
Print the client's Social Security Number (SSN) here, as it appears on the social security card. Do not enter a spouse's number or any number other than the client's social security number. Enter the nine digit number with the dashes as indicated: Ex: 000-00-0000.

Each client must have a SSN. It is the "key" to the client's file. If the client does not have a SSN when you are completing the Intake Form, leave the item blank but write "UNKNOWN" to the side so that a "dummy" number can be created. Instruct the client to get a SSN and/or help him/her to fill out a SSN Application. As soon as the SSN is available, submit a revised Client Intake Form or Change of Client Status Form with the correct SSN. Please indicate on the form that this is a revision to the social security number previously submitted.

4. INTAKE DATE: _____
Print the date on which you are completing the form; use numbers only, in this style: month - day - year.

5. INITIAL CONTACT DATE: _____
Print the date on which the client was first interviewed for any AAA service, assessment, information , or referral; once the earliest date of contact is determined for the region, it never changes. Use numbers only, in this style: month - day - year.
NOTE: This is to be used only on initial contacts of new clients.

6. REFERRAL SOURCE: _____

A.	Self	E.	DAAS	I.	Public House
B.	DHS Office	F.	Agency	J.	Nursing Home
C.	Friend/Family	G.	Public Health	V.	Other/Church
D	AAA/provider	H.	MD/Hospital	Z.	Unknown

Print the one response which identifies how this client became known to you/the AAA.
- A. Self: Client contacted you or your office directly and requested some type of assistance.
- B. DHS County Office: County Office of the Department of Human Services only. This category does not include referrals from county or local government offices.
- C. Friend/Family: Any individual the client identifies as a friend, neighbor, or relative.
- D. AAA/Provider: Client identified or initially contacted through efforts of AAA or a AAA Provider.
- E. DAAS: Client referred by Division of Aging.
- F. Agency: Any public or private agency, organization not specifically listed in any other response.
- G. Public Health: Arkansas Department of Health or any county health unit (public health).
- H. MD/Hospital: Hospital, doctor, or nurse, etc. not employed by public health.
- I. Public Housing: Representative/manager of a government/public housing project or agency and AAA housing projects.
- J. Nursing Home: Client referred by a Nursing Home for service or assessment.
- V. Other/Church: Client referred by a source not listed above or referred by a church.
- Z. Unknown: Client is not a "self" referral but correct source cannot be determined or source is anonymous.

7. LAST NAME: _____ FIRST NAME: _____ MID: ____
Print the client's last, first and middle names in the specified space. If the client is Medicaid eligible, print the client's name exactly as it appears on their Medicaid Card. If the client is not Medicaid eligible, print the name as it appears on their Social Security Card.

8. ADDRESS 1 _____ /ADDRESS 2 _____
CITY _____ ST _____ ZIP _____
Print the client's mailing address in the appropriate spaces. If the mailing address is not in Arkansas, put a "X" over AR and print the correct state. Should the client have a street address and a P. O. Box number, enter one in as Address 1 and the other as Address 2. BOTH HAVE TO BE ENTERED.

9. TELEPHONE: (__) ___-_____.
Print the telephone number where the client can be reached (in the client's home, if possible). If there is no phone available, print "N/A". If there is a message phone number, please list it and print message beside the number. If the area code is not (501), print the area code in the parentheses.

10. COUNTY CODE: _____
Print the two digit county code of the client's residence (home address). List of all valid county codes is in Attachment I. If county is not in Arkansas, print "N/A".

11. REGION: _____
Print the number of your AAA (the number of the AAA interviewing this client); use Roman Numerals I through VIII.

12. GEOGRAPHIC DESG.: _____
A. RURAL B. URBAN C. UNKNOWN
Print the letter of the correct response in the blank. Use the information provided by the Division of Aging and Adult Services to determine the category. For all clients living outside of Arkansas, print a "Z".

13. PROVIDER(S): _____
Print the four (4) digit "Provider Code" of the service delivered by the agency.

14. BIRTH DATE: _____ AGE: _____
Print the client's date of birth as month - day - year (12-30-1906). Be sure to print all four digits of the year of birth. Print the clients' age as number of years.

15. IF UNDER 60, REASON FOR SERVICE

X,	B/A *Client over 60)	D.	Handicap/Disabled Dep Lives w/Client
A.	Spouse	E.	Adult Protective Service
B.	Meal Volunteer	V.	Other
C.	Handicap/Disabled Lives in Elder Housing		

X. N/A: Not applicable because client is 60 or more years of age.
A. Spouse: Client is the spouse of another client who is 60 or more years of age.
B. Meal Volunteer: Client is a volunteer worker in the meal program of the AAA or Senior Center.
C. Handicapped/Disabled Lives in Elder Housing: Client is mentally and/or physically handicapped/disabled and is under 60 and lives in elder housing where congregate meals are served.
D. Handicapped/Disabled Lives in Elder Housing: Client is mentally and/or physically handicapped/disabled and is under 60 and is the legal dependent of and lives with a client who is at least 60 years old.
E. Adult Protective Service: Client is an Adult Protective Services referral under the age of 60.
V. Other: Client is less than 60 years of age but fits none of the other options in this item.

16. SEX: _____ A. FEMALE B. MALE Z. UNKNOWN
Print the letter of the correct response in the blank. This item should be based on your observation. If the interview is by telephone and you are unsure of the client's sex, you may print "z" for unknown.

17. RACE: _____

A.	White	D.	Am. Indian	Z.	Unknown
B.	Black	E.	Asian		
C.	Hispanic	V.	Other		

Ask the client his/her "race", print only the client's primary response. Do not base this response on your observation; do not question the client's response if it varies from your expectation. Note that "D" includes all types of "native Americans" including Alaskan native; "E" includes all Asian groups and Pacific Islanders.

18. PRIMARY LANGUAGE: _____

A.	English	D.	French	Z.	Unknown
B.	Spanish	E.	Sign		
C.	Vietnamese	V.	Other		

If the client speaks English easily, print "A" in the space; otherwise, list the client's primary language.
A. English - The client's primary language is English.
B. Spanish - The client's primary language is Spanish.
C. Vietnamese - The client's primary language is Vietnamese.
D. French - The client's primary language is French.
E. Sign - The client uses sign language for communication.
V. Other - The client's primary language is something other than what is listed above.
Z. Unknown - Client's primary language is unknown.

19. MARITAL STATUS: _____

A.	Married	C.	Widowed	Z.	Unknown
B.	Never married	D.	Separated/Divorced		

Print the one indicator of the clients current marital status.
A. Married: Client is legally married, spouse is living and both spouse and client have the same home address.
B. Never Married: Client has never been married or the marriage was annulled.
C. Widowed: Client's spouse has died and the client has not remarried.
D. Separated/Divorced: Client has been divorced and not remarried or is married but spouse does not live in the same household. NOTE: do not consider hospital, nursing home, or separation due to illness as "separated" if the client and spouse would be living together otherwise.
Z. Unknown: Client is unable to satisfactorily identify his/her marital status.

20. EDUCATION: _____-

A.	8th Grade or Less	C.	High School Dip/GED	E.	4 or more yrs College
B.	9th to 12th Grade	D.	1-3 Years College	W.	Refused
				Z.	Unknown

A, 8th Grade or Less: Client completed the 8th grade or less.
B. 9th to 12th Grade: Client completed more than the 8th grade but has not completed a high school diploma or GED.
C. High School Diploma/GED: Client completed high school with a diploma or GED.
D. 1-3 Years College: Client attended some post-high school but did not complete a Bachelor's Degree.
E. 4 or More Years College: Client completed at least a Bachelor's degree.
W. Refused:
Z. Unknown:

21. BENEFITS: _____

A.	Social Security	F.	SSI.	V.	Other
B.	Medicaid	G.	VA Benefits	W.	Refused
C.	Medicare	H.	QMB	Y.	None
D.	Food Stamps	I.	ElderChoice	Z.	Unknown

A. Social Security: Client receives Social Security Benefits/income.
B. Medicaid: Client receives Medicaid. If this option is true, be sure to enter the Medicaid number at the bottom of the intake in the appropriate space.
C. Medicare: Client receives Medicare. If this option is true, be sure to enter the Medicare number at the bottom of the intake in the appropriate space.
D. Food Stamps Client receives government issued "Food Stamps" which can be redeemed for groceries.
E. Rental Assistance: Client receives a rent subsidy for housing, e.g., client pays less rent than full-pay tenants due to low income or age or some other factor.
F. SSI: Client receives Supplemental Security Income benefits.
G. VA Benefits: Client receives VA benefits.
H. QMB: Client receives Qualified Medicare Beneficiary benefits.
I. ElderChoice: Client receives ElderChoice benefits.

V. Other Client receives some other "public" benefit.

W. Refused: Client refused to answer this question.
Y. None: Client does not receive any benefits.
Z. Unknown: Client receives some benefit but cannot identify which.

22. VETERAN: _____ A. YES B. NO Z. UNKNOWN
Veteran ID# _____
A. Yes: Client served in any branch of the U. S. Military.
B. No: Client has never served in the U. S. Military.
Z. Unknown: Unsure of client's military service.
'If the client answers "yes" to this question, enter their veteran ID # in the space provided.

23. NUMBER IN FAMILY: _____
Print the number of persons whose income is included in the MONTHLY FAMILY INCOME Item (i.e., all members of "family" including client). Do not confuse this count with the number of persons residing in the household.

24. NUMBER IN HOUSEHOLD (INCLUDING CLIENT): _____
Print the number of persons residing in the household, including client. If the client's Living arrangement is Residential Care Facility, Boarding Home, Nursing Home, or other group/Institutional housing, print "N/A".

25. MONTHLY CLIENT INCOME: _____
Print the client's individual monthly income from all sources. Do not include the spouse's or any other person's income. If the yearly income amount is more easily available or more accurate due to inter monthly fluctuations, note the yearly income, divide it by 12, and enter the result in the blank. Rounded to the nearest dollar.

26. MONTHLY FAMILY INCOME: _____
Print the total monthly income from all sources for all family members. Round to the nearest dollar.
NOTE: "FAMILY" means **only** client, spouse, and legal dependent of the client. Do not include children or others who are not legal dependents. If the yearly income amount is more easily available or more accurate due to inter monthly fluctuations, note the yearly income, divide it by 12, and enter the result in the blank.

27. SOURCES OF INCOME: _____

A.	SOC. SEC.	C.	V. A.	V.	Other
B.	S. S. I.	D.	Earned		

Print the letter or letters of the appropriate source of which the client's income is compiled. This must be filled out for SSBG eligible services.
A. Social Security: The client receives Social Security income benefits
B. S. S. I.: The client receives Supplemental Security income benefits.
C. V. S.: The client receives V. A. Pension benefits/income.
D. Earned: The client is working and their income is considered to be earned.
V. Other: The client's income is compiled of sources other than those listed above.

28. HOUSING TYPE: _____

A.	House/Own	E.	Nursing Home	Y.	None
B.	House/Rent	F.	Life Estate	Z.	Unknown
C.	Apt./Duplex	G.	Elderly Housing		
D.	Res. Care Fac.	V.	Other		

A. House/Own: Client owns or is purchasing single family house in which he/she lives.
B. House/Rent: Client rents or leases a single family residence in which he/she lives.
C. Apartment/Duplex: Client lives in an apartment, duplex, or similar multi-family housing.
D. Residential Care Facility: Client resides in a facility that is licensed by the Office of Long Term Care as a Residential Care Facility.
E. Nursing Home: Client resides in a licensed Nursing Home.
F. Life Estate: Retaining the right to possess and use a home and/or property until death although the property has been deeded to someone else.
G. Elderly Housing: Client resides in an Elderly Housing facility.
V. Other: Client resides in some other type of housing.
Y. None: Client has no housing (e.g. transient).
Z. Unknown: Client cannot explain their current, normal residence.

29. ELDERLY HOUSING OR RETIREMENT COMMUNITY: _____

A.	Yes	B.	No	C.	N/A

A. Yes: Client lives in an age restricted or predominantly elderly housing/community.
B. No: Client does not live in an age restricted house/community.
X. Not Applicable: Client lives in a nursing home, residential care facility, or other institution.

30. HOUSING COMPOSITION: _____

A.	Lives alone	D,	Live-in help	X.	N/A
B.	Spouse	E.	Boarder	Z.	Unknown
C.	Family/Friend	V.	Other		

List all persons who are sharing private residence with the client. Do not list any person more than once.
A. Lives alone: Client normally lives alone. If client normally shares housing with other(s) but there is a temporary separation (e.g., spouse in the hospital or visiting out of town), do not mark "lives alone."
B. Spouse: Client shares household with spouse.
C. Family/Friend: Client shares household with relative(s) or friend(s).
D. Live-in Help: Paid helper (e.g., housekeeper, nurse) lives in the home.
E. Boarder: Client shares household with a paying boarder.
V. Other: Client has other household member(s) not described above.
X. Not Applicable: Client lives in Residential Care Facility, Boarding Home, Nursing Home, or other group or institutional housing such that identification of other individuals in household is not appropriate or client has no one.
Z. Unknown: Unsure if client lives alone or with others.

31. ADL/IADL FUNCTION LIMITS: _____
(List all that are true)

List all ADL/IADLS that the client has a problem completing without assistance (e.g., if no one helped the client with laundry, would the client be unable to do it alone).
A. Walking: Walking or getting around in the home setting without wheelchair, cane, walker, or help from another person.
B. Housework: Cleaning surfaces and furnishings (dusting, washing dishes, etc.).
C. Heavy Cleaning/Yard: Mowing lawn, trimming shrubs, mopping and waxing floors, etc.
D. Getting Places: Getting to places outside the home setting without special assistance or special transportation because the client is physically or mentally unable (lack of vehicle or driver's license is not applicable).
E. Reading: Difficulty reading due to Vision problems, inability to read, etc.

F. Writing: Difficulty writing due to vision problems, physical problems, inability to write, etc.
G. Cooking: Preparing food appropriately for meals including safe use of appliances such as gas burners.

H. Laundry: washing, drying, and folding clothes and linens.
I. Business Affairs: Balancing a check book, paying bills, handling business affairs, making appointments, etc.
J. Shopping: Selecting and completing purchases (e.g., pushing grocery cart and picking up groceries).
K. Bathe/Shampoo: Bathing, getting in or out of the tub/shower, shampooing hair, etc.
L. Bowel/Bladder Accidents: Control of bladder and/or bowel function; cleansing self and adjusting clothing after an accident.
M. Dress/Grooming: Putting on clothes, buttoning or zipping, combing hair, arranging appearance, etc.
N. Taking Medications: Taking medications in the right amount at the right time.
O. Using Telephone: Dialing, hearing, speaking, etc.
P. Using Toilet: Getting to and from the toilet, cleansing after elimination, and adjusting clothing.
Q. Feeding Self: Eating/feeding self including use of special equipment (feeding tubes) if needed.
V. Other: Any ADL/IADL functional limitation not listed above.
Y. None: Client has no difficulty with any ADL/IADL.
Z. Unknown: Client is unable to respond to this question.

32. WHO HELPS (list all true): _____

A.	Family	D,	Has help but unsure who	Z	Unknown
B.	Friend/Neighbor	V.	Other		
C.	Paid Help	X.	N/A		

List all persons, **excluding** the AAA and its providers, who assist the client with any of the ADL/IADL problems above.
A. Family: Any relative of the client.
B. Friend/Neighbor: Any friend, neighbor, church member, etc. of client.
C. Paid Help: Any person who is paid to assist the client (e.g., cleaning lady, mowing/yard work, accountant, nurse).
D. Has help but unsure who: The client has assistance but unsure of relationship to the client.
V. Other: The client has other assistance not listed above (ex: home health, etc.)
X. N/A: Client has no need for assistance with any ADL/IADL (i.e., item above is Y. None)
Y. None: Client needs assistance but has no help. Note: Do not enter Y if client has some help but needs more; this response means the client has no assistance at all except the AAA provider.
Z. Unknown: Unsure if the client has or needs any assistance.

33. PRIMARY TRANSPORTATION: _____

A.	Own Car	D.	Sr. Trans	Y.	None
B.	Friend	E.	Family	Z.	Unknown
C.	Pub Trans	V.	Other		

List client's one most frequent of primary means of transportation.
A. Own Car: Client (or client's spouse) owns and operates a motor vehicle (car, truck, etc.).
B. Friend: Friend or neighbor of the client provides transportation for the client in a private vehicle.
C. Public Transportation: Client normally uses taxis, buses, or other public transportation.
D. Senior Center Transportation: Client normally uses the Senior Center Van or Vehicle for transportation.
E. Family: Any family member of the client who provides transportation for the client in a private vehicle.
V. Other: Print the type of transportation normally used. Note: Transportation provided by relatives should be noted here.
Y. None: Client currently has no means of transportation.
Z. Unknown: Client cannot indicate what kind of transportation they normally use.

34. PROSTHETIC DEVICES: _____

A.	Walker/Cane	D.	Glasses	V.	Other
B.	Wheelchair	E.	Dentures	Y.	None
C.	Hearing Aid	F,	Artificial Limb	Z.	Unknown

List all devices that the client uses all or part of the time.
A. Walker or Cane: Client uses a walker, cane, or crutches to aid in walking.
B. Wheel Chair: Client uses a wheel chair to aid mobility.
C. Hearing Aid: Client uses a hearing aid.
D. Glasses: Client uses glasses or contact lens.
E. Dentures: Client has/uses dentures to replace at least one-half of his/her natural teeth.
F. Artificial Limb: Client use an artificial limb(s) such as a leg, arm, hand or foot.
V. None: Client does not currently use or need any "prosthetic devices".
Z. Unknown: Client is unable to respond to this question.

35. MEDICARE: _____

Print the client's Medicare number here: nine numbers followed by two letters. This number may be used for Billing purposes.

36. MEDICAID_____
Print the client's Medicaid number here as it appears on their Medicaid card - this will be a ten digit number. This number will be used for billing purposes.

37. PHYSICIAN./PHONE: _____
Print the first and last name of the client's physician and his/her phone number in the blank. If the client does not have a regular physician, leave this blank.

38. EMERGENCY CONTACT / PHONE: _____
Print the name and phone number of the client's relative or other person which may be contracted in case of an emergency.

39. INTERVIEWER: _____
Print the name of the interviewer completing this form.

40. CLIENT/RELATIVE SIGNATURE: _____
Have the client/relative sign the Intake form. This is mandatory on all Title XX clients.

Attachment 1

COUNTY CODES

01	Arkansas
02	Ashley
03	Baxter
04	Benton
05	Boone
06	Bradley
07	Calhoun
08	Carroll
09	Chicot
10	Clark
11	Clay
12	Cleburne
13	Cleveland
14	Columbia
15	Conway
16	Craighead
17	Crawford
18	Crittenden
19	Cross
20	Dallas
21	Desha
22	Drew
23	Faulkner
24	Franklin
25	Fulton
26	Garland
27	Grant
28	Greene
29	Hempstead
30	Hot Springs
31	Howard
32	Indepenence
33	Izard
34	Jackson
35	Jefferson
36	Johnson
37	Lafayette
38	Lawrence
39	Lee
40	Lincoln
41	Little River
42	Logan
43	Lonoke
44	Madison
45	Marion
46	Miller
47	Mississippi
48	Monroe
49	Montogmery
50	Nevada
51	Newton
52	Ouachita
53	Perry
54	Phillips
55	Pike
56	Poinsett
57	Polk
58	Pope
59	Prairie
60	Pulaski
61	Randolph
62	Saline
63	Scott
64	Searcy
65	Sebastian
66	Sevier
67	Sharp
68	St. Francis
69	Stone
70	Union
71	Van Buren
72	Washington
73	White
74	Woodruff
75	Yell

ARKANSAS OMBUDSMAN REPORTING SYSTEM

Facility Information Report

❑1st Quarter (Oct. - Dec.) ❑ 2nd Quarter (Jan. - Mar.) ❑ 3rd Quarter (April - June) ❑4th Quarter (July - Sept.)

Name:	ID #:	AAA:

FacCode:	Facility:	City:
Type of facility: NF		
Number of Involuntary Transfers/Discharges during Quarter:		
Was this facility surveyed during this quarter: Yes ❑ No ❑ **If Yes, complete A & B below:**		

A Date of Survey:

- Substantial Compliance
- Not in Substantial Compliance
- Substandard Care

F221 - 225 = Resident Behavior & Facility Practice
F240 - 258 = Quality of Life
F309 - 333 = Quality of Care

B Your extent of participation:

- Spoke with OLTC over the phone/gave information.
- Was present during the survey.
- Was present at the exit conference.
- Was not notified about the exit by OLTC surveyor.
- Other:_____

If surveyors fail to make contact, document as an Ombudsman filed complaint under complaint category 108, Survey process: Ombudsman participation.

Family Council Meetings Attended (Dates)		Resident Council Meetings Attended (Dates)	

Training Conducted by Ombudsman for Facility Staff

Date:	# Staff Attending	Length:
Topic:		

Date:	# Staff Attending	Length:
Topic:		

Comments:

# Cases carried over from last quarter.	# New cases this quarter.	# Cases closed this quarter.	# Cases carried over to the next quarter.

****Submit a copy of all completed cases.**

FacCode: Facility: City/County:

	Dates Facility Was Visited
	Number of Residents Visited
	Total Number Residents for all Visits During the Quarter
	Privacy/Dignity Issues
	Choices
	Abuse/Neglect
	Clean/Comfort/Homelike
	Activities
	Pain/Comfort
	ADL Concerns
	Language/Communication
	Vision/Hearing/Sensory
	Abrasion/Bruise/Fx
	Restraints
	Adm./Transfer/Discharge
	Incontinence/Toileting Programs
	Catheter
	Tube Feedings
	Weight Change/Nutrition Needs
	Hydration/Electrolyte
	Assistive Device/Dentures
	Swallow/Dining Program
	Antibiotics/Infections
	Pressure Sores
	ROM/Contractures/Posit.
	Specialized Rehab
	Respiratory Care

Residents/Families willing to be interviewed by OLTC:

_____

_____

_____

_____

_____

Signed: _____

This provides definitions for concerns and observations noted during visits. The purpose is to help you keep track of what you come across during your visits to facilities. You should note only general observations. This should help you relate information to the surveyors in a manner that corresponds to their survey process.

Privacy/Dignity Issues:	Concerns about residents' right to privacy (accommodations, written and telephone communication, visitation, personal care) or if there are concerns that the facility does not maintain or enhance residents' dignity.
Choices:	Concerns about residents' ability exercise their rights as citizens; be free from coercion, discrimination or reprisal; participation in care planning and treatment changes and participation in resident and family groups and other community activities.
Abuse Neglect:	Concerns about resident abuse, neglect or misappropriation of resident property, or how the facility investigates and responds to allegations of abuse, neglect or misappropriation of personal property.
Clean Comfort Homelike:	Concerns about the facility environment including cleanliness, lighting levels, temperature, comfortable sound levels, or homelike environment. (The resident's ability to use their personal belongings and individualize their room to the extent possible.)
Activities:	Concerns about activities meeting the interests, preferences and needs of residents.
Pain Comfort:	Concerns about timely assessment and intervention with residents needing pain or comfort measures.
ADL Concerns:	Concerns that the resident is not given appropriate treatment and services to maintain or improve abilities in ADL's.
Language Communication:	Concerns about the facility assisting those residents with communication difficulties to communicate at their highest practicable level.
Vision Hearing Sensory:	Concerns about the facility assisting those residents with visual or hearing impairments to function at their highest practicable level.
Abrasions Bruises Fx:	Concerns about the presence and/or prevalence of abrasions, bruises or fractures.
Restraints:	Concerns about inappropriate use of physical restraints.
Adm. Transfer Discharge:	Concerns about resident transfers or discharge procedures; and care/treatment for residents recently admitted and those preparing for discharge/transfer.
Incontinence Toileting Programs:	Concerns relating to resident incontinence and facility toileting programs and the presence and/or prevalence of incontinent residents.
Catheter:	Concerns related to catheter use in the facility.
Tube Feeding:	Concerns related to tube feedings.
Weight Change Nutrition Needs:	Concerns about residents with weight changes and/or nutritional needs.
Hydration/Electrolyte:	Concerns about resident dehydration or electrolyte imbalance.

Assistive Devices Dentures:	Concerns about the need for absence of or use of special devices to assist residents in eating. (e.g. tables, utensils, hand splints, dentures, etc.) or concerns about any other assistive devices.
Swallow dining Program:	Concerns about the need for restorative dining programs or residents with swallowing problems that may affect dietary intake.
Antibiotics Infections:	Concerns about presence or prevalence of resident infections and facility infection control procedures or with antibiotic use patterns.
Pressure Sores:	Concerns about the occurrence, assessment, prevention or treatment of pressure ulcers or other necessary skin care.
ROM Contractures Posit.:	Concerns about the occurrences, prevention or treatment of contractures. Concerns with staff provision or lack of provision of ROM or the positioning of residents.
Specialized Rehab:	Concerns about the facility's provision or lack of provision of Specialized Rehabilitative Services including: Physical therapy, speech/language pathology, Occupational therapy, Health rehabilitative services for MI/MR.
Respiratory Care:	Concerns about care provided to residents with tracheotomies, ventilators, residents needing suction, etc.

Signed: _____

ARKANSAS OMBUDSMAN REPORTING SYSTEM

Quarterly Report Information

All Local Ombudsman activities should be included in this report.

AAA:_____

☐ 1st Quarter (Oct. - Dec.) ☐ 2nd Quarter (Jan. - Mar.) ☐ 3rd Quarter (April - June) ☐ 4th Quarter (July - Sept.)

A. Number of full time Ombudsmen: _____ Number of part time Ombudsmen: _____

List Full Time Ombudsmen	List Part Time Ombudsmen	% of Time
		%
		%
		%
		%
		%

☞Items **B** and **C** for approved Volunteer Ombudsman programs only.

B. Volunteer Coordinator: _____

C. Number of Volunteer Ombudsmen: _____ ATTACH LIST INCLUDING FACILITY ASSIGNMENTS

D. Training for Ombudsman staff and volunteers: # of Sessions:_____ # of Hours:_____

Total number of people trained: # of Volunteers:_____ # of Staff:_____

E. Technical assistance to local Ombudsmen and/or volunteers:

Estimated **percentage** of total staff time _____%

F. Consultation to facilities/providers: **Number** of consultations: _____
(Consultation: Providing information and technical assistance, often by telephone)

Three most frequent requests/needs:

1) _____

2) _____

3) _____

G. Information and consultation to individuals **Number** of consultations: _____
(Usually by telephone)

Three most frequent requests/needs:

1) _____

2) _____

3) _____