

From: Genacross Lutheran Services
2021 N. McCord Rd.
Toledo, OH, 43615
Fax Number: (876) 567-8904
Fax Date: 2/20/2026
Fax Time: 12:00 PM
Sender's Name: Amanda Schroeder S
Phone: 419-309-4288

FAX

To: TT11

Fax: +19725329272

Phone: 098-765-4321

Pages: 11

Contact Person:

Fax Subject: 098-765-4321

CONFIDENTIAL

IMPORTANT: This facsimile transmission and any attached documents may contain confidential and legally privileged information, including Protected Health Information (PHI) as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, intended only for the use of the recipient named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you have received this transmission in error, please immediately notify the sender by telephone and destroy all copies of this fax.

Assessment: HUD SFS W/Risk Score**Created by:** Schroeder S , Amanda**Last Updated:** 01/20/2026, 03:20**Client:** Baumgartner, Marcia Mae (86F)**Created On:** 01/20/2026, 03:20**Status:** Unsigned**Related Enrollments:****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

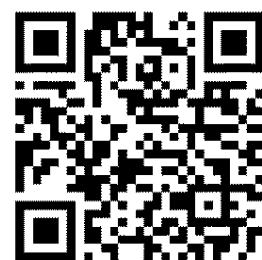
Living With Domestic partner

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