DATA COLLECTION FORM

Client First Name:	Auto-populate.	**Client Last Name:**	Auto-populate.
Client Age:	Auto-populate.	**Client Gender:**	Auto-populate.
Client Race:	Auto-populate.	**If "Other" Race, Explain:**	Enter text.
Client Ethnicity:	Auto-populate.	**Contact (If Not Client):**	Enter text.
SLRC County:	Choose an item.	**Personal ID Number:**	Enter text.

Check All That Apply: ☐ Individual with disability ☐ Veteran ☐ Caregiver ☐ None apply

Identified Needs & Wants:
☐ Access to Health Care ☐ Employment/Job Training ☐ Food Access
☐ Health Insurance ☐ Housing ☐ Mental Health
☐ SUD Treatment ☐ Transportation

Information at First Person-Centered Counseling Encounter

Date of First PCC:	Auto-populate current date.	**90-Day Follow-Up Date:**	Auto-populate 90 days out.
Living Setting:	Choose an item.	**Payor Source:**	Choose an item.
Is this a SHIP Encounter?	Choose an item.	**Is this a VDC Encounter?**	Choose an item.
PC Plan / Action Plan:	Choose an item.	**Plan Format:**	Choose an item.

Encounter Sub-Forms

☐ Application Assistance ☐ Hospital Care Transitions ☐ NH Family Caregiver Support Program

Information at 90-Day Follow-Up

Date of Follow-Up:	Auto-populate current date.	**Contact (If Not Client):**	Enter text.
Living Setting:	Choose an item.	**Payor Source:**	Choose an item.

In the past 90 days, approximately how many days were spent in the following settings:

Personal Home Alone:	#	Personal Home with Others:	#	Adult Foster Care/Adult Family Setting:	#
Assisted Living:	#	Nursing Facility:	#	Provider/Group/Residential Home:	#
Hospital:	#				

APPLICATION ASSISTANCE			
Was the individual supported with a financial assessment for a public program?			Choose an item.
Was the individual supported with a functional assessment for a public program?			Choose an item.
Was the individual assisted with an application for one or more public programs?			Choose an item.
Were any of the assessments or applications for the following types of public programs?			
☐ Medicaid LTSS	☐ VA Program	☐ Other Federal/State LTSS	☐ None Apply
Programs Assisted With:	☐ ANB ☐ Medical Assistance ☐ LIS/Extra Help ☐ OAA ☐ SNAP	☐ APTD ☐ FANF Cash ☐ MSP ☐ Public/Subsidized Housing	☐ Child Care Scholarship ☐ HCBC/HC-CSD ☐ NF ☐ SafeLink

HOSPITAL CARE TRANSITIONS				
Information Prior to Hospitalization				
Living Setting:	Choose an item.	**Payor Source:**	Choose an item.	
Information Regarding Hospitalization				
Conditions Resulting in Hospitalization:	☐ AMI ☐ Heart Failure ☐ THA/TKA	☐ COPD ☐ Pneumonia ☐ Other: Enter Text.	☐ Coronary Artery Bypass Surgery	
Number of Days Hospitalized:	#	**Is 30-Day All-Cause Readmission Data Available?**	Choose an item.	
Information Directly After Discharge				
Living Setting:	Choose an item.	**Payor Source:**	Choose an item.	
Was the individual transferred directly to the following setting(s)?		☐ HCBS	☐ Hospice	☐ N/A
Which apply to the individual's status 30 days post-discharge?		☐ Readmitted	☐ Passed away	☐ N/A

NH FAMILY CAREGIVER SUPPORT PROGRAM

Specialist First Name:	Auto-populate.	**Specialist Last Name:**	Auto-populate.
Caregiver Residence:	Auto-populate.	**Rural:**	Auto-pop. based on residence.
Date of Initial Contact:	Choose a date.	**Referral Source:**	Choose an item.

Services Utilized:

- ☐ Assistive Technology
- ☐ Caregiver Support
- ☐ Chore Services
- ☐ Environment Services
- ☐ Home Delivered Meals
- ☐ Home Modifications
- ☐ Homemaker Services
- ☐ Nursing Care at Home
- ☐ Occupational Therapy
- ☐ Personal Care
- ☐ Powerful Tools for CGs
- ☐ Respite Care
- ☐ Support Group
- ☐ Other: Enter Text.

Caregiver Information

First Name:	Auto-populate.	**Last Name:**	Auto-populate.
Date of Birth:	Auto-populate.	**Age:**	Auto-populate.
Gender:	Auto-populate.	**Marital Status:**	Auto-populate.
Race:	Auto-populate.	**Ethnicity:**	Auto-populate.
Relationship to Recipient:	Choose an item.		
If "Other," Please Specify:	Enter text.		
Children Under 18 Receiving Care (If Any):	#	**Annual Income:**	Choose an item.
Primary Reason That Care is Being Provided:	Choose an item.		

Care Recipient Information

Care Recipient #1

First Name:	Enter text.	**Last Name:**	Enter text.
Date of Birth:	Choose a date.	**Age:**	Choose an item.
Gender:	Choose an item.	**Living Arrangement:**	Choose an item.
Date Recipient Was Added:	Choose a date.	**Functional Impairments:**	Choose an item.
Cognitive Impairments:	Choose an item.	**Annual Income:**	Choose an item.
Assets:	Choose an item.		

Add Another Care Recipient

Annual Update for Fiscal Year: Choose an item.			
Program Status			
Is the Client currently receiving Caregiver funding?	☐ Yes (ADRD)	☐ Yes (Title III E)	☐ No
Has the Client previously received Caregiver funding?	☐ Yes (ADRD)	☐ Yes (Title III E)	☐ No
Is or has the Client ever been waitlisted for Caregiver funding? ☐ Yes, Client is currently waitlisted (ADRD) ☐ Yes, Client was previously waitlisted (ADRD) ☐ No, Client has no waitlist history	☐ Yes, Client is currently waitlisted (Title III E) ☐ Yes, Client is currently waitlisted (Title III E)		
Reason for Current Waitlist (If Applicable): ☐ Client reached funding limit (ADRD) ☐ Client received some but needed more (ADRD) ☐ Currently no funding available (ADRD) ☐ N/A	☐ Client reached funding limit (Title III E) ☐ Client received some but needed more (Title III E) ☐ Currently no funding available (Title III E)		
If waitlisted at the time of annual update, is need still present?	Choose an item.		
Financial Information			
Type of Funds Used:	☐ Respite (ADRD)	☐Respite (Title III E)	☐ Supplemental (Title III E)
How Are Supplemental Funds Spent?	☐ Consumable Supplies ☐ Homemaker-Delivery ☐ Transportation	☐ Assistive Tech., Durable Medical Equip., Emergency Response ☐ Chores, Heavy Cleaning, Snowplowing, Yardwork ☐ Other: Enter Text	
Add Another Annual Update			

Discontinuing Information			
Reason for Discontinuing:	Choose an item.	**Date of Discontinuation:**	Choose a date.
Date Enrolled in Medicaid:	Choose a date.	**Date CFI Services Began:**	Choose a date.