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FAX

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Fax Subject: Test

Fax Description: Test

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Assessment: HUD SFS W/Risk Score**Client:** Baumgartner, Marcia Mae (86F)**Related Enrollments:****Created by:** Schroeder S , Amanda**Created On:** 01/20/2026, 03:20**Last Updated:** 01/20/2026, 03:20**Status:** Unsigned**WHO IS COMPLETING ASSESSMENT:** Family**ASSESSMENT TYPE:** HUD SFS W/Risk Score**ASSESSMENT DETAILS****Intake date / move in date**

January 6, 2026

First Name

Marcia

Last Name

Baumgartner

Birth Date

1939-11-06

Age

86

Age Risk Score

2

Gender

5 = Other

Ethnicity

99 = Individual does not know

Marital Status

Living With Domestic partner

Race

2 =Asian

Did the resident refuse to complete the assessment?

Yes

Head of household status

-

Veteran Status

-

Disability Status

-



If yes, what types of disabilities do you have?

-

Are you currently employed?

-

Employer

-

Income

-

Do you receive supplemental social security?

-

If yes, enter monthly gross

-

Do you receive Social Security Disability Insurance?

-

If yes, enter monthly gross

-

Do you have any other sources of income?

-

Total Gross Monthly Income (Dollar amount in whole dollars)

-

Household Housing cost (Rent or Mortgage, utilities, property tax)

-

Household transportation cost (car payments, insurance, repairs, gas, parking, public transporation)

-

Highest education level

-

If Grade 1- Grade 11 selected, enter grade completed.

-

Functionally Literate

-

Primary Language

-

Interpreter / Translator

-

Do you have health insurance?

-

Primary Insurance

Medicare

Secondary Insurance

-

Medicaid #

MD862736

Medicare #

-

Client does not have insurance

-

Do you have advance directive?

-

Do you have a Primary Health Care Provider?

1 = Yes

Primary Health care provider (name, address, phone)

Reed, Marcus | 333 Medical Plaza Dr, Holland, OH | (960) 748-4033

Current Pharmacy Name, Address, Phone

-

Do you have any specialty Doctors?

-

If yes, enter type, name, type, address, phone number

-

Height (in Feet)

-

Height (in inches)

-

Weight (in lbs)

-

BMI

-

BMI Risk Score

-

Have you been to a routine medical checkup with your primary care provider in the last 12 months?

-

How many visits have you had with your Primary Care Provider in the last 12 months?

-

Past 12 PCP visits Risk Score

-

Have you been diagnosed with Dementia / Alzheimers?

-

Dementia / Alzheimers Risk Score

-

Does the client shows any signs of cognitive decline?

-

Instructions: Tell the patient you are going to say three words. Say the words clearly and slowly, then ask the patient to repeat them. The words are Sock, Blue and Bed

-

Clock Drawing Test Results

-

Clock Drawing Completed

-

All Numbers Present

-

Hands Correctly Placed

-

Cognitive Score

-

What are your current Health diagnosis?

-

Do you have any chronic illnesses?

-

Select

-

Have you been diagnosed with Cancer?

-

If yes, enter type and stage.

-

Have you been diagnosed with HIV?

-

As the assessor which category do you feel best suits your client?

-

Assessor chronic category selection risk score

-

Are you currently taking any medications?

-

If yes, enter medication lists.

-

How many medications are you currently taking?

-

Count of Medications Risk Score

-

Do you currently receive any assistance with medications?

-

If yes, enter type of assistance.

-

Do you have any allergies?

-

If yes, enter type of allergies.

-

Have you received any immunizations in the last 12 months?

-

If yes, enter type of immunization and date.

-

To make sure we can support you: Do you currently have any diagnosis related to your mental or behavioral health?

-

If yes, enter diagnosis.

-

Is your diagnosis currently stabilized with medication?

-

Over the past two weeks have you experienced any of the following?

-

If yes, select from below:

-

As the assessor which category do you feel best suits your client?

-

Mental health / Behavioral Health Risk Score

-

Little interest or pleasure in doing things

-

Feeling down, depressed or hopeless

-

Little interest or pleasure in doing things

-

Feeling down, depressed, or hopeless?

-

Trouble falling or staying asleep, or sleeping too much?

-

Feeling tired or having little energy?

-

Poor appetite or overeating?

-

Feeling bad about yourself - or that you are a failure or have let yourself or your family down?

-

Trouble concentrating on things, such as reading the newspaper or watching television?

-

Moving or speaking so slowly that other people could have noticed? Or so fidgety or restless that you have moving a lot more than usual?

-

Thoughts that you would be better off dead, or thoughts of hurting yourself in some way?

-

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

-

PHQ9 Score

-

PHQ9 Interpretation

-

Does the client use any devices / interventions for hearing, dental or vision?

-

If yes, enter comment.

-

Do you have a Dentist?

-

If yes, enter details such as name, address and phone number

-

Have you been to the dentist in the last 12 months?

-

If yes, enter last visit date.

-

Have you had your vision checked in the last 12 months?

-

If yes, enter last visit date.

-

Have you had your hearing checked?

-

If yes, enter last visit date.

-

Would you like assistance with finding a provider for dental, vision or hearing?

-

Have you been treated in the ER in the last 12 months?

-

If yes, enter number of ER visit/s, date/s and reason/s.

-

Counts of ER Visits in past 12 months

-

Last 12 months ER visits Risk Score

-

Have you been admitted to the hospital in the last 12 months?

-

If yes, enter number of hospital admission/s, date/s and reason/s.

-

Counts of hospital admissions in past 12 months

-

Last 12 months Hospital Admissions Risk Score

-

Have you had any falls in the last 6 months?

-

If yes, enter number of falls, date/s and reason/s.

-

What is the current living situation?

-

What is the current living condition?

-

If animals in the home enter types and amount.

-

Do you currently live alone?

-

If yes, who do you live with?

-

Do you ever feel threatened or abused?

-

If yes, enter comment.

-

Are you ever concerned of someone in the home abusing drugs or alcohol?

-

If yes, enter comment.

-

In the past 12 months have you ever worried that your food would run out before you were able to purchase more?

-

Do you currently receive SNAP benefits?

-

If yes, enter amount.

-

Do you currently receive any other types of food assistance?

-

If yes, enter comment.

-

Do you currently receive TANF benefits?

-

If yes, enter amount.

-

In the last 12 months, have you received a disconnection notice from the electric, heating or water company?

-

In the past 12 months has the lack of transportation kept you from medical appointments or any activities of daily living?

-

Do you currently need assistance with daily activities?

-

If yes, select Activities of Daily Living.

-

Numer of ADL's receiving assistance

-

Do you currently need assistance with instrumental daily activites?

-

If yes, select Instrumental Activities of Daily Living.

-

Numer of IADL's receiving assistance

-

Do you currently receive any assistance with activities of daily living?

-

If yes, enter comment.

-

Do you have any adaptive devices?

-

If yes, select all that apply:

-

Do you ever feel alone or isolated?

-

Do you currently use or have you used tobacco or E cigarettes?

-

If yes - currently using enter consumption amount.

-

If yes - previous user enter cessation date.

-

Tobaccos or E-cigarettes Risk Score

-

Do you currently or have you previously consumed alcohol?

-

If yes - currently using enter consumption amount.

-

If yes - previous user enter cessation date.

-

Do you currently or have you previously used illegal drugs or misused prescription drugs?

-

If yes - currently using enter consumption amount.

-

If yes - previous user enter cessation date.

-

Do you currently or have you previously had a substance use disorder?

-

Substance Abuse Risk Score

-

Did the Participant receive a housing and supportive services assessment? Hidden question

-

Based on your assessment findings which category describes your client fall?

-

Assessors Risk Score

-

Total Risk Score

-

Time to Complete Assessment

5