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| Participant Information | |
| Name: Click here to enter text. | **Date of Birth:** Click here to enter text. |
| Who did you speak with?  Click here to enter text. | **Date and Time of Contact:** Click here to enter text. |
| Relationship to Participant (if not speaking with the participant):  Click here to enter text. | **Reason given for not speaking directly to the participant:**  Click here to enter text. |

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| Questions |
| Are you hungry or thirsty?  Yes  No  Do you have food and drinks to address that?  *Comments:* Click here to enter text. |
| Are you taking all of the medicines your doctor told you to take?  Yes  No  *Comments:* Click here to enter text. |
| Are you running low on medications or out of any medications?  Yes  No  *Comments:* Click here to enter text. |
| Are there any household essentials that you do not have like toilet paper or hygiene supplies?  Yes  No  *Comments:* Click here to enter text. |
| Has your health changed or how you are feeling gotten worse since we last talked?  Yes  No  *\*If the participant is experiencing a significant change his health, the caller should notify the center’s nurse.*  What symptoms are you feeling? Click here to enter text. |
| Is everything okay with your housing? Are utilities on, can you lock your doors, etc.?  Yes  No  *Comments:* Click here to enter text. |
| Do you feel safe?  Yes  No  If not, why?  *Comments:* Click here to enter text. |
| Are you feeling more sad or anxious than the last time we talked?  Yes  No  *Comments:* Click here to enter text. |
| Are there any additional questions you need to ask me or things you want me to know?  Click here to enter text. |
| Additional Comments: Click here to enter text. |

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| Employee Signature: *\*Electronic signature is acceptable.*  Click here to enter text. | Print Name: Click here to enter text. |
| *By signing above, I hereby certify, under the penalty of perjury, that the foregoing information is true and correct. This record will be maintained for at least 5 years from the date of creation and shall immediately be available to the Kentucky Department for Medicaid Services upon request.* | |