

Client Information Collection Requirements - ADSD Subawards

Subrecipients must attempt to collect demographic information from clients served with ADSA funding and report the information in a designated reporting system, such as WellSky A&D (formerly SAMS).

Subrecipients must attempt to obtain certain demographic information and educate clients on the use of the information in aggregate (de-identified) to obtain continued and additional funding for Nevada. Clients have the right to refuse to provide personal information.

WellSky A&D

When updating a client's information in A&D, subrecipient staff must use the "Consumer Details Last Reviewed" field in Details to indicate the date the information was last reviewed with the client for accuracy. Subrecipients may also use the "Notes" field to add information that may be helpful to all A&D Providers, being mindful of [HIPAA security and confidentiality rules](#). As such, health information must not be added.

In most cases, A&D client files are shared between multiple Providers; therefore, if a client's information has been reviewed within the required timeframe by any Provider, it does not have to be reviewed with the client again until an annual recertification with one of their ADSA-funded service providers.

Required Information Collection

A list of required client demographics is below. ADSA has also prepared a sample client registration form on page 3 should subrecipients need a data collection instrument. The sample contains the basic, required demographics, with additional required demographics, by service, and optional questions on the following pages. The sample form can be manipulated by copying and pasting items as needed. A signed client registration form is not required from subrecipients as of 10/1/2021. Reporting systems will be monitored for subrecipient compliance with providing updated, required client information.

All information is self-disclosed. Verification is not required.

Required for All Funded Services (Exceptions – support groups, nutrition education):

- Full Legal Name
- Gender
 - Male; Female; Other
- Date of Birth
- Full Address
- Ethnicity
 - Hispanic or Latino; Non-Hispanic or Latino
- Race (clients must have the option to choose more than one race if needed)
 - American Indian or Alaska Native; Asian; Black or African American; Hispanic; Native Hawaiian or Pacific Islander; White; Other
 - Self-identification with a national origin or sociocultural group. (Source: U.S. Census Bureau/OMB)

- American Indian or Alaska Native: Having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- Asian: Having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black or African American: Having origins in any of the black racial groups of Africa.
- Native Hawaiian or Pacific Islander: Having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- White: Having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- Other: Having origins in areas other than above.
- Poverty (per the most current Federal Poverty Guidelines)
 - At or Below Poverty; Above Poverty
- Household Status
 - Lives Alone; Lives with Others
- ADSD Notice of Privacy Practices has been received

Required for Caregiver Services (excluding support groups):

- 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; Grandparent; Parent; Other Relative; Non-Relative
- For Older Relative Caregiver (aka Grandparent Respite) programs only:
 - Number of children age 18 or less receiving care
 - Number of adults with disabilities age 18-59 receiving care

Required for Congregate, Home-Delivered Meal and Nutrition Counseling Services:

- Nutrition Risk Score (for Older Adults only (age 60+)) using the DETERMINE your Nutritional Risk checklist)
 - 0-5 (indicates the person is not considered at high nutritional risk)
 - 6+ (indicates the person is considered at high nutritional risk)

Required for Legal Assistance and Nevada Care Connection (NVCC)

- Household Status, add: Lives in Long-Term Care (LTC) Facility

Required for Senior Companion, Homemaker, Home-Delivered Meals, Adult Day Care/Health, and Case Management Services:

- Activities of Daily Living (ADL) Limitations
 - Score of 0-6
 - Activities include bathing, dressing, toileting, transferring, continence, and feeding.
- Instrumental Activities of Daily Living (IADL) Limitations
 - Score of 0-8
 - Activities include ability to use telephone, shopping, food preparation, housekeeping, laundry, mode of transportation, medication management, and ability to manage finances.

Optional for All Services:

- Client Nickname (“A.K.A Name” in WellSky A&D)
- Physical vs. Mailing Address; Option for “No Current Address/Residence”
- Emergency Contact Information (Name, Relationship, Phone #)

- Cognitive Impairment
- Primary Language
- Living with a Disability(ies)
- Veteran or Served in Armed Forces
- State Medicaid Status
- Medicare Status (if yes, what Parts)

Next: Sample Client Registration Form (OPTIONAL)

This sample contains ALL required and optional demographics and can be manipulated as needed for the funded service.

LEGAL NAME (First/Last): _____

ADDRESS: _____

(City, State, Zip Code)

DATE of BIRTH: ____ / ____ / ____

GENDER:

Male Female Other: _____

Phone Number: _____

ETHNICITY: Hispanic or Latino Non-Hispanic or Latino

RACE: American Indian / Alaskan Native

Asian

Black / African American

Native Hawaiian or Other Pacific Islander

White

Other: _____

**FEDERAL POVERTY
GUIDELINES – Is your
income:**

At or Below Poverty

Above Poverty

HOUSEHOLD - Do you:

Live Alone

Live with Others

Have you received the ADSD Notice of Privacy Practices? Yes No

[Subrecipients: Additional mandatory sections are included on the next page for various services. On the last page are optional fields for all services. As needed, you can paste these sections into the client registration form (in this area of the page) if you are using this template.]

Caregiver Services (excluding support groups)

Caregiver: What is your relation to the person who is receiving care? You are their:

- Husband Wife Domestic Partner Son/Son-in-Law Daughter/Daughter-in-Law
 Sister Brother Grandparent Parent Other Relative: _____

[For Grandparent Respite programs only]

How many children, age 18 or less are in your care: _____

How many adults with disabilities, ages 18 – 59 are in your care: _____

Congregate, Home-Delivered Meal and Nutrition Counseling Services

No added fields, but programs will need clients to complete the DETERMINE your Nutritional Risk survey/checklist and note the results in A&D in the High Nutritional Risk field as Yes for scores 6 and higher, and No for scores 0-5. See additional item below for Home-Delivered Meals.

Legal Assistance and Nevada Care Connection (NVCC) - For Household, add:

- Lives in Long-Term Care (LTC) Facility

Senior Companion, Homemaker, Home-Delivered Meals, Adult Day Care, and Case Management Services:

Activities of Daily Living (ADLs) - Without assistance, I am unable to:

- Bathe Get Dressed
 Eat Use the Bathroom
 Maintain Continence
 Transfer In or Out of a Bed or Chair
 None – I can perform these activities

Instrumental Activities of Daily Living (IADLs) - Without assistance, I am unable to:

- Prepare Meals Manage Medication
 Do Housework Do Laundry
 Manage Money Use the Telephone
 Shop Use Transportation Services
 None – I can perform these activities

Recommended (not Required) for All Services:

NICKNAME: _____

PHYSICAL ADDRESS:

(City, State, Zip Code)

MAILING ADDRESS (If Different):

(City, State, Zip Code)

No Current Address/Residence

EMERGENCY CONTACT INFORMATION:

NAME (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (____) _____ WORK OR CELL PHONE: (____) _____

If you do not speak English, what is your primary language? _____

Do you have a Disability or Disabilities? Yes No

Are you a Veteran or have you Served in the Armed Forces? Yes No

Are you on Medicaid through the State of Nevada? Yes No

Are you on Medicare? Yes No

If yes, which Parts? Part A: Hospital Part B: Medical

Part C: HMO (Medicare Advantage)

Part D: Prescriptions