

NAPIS Intake-Authorization Form
CITY AND COUNTY OF HONOLULU - ELDERLY AFFAIRS DIVISION

Date Registered: _____
 Date Updated: _____
 Reassessment Date: _____

Provider/Program: _____ Worker: _____

NAME _____
 Last _____ First _____ M.I. _____
DATE OF BIRTH: _____ **SSN 4-Digit:** _____ **SEX:** F or M **PHONE:** _____
 Mo. Day Yr.

HOME ADDRESS: _____ **City:** _____ **HI ZIP** _____

MAIL ADDRESS: _____ **City:** _____ **HI ZIP** _____
 (If different from HOME ADDRESS)

UNDERSTANDS ENGLISH? Yes No
 If "No", Primary language: Cantonese Mandarin Tagalog Ilocano
 Japanese Korean Visayan Other _____

ETHNICITY: Hispanic or Latino Not Hispanic or Latino

RACE (check all that apply below): then select ... NATIONALITY (check all that apply below for each selected RACE):

<input type="checkbox"/> American Indian or Alaskan	<input type="checkbox"/> Am. Indian or Alaskan Native
<input type="checkbox"/> Asian	<input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Indian (Asian)
	<input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Tongan
	<input type="checkbox"/> Other Pacific Islander _____
<input type="checkbox"/> White	<input type="checkbox"/> White
<input type="checkbox"/> Other	<input type="checkbox"/> Other

INCOME BELOW POVERTY: Yes No **DOES CLIENT LIVE ALONE:** Yes No

Medicaid - QExA: Yes No Don't Know

ADL's - Can the Client Do the Following Without Help:

Eating	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dressing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Using Toilet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Transferring	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Walking (Getting around the house)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Total "No"		0

Cognitive or Mental Impairment Yes No

IADL's - Can the Client Do the Following Without Help:

Prepare Meals	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shopping	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Take Medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Manage Money	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Use Telephone	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heavy Housework	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Light Housework	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Use Public Transportation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Total "No"		0

Client Representative: _____ **Phone:** _____

Relationship: _____ **Phone(other)** _____

Provider/Program:

0 Worker:

NAME:

Last

First

M.I.

Nutritional Risk (for III-C o Case Managem e t)

	Yes	No	
1 Has the client made any changes in lifelong eating habits because of health problems?	<input type="checkbox"/>	<input type="checkbox"/>	2
2 Does the client eat fewer than 2 meals per day?	<input type="checkbox"/>	<input type="checkbox"/>	3
3 Does the client eat fewer than 5 servings (1/2 cup each) of fruits or vegetables every day?	<input type="checkbox"/>	<input type="checkbox"/>	1
4 Does the client eat fewer than 2 servings of dairy products (such as milk, yogurt, or cheese) every day?	<input type="checkbox"/>	<input type="checkbox"/>	1
5 Does the client have trouble eating well due to problems with biting or chewing or swallowing?	<input type="checkbox"/>	<input type="checkbox"/>	2
6 Does the client sometimes not have enough money to buy food?	<input type="checkbox"/>	<input type="checkbox"/>	4
7 Does the client eat alone most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	1
8 Does the client take 3 or more different prescribed or over-the-counter drugs per day? (Including aspirin, laxatives, antacids, inhalers, herbs, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	1
9 Without wanting to, has the client lost or gained 10 pounds in the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	2
10 Is the client not always physically able to shop or cook or feed themselves (or to get someone to do it for them)?	<input type="checkbox"/>	<input type="checkbox"/>	2
11 Does the client have 3 or more drinks of beer, liquor or wine almost every day?	<input type="checkbox"/>	<input type="checkbox"/>	2

Nutrition Risk Score: 0

(III-C Programs Only)

What is the client's nutritional risk score rating?	<input type="checkbox"/> No risk (0-2)	<input type="checkbox"/> Moderate Risk (3-5)	<input type="checkbox"/> High Risk (6-21)
What is the client's body mass index (*BMI)	Height Feet <input type="checkbox"/> Inches <input type="checkbox"/>	Weight (lbs) <input type="checkbox"/>	BMI <input type="checkbox"/>
What is the client's body mass index (BMI) rating?	<input type="checkbox"/> Less than 22	<input type="checkbox"/> Between 22 and 27	<input type="checkbox"/> More than 27
Describe the client's diet type:	<input type="checkbox"/> Regular	<input type="checkbox"/> Modified	
NSIP Meals Eligible	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Eligibility Type	<input type="checkbox"/> Age (60 or Over)	<input type="checkbox"/> Other	<input type="checkbox"/> Disabled in Elderly Housing
			<input type="checkbox"/> Helper/Spouse
			<input type="checkbox"/> Tribal Age Specification
			<input type="checkbox"/> Volunteer

Client is receiving the following Services:

<input type="checkbox"/>	Bathing	<input type="checkbox"/>	Homemaker	<input type="checkbox"/>	Chore	<input type="checkbox"/>	Home Delivered Meals
<input type="checkbox"/>	Case Management	<input type="checkbox"/>	Transportation	<input type="checkbox"/>	Assisted Transportation	<input type="checkbox"/>	Attendant Care

CARE PLAN (Service Order):

SERVICE	FROM	TO	UNITS	UNIT PRICE	TOT PRICE
Funding depending on availability of funds.					
				TOTAL \$	-

Justification for provision of Service:

(attach sheet if additional justification is required)

I hereby certify that to the best of my knowledge the information above is correct.

Care Plan Staff:

Phone/e-mail:

Signature:

Date: 1/0/1900

EAD Service Authorization:

EAD Staff: <input type="text"/>	Phone/e-mail: <input type="text"/>
Signature: <input type="text"/>	Date: <input type="text"/>

Provider Staff Notified: <input type="checkbox"/>	Date: <input type="text"/>
Method Notified: <input type="checkbox"/> Fax Transmitted	<input type="checkbox"/> Yes <input type="checkbox"/> No

NAPIS Intake-Authorization Form
CITY AND COUNTY OF HONOLULU - ELDERLY AFFAIRS DIVISION

Date Registered: _____
 Date Updated: _____
 Reassessment Date: _____

Provider/Program: _____ Worker: _____

NAME _____
 Last _____ First _____ M.I. _____
DATE OF BIRTH: _____ **SSN 4-Digit:** _____ **SEX:** F or M **PHONE:** _____
 Mo. Day Yr.

HOME ADDRESS: _____ **City:** _____ **HI ZIP** _____

MAIL ADDRESS: _____ **City:** _____ **HI ZIP** _____
 (If different from HOME ADDRESS)

UNDERSTANDS ENGLISH? Yes No
 If "No", Primary language: Cantonese Mandarin Tagalog Ilocano
 Japanese Korean Visayan Other _____

ETHNICITY: Hispanic or Latino Not Hispanic or Latino

RACE (check all that apply below): then select ... NATIONALITY (check all that apply below for each selected RACE):

<input type="checkbox"/> American Indian or Alaskan	<input type="checkbox"/> Am. Indian or Alaskan Native
<input type="checkbox"/> Asian	<input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Indian (Asian)
	<input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Tongan
	<input type="checkbox"/> Other Pacific Islander _____
<input type="checkbox"/> White	<input type="checkbox"/> White
<input type="checkbox"/> Other	<input type="checkbox"/> Other

INCOME BELOW POVERTY: Yes No **DOES CLIENT LIVE ALONE:** Yes No

Medicaid - QExA: Yes No Don't Know

ADL's - Can the Client Do the Following Without Help:

Eating	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dressing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Using Toilet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Transferring	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Walking (Getting around the house)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Total "No"		0

IADL's - Can the Client Do the Following Without Help:

Prepare Meals	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shopping	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Take Medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Manage Money	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Use Telephone	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heavy Housework	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Light Housework	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Use Public Transportation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Total "No"		0

Cognitive or Mental Impairment Yes No

Client Representative: _____ **Phone:** _____

Relationship: _____ **Other Phone** _____

Provider/Program: 0 Worker:

NAME: Last First M.I.

Client is receiving the following Services:

<input type="checkbox"/>	Bathing	<input type="checkbox"/>	Homemaker	<input type="checkbox"/>	Chore	<input type="checkbox"/>	Home Delivered Meals
<input type="checkbox"/>	Case Management	<input type="checkbox"/>	Transportation	<input type="checkbox"/>	Assisted Transportation	<input type="checkbox"/>	Attendant Care

CARE PLAN (Service Order):

SERVICE	FROM	TO	UNITS	UNIT PRICE	TOT PRICE
Funding depending on availability of funds.					TOTAL \$ -

Justification for provision of Service:

(attach sheet if additional justification is required)

I hereby certify that to the best of my knowledge the information above is correct.

Care Plan Staff: Phone/e-mail: _____

Signature: _____ Date: _____

EAD Service Authorization:

EAD Staff: _____ Phone/e-mail: _____
 Signature: _____ Date: _____

Provider Staff Notified: _____ Date: _____

Method Notified: Fax Transmitted Yes No

**Elderly Affairs Division
SERVICE PROVIDER'S INVOICE**

Month
July 2015

Contract #
CT-DCS-

Vendor #

Contractor's Name and Address:

Service Category	Unit of Measure	July 2015 Units Served	Unit Rate	Amount
Program A			\$0.00	\$0.00
Total:				\$0.00

Total Cost of Service:

Month	Account No.	Unit Rate	Units Served	Total Monthly Invoice	Balance of Contract
Total Contract Amount					
July 2015		\$0.00	0	\$0.00	\$0.00
August 2015					\$0.00
September 2015					\$0.00
October 2015					\$0.00
November 2015					\$0.00
December 2015					\$0.00
January 2016					\$0.00
February 2016					\$0.00
March 2016					\$0.00
April 2016					\$0.00
May 2016					\$0.00
June 2016					\$0.00
Total Y-T-D				\$0.00	\$0.00

I certify that to the best of my knowledge and belief that payment is due and it has not been previously requested.

Authorized Signature	Date	For Elderly Affairs Use Only
Title:	Date	Approved for Payment

Submit: Original and 3 copies

**Elderly Affairs Division
SERVICE PROVIDER'S INVOICE**

Month July 2015
Contract # CT-DCS-
Vendor #

A. Contractor's Name and Address:

Service Category	Unit of Measure	Annual Goal	July 2015	Unit Rate	Amount
Program A				\$0.00	\$0.00
Program B				\$0.00	\$0.00
Program C				\$0.00	\$0.00
Program D				\$0.00	\$0.00
Program E				\$0.00	\$0.00
Total:					\$0.00

C. Total Cost of Service:

Month	Account No.	Total Monthly Invoice	Balance of Contract
Total Contract Amount			\$0.00
July 2015		\$0.00	\$0.00
August 2015			\$0.00
September 2015			\$0.00
October 2015			\$0.00
November 2015			\$0.00
December 2015			\$0.00
January 2016			\$0.00
February 2016			\$0.00
March 2016			\$0.00
April 2016			\$0.00
May 2016			\$0.00
June 2016			\$0.00
Total Y-T-D		\$0.00	\$0.00

I certify that to the best of my knowledge and belief that payment is due and it has not been previously requested.

Authorized Signature	Date	For Elderly Affairs Use Only
Title:	Date	Approved for Payment

Submit: Original and 3 copies

Monthly SPPR & Waitlist

Contractor's Name & Address
 0
 0
 0

Contract Number
 CI-DXS-

Service Category	Unit of Measure	Annual Goal	July 2015	August 2015	September 2015	1st QTR Total	October 2015	November 2015	December 2015	2nd QTR Total	January 2016	February 2016	March 2016	3rd QTR Total	April 2016	May 2016	June 2016	4th QTR Total	Year to Date Total	% of Annual Goal	
Program A	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	#N/A/01
Program B	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	#N/A/01
Program C	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	#N/A/01
Program D	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	#N/A/01
Program E	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	#N/A/01

Unduplicated Persons	Unit of Measure	Annual Goal	July 2015	August 2015	September 2015	1st QTR Total	October 2015	November 2015	December 2015	2nd QTR Total	January 2016	February 2016	March 2016	3rd QTR Total	April 2016	May 2016	June 2016	4th QTR Total	Year to Date Total	% of Annual Goal	
Program A	0					0				0									0	0	#N/A/01
Program B	0					0				0									0	0	#N/A/01
Program C	0					0				0									0	0	#N/A/01
Program B	0					0				0									0	0	#N/A/01
Program C	0					0				0									0	0	#N/A/01

Waitlist	July 2015	August 2015	September 2015	October 2015	November 2015	December 2015	January 2016	February 2016	March 2016	April 2016	May 2016	June 2016
Program A												
Program B												
Program C												
Program B												
Program C												

Monthly Narrative Report

(Narrative should be no more than one page in length)

I. Activities/Accomplishments

A. *Anecdotal information, individual case studies/history*

II. Significant Findings and Events (including areas of concern)

A *Identify any emerging issues, notable trends or any other events that occurred which may impact service quality*

B. *What plans will be taken to address these problems*

III. Personnel Changes

A. *Any changes in program personnel since the last report*

IV. Other

FINANCIAL STATUS REPORT

Contractor's Name, Address and Program
 Name: _____
 Address: _____
 City: _____
 State: _____
 Zip: _____

(II) Budget Period: FROM: mm/dd/yyyy TO: mm/dd/yyyy
 Reporting Period: FROM: mm/dd/yyyy TO: mm/dd/yyyy
 Final Report: YES: _____ NO: _____

Contract # CT-DCS 123
 Contract Amount \$ 456

(III) Budget Categories (Cumulative Cash Disbursements Only)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	TOTAL
(a) Personnel										\$0.00
(b) Fringe Benefits										\$0.00
(c) Equipment										\$0.00
(d) Consumable Supplies										\$0.00
(e) Travel										\$0.00
(f) Consultant Services										\$0.00
(g) Raw Food										\$0.00
(h) Other Expenses										\$0.00
(I) TOTAL DIRECT PROGRAM COST	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

FUNDS	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	TOTAL
Federal Share										\$0.00
State Share										\$0.00
County Share										\$0.00
Program Income										\$0.00
NSIP										\$0.00
Grantee Portion										\$0.00
TOTAL SOURCE OF FUNDS	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

(IV) Cumulative Receipts, Disbursements and Balances	Federal	State	County	Program Income	NSIP	Grantee	Total	Disbursement Percentage	Federal #DIV/0!	State #DIV/0!	County #DIV/0!	Program Income #DIV/0!	NSIP #DIV/0!	Grantee #DIV/0!
A. Resources Received and Contributed	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00							
B. Disbursements through Report Period														
C. Cash Balance on Hand	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00							
D. Unliquidated Obligations														

(V) Remarks

(VI) I certify that the information contained in this report is accurate to the best of my knowledge, and that all expenditures reported herein have been made in accordance with appropriate grant policies and conditions of this award.

SUBMIT: Original and 3 copies

Signature of Person Authorized

Date

PROGRAM INCOME FINANCIAL STATUS REPORT

Contractor's Name, Address and Program

Name:

Address:

Address:

Project:

(II) Budget Period:
Reporting Period:
Final Report:

FROM: mm/dd/yyyy TO: mm/dd/yyyy
FROM: mm/dd/yyyy TO: mm/dd/yyyy
YES: No

Contract Number: # CT-DCS- 123
Contracted Amount: \$ 456

(III) Budget Categories (Cumulative Cash Disbursements Only)

(a) Personnel	Program Income	Other Gov't	Grantees	TOTAL
(b) Fringe Benefits				\$0.00
(c) Equipment				\$0.00
(d) Consumable Supplies				\$0.00
(e) Travel				\$0.00
(f) Consultant Services				\$0.00
(g) Raw Food				\$0.00
(h) Other Expenses				\$0.00
(I) TOTAL DIRECT PROGRAM COST	\$0.00	\$0.00	\$0.00	\$0.00

(IV) Cumulative Receipts, Disbursements and Balances

A. Resources Received and Contributed	Program Income	Other Gov't	Grantees	TOTAL
B. Disbursements through Report Period	\$0.00	\$0.00	\$0.00	\$0.00
C. Cash Balance on Hand	\$0.00	\$0.00	\$0.00	\$0.00
D. Unliquidated Obligations				\$0.00

(V) Remarks

(VI) I certify that the information contained in this report is accurate to the best of my knowledge, and that all expenditures reported herein have been made in accordance with appropriate grant policies and conditions of this award.

Signature of Person Authorized _____ Date _____

SUBMIT: Original and 3 copies

Nutrition Services Utilization Profile Report

AAA ID:

Quarterly Report:

AAA Contact:

Annual Report for:

FY _____

State _____

Federal _____

PROFILE - HOME DELIVERED MEALS

HOME DELIVERED MEALS	This Quarter	Year-To-Date
1. Volunteers		
a. Total Number of Full & Part-time Volunteers (Any Age)		
b. Total Number of Volunteer Hours		
2. Home-Delivered Meals Information:		
a. Total Number of NSIP Eligible Meals (Sum of 1,2, & 3 below)		
(1) Meals Served: Elderly 60+		
(2) Meals Served: Disabled Under 60		
(3) Meals Served: Volunteer Any Age		
(4) Meals Served: Spouse/Helper (any age)		
b. Number of Home-Delivered (HD) Meals Served According to the Following Categories:		
(1) Regular Meals		
(2) Special Menu Meals		
(a) Modified (Soft, Low Fat, Low Salt, Low Calorie)		
(b) Therapeutic (Prepared Under the Supervision of a Registered Dietician)		
3. Nutrition Education:		
a. Number of Persons Provided with Nutrition Education		
4. Nutrition Counseling:		
a. Number of Persons Who Received Nutrition Counseling Provided by a Qualified Individual		
b. Total Number of Hours of Nutritional Counseling Provided		
5. Nutritional Health Checklist:		
a. Number Screened by All Designated Staff		
b. Number of Persons Assessed as High Nutritional Risk		
c. Total Number of Persons Screened for Body Mass Index (BMI)		
(1) Number of Persons with BMI Less than 22		
(2) Number of Persons with BMI Greater than 27		

Annual Narrative Requirements

A. Service(s) Provided

- How many units did you serve?
- How many unduplicated persons did you serve?
- Describe any program-specific initiatives or activities.

Service Category	Unit of Measure	Total served in FY2016
Name of Service	1 person, session, trip etc.	
Unduplicated Persons	Unit of Measure	Total served in FY2016
Name of Service	1 person	

B. Client Satisfaction Survey

- Please provide specific methodologies of how your client satisfaction survey is conducted (i.e. conducted annually, after each class, etc.)
- Please summarize the results of your client satisfaction survey.
- Please provide a sample form of your client satisfaction survey.

C. Target Population

According to the Hawaii State Databook 2013, there are over 200,000 adults 60 years or older living in Oahu. It is divided into the categories listed in the table below. Please complete the table.

- Please state the total number of clients and percentage of each targeted group as indicated by the table

Description	FY2014	Provider Numbers
Cognitive Impairment	9.1%	
Disabled	28.3%	
Low-Income	7.2%	
Minority	79.8%	
Low-Income Minority	7.6%	
Language Barrier (speaking English not well or not at all)	11.8%	
Lives Alone	16.6%	

Categories	Total Clients FY 2015	Percentage for FY 2015	Total Clients FY 2014	Percentage for FY 2014	Total Clients FY 2013	Percentage for FY 2013
Ethnicity						
• Afro American						
• Cambodian						
• Chinese						
• Filipino						
• Hispanic						
• Indian (Asian)						
• Korean						
• Japanese						
• Laotian						
• Hawaiian/Part Hawaiian						
• Native Alaskan/ American Indian						
• Samoan						
• Tongan						
• Vietnamese						
• White						
• Other Asian						
• Other Pacific Islander						
• Unknown						

(1) Severe Disability – Severe, chronic disability attributable to mental or physical impairment, or a combination of mental and physical impairments, that: is likely to continue indefinitely; and results in substantial functional limitation in 3 or more of the following major life activities: (A) self-care, (B) receptive and expressive language, (C) learning, (D) mobility, (E) self-direction, (F) capacity for independent living, (G) economic self-sufficiency, (H) cognitive functioning and (I) emotional adjustment. (OAA, Sec. 102 (9)). For purposes of this report, “Severe Disabled” means if the person is determined to be functionally impaired because the individual is unable to perform at least two (2) activities of daily living (ADL’s) without substantial human assistance, including verbal reminding, physical cueing, or supervision; or due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual (EOA Guidelines 11/2006).

(2) Greatest Social Need – The need caused by non-economic factors, which include: (A) physical and mental disabilities, (B) language barriers and (C) cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that: (i) restricts the ability of an individual to perform normal daily tasks, or (ii) threatens the capacity of the individual to live independently. (OAA, Sec. 102 (28)). For purposes of this report, “Greatest Social Need” shall be based on three factors: (1) Disability: It is operationally defined as “having impairment of at least two ADLs, IADLs, or substantive cognitive impairment; and an unmet need of at least one or more ADLs, or one or more IADLs”; (2) Language Barrier: It is operationally defined as speaking English “not well” or “not at all”; (3) Geographic Isolation: It is operationally defined as living in a rural area, “Rural is defined as areas that are not urban. (EOA Guidelines 11/2006).

- How does your agency compare to these statistics?
- If the variance is greater or less than 10%, what is being done to serve this population(s)?

D. Issues and Trends

- Describe concerns, issues, and trends that have affected your program this past year.
- Do you foresee these factors continuing during in the future? How do you plan to address them?
- What do you see as the biggest challenges or concerns for your organization in the next fiscal year?
- What gaps in services have you noticed during the year? How are you planning to address them in the future?