

Client's Initials _____

GOVERNOR'S OFFICE OF ELDERLY AFFAIRS
Louisiana Independent Living Assessment (LILA)
Statewide Comprehensive Needs Assessment Form

GOVERNOR SHEET		Client's Initials _____	Client a Veteran? o-Y o-N
Assessment Date: _____	Re-Assessment Date: _____	Nutrition Score ADL IADLS	Client a Veteran dependent? o-Y o-N
First Name _____	Middle Name _____	Client's Suffix _____	Client's Maiden Name _____
Marital Status o-D=Divorced o-L=Legally Separated o-M=Married o-S=Single o-W=Widowed		Client's Gender o-Male o-Female	Client's Date of Birth ___/___/___
Client's SS # Last 4 only _____	Client's ID # _____	Information Release Authorization o-Y=Yes o-N=No	Client's Age in *Years. ()-___-___
Client's Residence Address Street / P.O. Box _____ Town _____ State _____ Zip Code _____		Client's Mailing Address Street Address _____ Town _____ State _____ Zip Code _____	*CO-MEMBERSHIP ACCEPTED DECEASED
NARIS		Insurance	
Ethnicity o-H=Hispanic or L=Latino o-N=Not Hispanic or Latino o-U=Unknown	Lives Alone? o-Y=Yes o-N=No	In Poverty? o-Y=Yes o-N=No	Number of ADL's _____ Number of IADL's _____ Medicaid # _____ Medicaid Policy # _____ Medicare # _____ Medical Assistance ID _____
High Nutritional Risk? o-D=Don't Know o-Y=Yes o-N=No	Is Client Rural? o-D=Don't Know o-Y=Yes o-N=No		

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* Please Complete Only the Items Noted With An Asterisk *

Assessment Document

Emergency Contact:
(Lines 1.a.b.c.d)

Name: _____
Address: _____
Phone: _____

Relative/ Friend: (other than Spouse/Partner not living in the household to contact in case of emergency.)

Name: _____
Address: _____
Phone: _____
Relationship: _____

Directions to Client's Home:

Do you have prescription drug insurance?
o-Y=Yes o-N=No o-D=Don't know

The client formally authorized release of information.
Attached copy of signed and dated authorization to this assessment.

o-Y=Yes o-N=No o-D=Don't know

Donations the client has been advised that he/she has an opportunity to make voluntary and anonymous donations for any service they may receive.

o-Y=Yes o-N=No o-D=Don't know

Client's Signature: _____ *Date: _____

Assessor's Signature: _____ Date: _____

List all services the client will receive in the bottom of this form.

MEDICATION REVIEW (Addendum to PAF4019)

*** A. MEDICATION USE:** *(Ask the client if you can see the medications so that you can verify frequency, dosage, etc. Include over the counter drugs like aspirin, laxatives, and vitamins. Some medicines may be refrigerated.)*

1. Are you taking any medicines? If so, could you show them to me so we can list their names and dosage?

MEDICATION NAME	PRIMARY DIAGNOSIS	DIRECTIONS/ STRENGTH/DOSAGE	PRESCRIBING DOCTOR AND PHONE	MANUFACTURER AND COST

*** 2. Do you have problems or difficulty remembering to take your medications?** a. Yes b. No
(If necessary, prompt the client by asking if s/he is concerned about forgetting. What steps does s/he take to remember?)

*** 3. Please list your drug allergies:** _____

4. Referral made: _____



EAST BATON ROUGE COUNCIL ON THE AGING, INC.
5790 FLORIDA BOULEVARD
BATON ROUGE, LOUISIANA 70806-4244
(225) 923-8000 • FAX (225) 923-8030

Waiver of Confidentiality

*Name: _____ *Address: _____

*Social Security #: _____

I, _____, understand that the information contained in my
Records are confidential. However, I give my consent for _____

_____ To release to and/or from the East Baton Rouge
Council on the Aging a copy of any information, which might be pertinent for case evaluation.

I also give permission for the East Baton Rouge Council on the Aging to give information to doctors
and/or professionals involved in my case management when, in the discretion of the Council on Aging's
administrative staff, it would be beneficial for my case.

This consent is subject to written revocation at any time except to the extent that action has already been
taken.

I further agree that this authorization shall be valid and effective unless and until it is revoked by me in
writing and that a photocopy of this authorization may serve as the original.

* _____
Client

* _____
Date

Witness/EBR/COA Representative

Date