New Mexico Universal Consumer Information Tool (UCIT)

Section 1—Consumer Demographics

Assessment Information (For Internal Use Only)

Question	*Response*
1. Type of assessment	☐ Initial Assessment ☐Reassessment
2. Initial Assessment: What service are you interested in?	
3a. Reassessment: Do you want to continue with your current service?	☐ Yes ☐ No
3b. If yes, what service is the consumer currently receiving?	
4. This form is being completed for a:	☐ Consumer who is seeking or using Cluster 1, 2, or 3 services only ☐ Care Recipient, who is a consumer that also has a caregiver where both parties need services ☐ Caregiver of an Older Adult ☐ Older Relative Caregiver (formerly Grandparents raising Grandchildren)
5. The assessor works for which agency?	☐ Community Provider ☐ ALTSD ☐ ADRC ☐ APS ☐ Health Professional ☐ Home Care Provider ☐ IAAA Provider ☐ Other

Notes

Section 1—Consumer Demographics—continued		
B. Basic Information (ACL)		
Question	*Response*	*Notes*
1. What is your first name? (ACL)		
2. What is your middle initial? (ACL)		
3. What is your last name? (ACL)		
4. What is your date of birth? (ACL)		
5. What is your primary phone #?		
6. What is your cell phone #?		
7. What is your email address?		
8a. What is your marital status?	☐ Single ☐ Married ☐ Significant Other ☐ Separated ☐ Divorced ☐ Widowed	
8b. What is the name of your spouse / partner?		
9a. What is your primary language?	☐ English ☐ Spanish ☐ Spanish speaking, reads English ☐ American Sign Language ☐ Other	
9b. If your primary language is other, specify language		
10. What is your gender? (ACL)	☐ Female ☐ Male ☐ Other	
11. What is your sexual orientation? (NM)	☐ Heterosexual / Straight ☐ Bisexual ☐ Gay / Lesbian ☐ Declined to answer	
12. What is your ethnicity? (ACL)	☐ Hispanic or Latino ☐ Not Hispanic or Latino	
13a. What is your race? (ACL)	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White	
13b. If you are American Indian, Alaska Native or Native Hawaiian / Pacific Islander, specify Tribal affiliation (ACL)		

Section 1—Consumer Demographics—continued		
B. Basic Information (ACL)		
Question	*Response*	*Notes*
14. Is your household income at or below 100% poverty threshold based on the Federal Poverty Guidelines? (website reference below) (ACL) https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references/2024-poverty-guidelines-computations	☐ Yes ☐ No	
15. What is your veteran status?	☐ Veteran ☐ Eligible spouse of veteran ☐ Not a Veteran	
16a. Do you live alone? (ACL)	☐ Yes ☐ No	
16b. If no, how many people live in the home?		
17. Do you have permanent housing?	☐ Yes ☐ No	
C. Address		
1. What is your street address?		
2. What is the city or town?		
3. What is the county?		
4. What is the state?		
5. What is the zip code?		
6. Do you live in a rural or non-rural area? (RUCA Code)	☐ Rural ☐ Non-Rural	
7. What is your mailing address or PO box?		
8. What is the city or town?		
9. What is the state?		
10. What is the zip code?		
D. Consumer's Emergency Contacts		
1a. Who is your primary contact?		
1b. What is their phone number?		
2a. Who is your secondary contact?		
2b. What is their phone number?		
E. Physical Health		
1. How do you rate your overall health?	☐ Excellent ☐ Fair ☐ Good ☐ Poor ☐ Information Unavailable	
2. Have you seen your Primary Care Physician in the last year? (doctor)	☐ Yes ☐ No	
3a. Have you fallen in the last six months?	☐ Yes ☐ No	
3b. If yes, please indicate why you fell		
4. Have you been hospitalized in the last six months?	☐ Yes ☐ No	

Section 1—Consumer Demographics—continued			
B. Basic Information—continued			
Question	*Response*		*Notes*
F. Benefits[NM]			
1. What benefits do you have?	☐ SNAP (food benefits) ☐ Social Security Disability ☐ Supplemental Security Income ☐ General Cash Assistance ☐ Senior Farmers Market ☐ Subsidized Housing ☐ Section 8 Housing ☐ Commodities ☐ LIHEAP (energy assistance)		
G. Health Insurance [NM]			
1. Do you have health insurance?	☐ Yes ☐ No		
2. Do you have any of the following types of insurance or benefits?	☐ Medicare—Part A ☐ Medicare—Part B ☐ Medicaid ☐ Employer-based Insurance ☐ Private Insurance		
3a. Medicare number, if applicable **(ONLY to be asked, if necessary, depending on the service)**			
3b. Medicaid number, if applicable **(ONLY to be asked, if necessary, depending on the service)**			
H. Emergency Preparedness [NM]			
1. Do you depend on electricity for medical needs, for example, for oxygen, etc.?	☐ Yes ☐ No		
2. Do you use a wheelchair, scooter, walker, or cane?	☐ Yes ☐ No		
3. Can you get out of your home in case of an emergency?	☐ Yes ☐ No		
4a. If there is an emergency / power outage, will your home remain heated / cooled?	☐ Yes ☐ No		
4b. If yes, what main source of heat / energy does your home use?	☐ Wood ☐ Natural Gas	☐ Propane ☐ Other	
5. If there is an emergency / power outage, will you have clean water in your home?	☐ Yes ☐ No		

Section 2— ADLs / IADLs / Nutritional Health Assessment		
A. Section Trigger		
This section shall be complete with the following services: **Adult Day Care/Health, Assisted Transportation, Case Management, Chore, Congregate Nutrition, Home Delivered Nutrition, Nutrition Counseling, Personal Care**		
B. Supports Overview		
Question	*Response*	*Notes*
☐ Yes—Complete Section ☐ No		
1a. Do you have family or other support you need?	☐ Yes ☐ No	
1b. If yes, how much support is given each week?	☐ None ☐ 24 hours or less ☐ 25–40 hours ☐ 40–60 hours	
1c. Please describe the type of support(s)		
2a. Do you receive services from another program / provider?	☐ Yes ☐ No	
2b. If yes, please indicate the program / provider name and describe the type of service(s)		

Section 2— ADLs / IADLs / Nutritional Health Assessment			
C. **Katz Index (evidence based) of Activities of Daily Living (ADLs)**— (1=Independence. 0=Dependence. **Total the number of ones [1] for the score.** 6=High=Independent. 0=Low=Dependent.) **Independence** = No supervision, direction, or personal assistance **Dependence** = With supervision, direct, personal assistance, or total care			
☐ Consumer refuses to answer		Score	*Notes*
1. Do you need help bathing?	☐ Independence=1 ☐ Dependence=0		
2. Do you need help dressing?	☐ Independence=1 ☐ Dependence=0		
3. Do you need help using the toilet?	☐ Independence=1 ☐ Dependence=0		
4. Do you need help transferring from one place to another?	☐ Independence=1 ☐ Dependence=0		
5. Are you able to control your bladder and bowel movements?	☐ Independence=1 ☐ Dependence=0		
6. Are you able to eat by yourself?	☐ Independence=1 ☐ Dependence=0		
Total ADL Score **Number of ADLs for Administration for Community Living (ACL) Older Americans Act Performance System (OAAPS) Reporting (Internal reference only)**			

Section 2— ADLs / IADLs / Nutritional Health Assessment			
D. **LAWTON-BRODY SCALE (evidence based) OF INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs) —** Select ONLY one (1) answer per question. Total the points. 0 (low function, dependent) to 8 (high function, independent)			
☐ Consumer refuses to answer			
Question	*Response*	*Score*	*Notes*
1. Can you use the telephone?	• Operates telephone on own initiative - looks up and dials numbers, etc. (1 point) • Dials a few well-known numbers (1 point) • Answers telephone but does not dial (1 point) • Does not use telephone at all (0 points)		
2. Are you able to complete you own shopping?	• Takes care of all shopping needs independently (1 point) • Shops independently for small purchases (0 points) • Needs to be accompanied on any shopping trip (0 points) • Completely unable to shop (0 points)		
3. Are you able to prepare your own food?	• Plans, prepares and serves adequate meals independently (1 point) • Prepares adequate meals if supplied with ingredients (0 points) • Heats, serves and prepares meals, or prepares meals but does not maintain diet (0 points) • Needs to have meals prepared and served (0 points)		
4. Are you able to complete you own housekeeping tasks	• Maintains house alone or with occasional assistance (1 point) • Performs light daily tasks such as dish washing, bed making (1 point) • Performs light daily tasks but cannot maintain acceptable level of cleanliness (1 point) • Needs help with all home maintenance tasks (1 point) • Does not participate in any housekeeping tasks (0 points)		

	Question	*Response*	*Score*	*Notes*
5.	Do you take care of your own laundry?	• Does personal laundry completely (1 point) • Launders small items - rinses stockings, etc. (1 point) • All laundry must be done by others (0 points)		
6.	Are you able to transport yourself where you need to go?	• Travels independently on public transportation or drives own car (1 point) • Arranges own travel via taxi, but does not otherwise use public transportation (1 point) • Travels on public transportation when accompanied by another (1 point) • Travel limited to taxi or automobile with assistance of another (0 points) • Does not travel at all (0 points)		
7.	Do you take care of your medications?	• Is responsible for taking medication in correct dosages at correct time (1 point) • Takes responsibility if medication is prepared in advance in separate dosage (0 points) • Is not capable of dispensing own medication (0 points)		
8.	Do you handle your financial matters?	• Manages financial matters independently, collects and keeps track of income (1 point) • Manages day-to-day purchases, but needs help with banking, major purchases, etc. (1 point) • Incapable of handling money (0 points)		
		Total IADL Score		
	Number of ADLs for Administration for Community Living (ACL) Older Americans Act Performance System (OAAPS) Reporting (Internal reference only)			

Section 2— ADLs / IADLs / Nutritional Health Assessment			
D. Nutritional Health Assessment **(Yes = 1 point. No = 0 points. Total the points.)** **0 – 2 = Good. 3 – 5= Moderate Nutritional Risk. 6 or more = High Nutritional Risk.**			
Question	*Response*	*Notes*	
1. Do you have an illness or condition that makes you change the kind and /or amount of food you eat?			
2. Do you eat fewer than two meals per day?			
3. Do you eat fewer than 5 servings of fruits or vegetables per day?			
4. Do you eat fewer than 2 servings of dairy per day?			
5. Do you have three or more drinks of beer, liquor or wine almost every day?			
6. Do you have tooth or mouth problems that make it hard for you to eat?			
7. Answer this statement with a yes or no, "I don't always have enough money to buy the food I need."			
8. Do you eat alone most of the time?			
9. Do you take three or more different prescribed or over -the-counter drugs a day?			
10. Without wanting to, have you lost or gained 10 pounds in the last six months?			
11. Without wanting to, have you lost or gained 10 pounds in the last six months?			
Total Nutritional Health Assessment Score **Number of ADLs for Administration for Community Living (ACL) Older Americans Act Performance System (OAAPS) Reporting (Internal reference only)**			

Section 3— Caregiver Services		
A. Caregiver Information		
Question	*Response*	*Notes*
1. Does the consumer have a primary caregiver?	☐ Yes—Complete Caregiver Assessment On Caregiver ☐ No	
2. Is the person requesting the service a primary caregiver?	☐ Yes—Complete Caregiver Assessment ☐ No	
3. What is the name of the primary caregiver?		
4. What is the date of birth of the primary caregiver?		
5. What is the date of birth for the care recipient?		
6. What is the phone number for the primary caregiver?		
7. What is the relationship of the caregiver to the care recipient?	☐ Husband ☐ Wife ☐ Domestic Partner, including civil union ☐ Son / Son-in-law ☐ Daughter / Daughter-in-law ☐ Sister ☐ Brother ☐ Other Relative ☐ Non-Relative ☐ Grandparent ☐ Parent ☐ Other Elderly Relative ☐ Elderly Non-Relative	

Section 4— Assessment Outcome		
A. Assessment Outcome		
Question	*Response*	*Notes*
1a. Did you have help from a family member or friend answering the questions on this form?	☐ Yes ☐ No	
1b. If yes, by whom		
2. Assessor recommended services—Subservices vary with each AAA and Provider. **(Assessor, select which service(s) the consumer is eligible for based on the services available.)**	☐Cluster 1: Personal Care ☐Cluster 1: Homemaker ☐Cluster 1: Chore ☐Cluster 1: Home Delivered Nutrition ☐Cluster 1: Adult Day Care / Health ☐Cluster 1: Case Management ☐Cluster 2: Congregate Nutrition ☐Cluster 2: Nutrition Counseling ☐Cluster 2: Assisted Transportation ☐Cluster 3: Transportation ☐Cluster 3: Information and Assistance ☐Cluster 3: Evidence-based Health Promotion ☐Cluster 3: Non-Evidence-based Health Promotion ☐Cluster 3: Nutrition Education ☐Cluster 3: Legal Assistance ☐Cluster 3: Other Services ☐Caregiver Counseling ☐Caregiver Training ☐Caregiver Support Group ☐Caregiver Respite (In-Home) ☐Caregiver Respite (Out-of-Home, Day) ☐Caregiver Respite (Out-of-Home, Overnight) ☐Caregiver Respite (Other) ☐Caregiver Assistance: Case Management ☐Caregiver Assistance: Information and Assistance ☐Caregiver Information Services ☐Caregiver Supplemental Services	

Section 4— Assessment Outcome		
Assessment Outcome—continued		
Question	*Response*	*Notes*
Follow through needed? **(Assessor, after selecting which service(s) the consumer is eligible for based on the services available, determine if follow through is needed.)** 3.	☐ Yes ☐ No	
Section 4— Assessment Outcome / Scoring / Recommendations **Summarize the scores from the UCIT. Add any additional notes from your observation during the assessment.**		
4. Assessment Summary—Scores attained on the following:		
Question	*Response*	*Notes*
Section 2 C. Katz Index of ADLs→ enter score		
Section 2 D. Lawton-Brody IADLs→ enter score		
Section 2 E. Nutritional Health Assessment → enter score		
Additional Factors		
Lives Alone (Section 1 17a.)	☐ Yes ☐ No	
Do you have permanent housing? (Section 1 18.)	☐ Yes ☐ No	
Notes		