Area Agency on Aging of the Capital Area

Thank you for participating in the

Medication Screening Program

What You Can Expect:

- ☑ A written consultation report from a Pharmacist
- ☑ A review of your medications and supplements
- ☑ Informative tips
- ☑ Alerts of potential negative interactions
- ☑ A follow up call

Questions?

Please contact:

Jacqueline Capistrán

Area Agency on Aging of the Capital Area

6800 Burleson Rd.◆ Bldg. 310, Ste. 165◆ Austin, TX 78744
Toll-Free: 1-888-622-9111 x6059 ◆ Direct: 512-916-6059

Fax: 512-916-6042

Email: jcapistran@capcog.org ◆ Website: www.aaacap.org

Provided by the Area Agency on Aging of the Capital Area and partially underwritten by a generous grant from St. David's Foundation

St. David's Foundation

About Us

Providing Quality Services to Support and Advocate for the Health, Safety and Well-Being Of the Older Individuals In the Capital Region

The **Area Agency on Aging of the Capital Area** (AAACAP):

- Is a trusted community source for information on services and supports for older individuals and their caregivers
- Provides assistance for older individuals to maintain independence in their homes and communities
- Is a program of the Capital Area Council of Governments. We are a not-for-profit organization
- Part of the national aging services network created by the Older Americans Act (OAA) of 1965 and subsequent amendments

Services

Information & Referral/Assistance (I&R/A): provides information about region-wide resources; assistance with referrals determining next steps in seeking help.

Benefit Counseling: provides information and counseling on government benefits programs; assistance with understanding and navigating benefits eligibility. Available to individuals of any age who are Medicare eligible.

Ombudsman Program: provides friendly advocates for seniors living in nursing or assisted living facilities. Specially trained and certified, the Ombudsman develops positive relationships with residents and facility staff to ensure issues are addressed and resident rights are preserved.

Health and Wellness: promoting and assisting in healthy aging, such as physical activity and fall prevention, with the goal of supporting the independence of older individuals.

Care Coordination: offers and assessment of needs by a Care Coordinator to link consumers to in-home resources. Consumers are adults, who are 60 years of age or older, who have recently been hospitalized or suffered a health crisis, have mild to moderate impairment, or a temporary sever impairment.

Caregiver Support Services: is a program offering support for family members who are caring for older individuals.

- Arrangement of services to support the caregiver
- Assistance in long-term care planning
- Education and support
- Grandparents or non-parent relatives age 55 or older with formal or informal custody of a child age 18 years or younger

Funded in part by Health and Human Services, our services are provided without cost to residents throughout the 10-county CAPCOG region:

Bastrop, Blanco, Burnet, Caldwell, Fayette, Hays, Lee, Llano, Travis and Williamson Counties

Area Agency on Aging of the Capital Area

Medication Screening Program

St David's Foundation

Please complete the following information:

Name: _____ DOB: _____ ☐ M ☐ F

Home Address: _____ City/St: _____ Zip: _____

Mailing Address: _____ City/St: _____ Zip: _____

Phone Number: _____ Email Address: _____

County Where Service Provided: ® indicates the county is Rural

☐ Bastrop ® ☐ Caldwell ® ☐ Hays ☐ Travis ☐ Williamson

Race:

☐ American Indian or Alaskan Native ☐ Black or African American
☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ White Non-Hispanic
☐ White Hispanic ☐ Some Other Race ☐ Not Reported

Ethnicity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Not Reported

Annual Income:

Persons in Family Unit	Poverty ☐	Low ☐	Moderate ☐	High ☐
1	$12,060 or below	$24,120	$36,180	$48,240 or above
2	$16,240 or below	$32,480	$48,720	$64,960 or above
Each additional person, add:	$4,180	$8,360	$12,540	$16,720
Any income amount over the income shown moves the person to the next income interval. For example, if a person who lives alone has an income of $ 24,121, they would be considered Moderate Income or has an income of $12,060; they would be considered Low Income.				

Emergency Contact:_____ Phone: _____

Primary Care Physician:_____ Phone: _____

Drug Allergies: _____ Visual Impairment: _____

Smoke: ☐ No ☐ Yes; how much:_____ Alcohol: ☐ No ☐ Yes; how much:_____

Caffeine: ☐ No ☐ Yes; how much:_____ Date of last flu vaccine: _____

Health Conditions: *(please list all known)* _____ Date of last pneumococcal vaccine: _____

_____

_____

Comments/Notes: _____

_____

I authorize the pharmacist to speak to the following person/s in regards to my health conditions, medications and interactions:

Name: _____ Relationship:_____ Phone: _____

Revised: 10/2017

☐ Declined

Medication Screening Program
Questionnaire

Consumer Name:	DOB:

We would like to ask you a few questions that will assist us in better serving you and your community:

Improved Well-Being:
Have your medications been screened by a pharmacist, in the past six months? ☐ Yes ☐ No

Decreased Falls:
How many times have you fallen in the past 30 days? _____

Medication Compliance & Increased Level of Compliance:
Do you ever forget to take your medication? ☐ Yes ☐ No
Do you sometimes forget to refill your prescriptions? ☐ Yes ☐ No
When you feel better, do you stop taking your medicine? ☐ Yes ☐ No

Thank you very much!
Your comments will help us improve the program.

For Staff Use Only

☐ Verbal Report ☐ Printed Report ☐ Phone Report ☐ Other: _____

Post Questionnaire

Improved Well-Being:
Do you feel like the medication screening has positively affected your health and wellness? ☐ Yes ☐ No

Decreased Falls:
How many times have you fallen in the past 30 days? _____

Medication Compliance & Increased Level of Compliance:
As a result of the screening, has there been any changes with your medications? ☐ Yes ☐ No
Do you have a better understanding of your medications? ☐ Yes ☐ No

- **Did you find the service helpful? Why or why not?**

_____
_____
_____

Date of Pre-Screen: _____ Completed By: _____

Date of Post-Questionnaire: _____ Completed By: _____

Consumer's Full Name: **DOB:**

Medication (prescriptions, over-the-counter, herbals & vitamins)	**Dose**	**Form**	**Directions** (as listed on pharmacy label)
Ex: Namenda	10mg	Tab	Take 1 tablet by mouth twice daily

Additional notes for the Pharmacist:

Area Agency on Aging of the Capital Area
Consumer Rights & Responsibilities for Older Americans Act Programs

The Area Agency on Aging of the Capital Area welcomes you as a participant in programs for older individuals and family caregivers in our region. This program is mandated by the Older Americans Act of 1965, as amended, and provides access and assistance and other supportive services. The programs and services are administered by the Area Agency on Aging with funding provided through the Texas Department of Aging and Disability Services, consumer contributions and local funding.

Programs and services are designed for individuals age 60 or older and/or their family members and other caregivers. Our goal is to assist older individuals in leading independent, meaningful and dignified lives in their own homes and communities as long as possible through the provision of limited support services. Information will not be released to anyone, or any agency without your informed consent, with the exception of records subpoenaed by a court of law.

Consumer rights and responsibilities:

1. You have the right to be treated with respect and consideration. You have the right to have your property treated with respect.
2. You may not be denied services on the basis of race, religion, color, national origin, sex, disability, marital status, or inability and/or unwillingness to contribute.
3. You have the right to make a complaint/grievance or recommend changes to policy or service, without restraint, interference, coercion, discrimination or reprisal. To make a complaint or grievance contact the Area Agency on Aging. Contact information is identified below:

Patricia Bordie
Director of Aging Services
Area Agency on Aging of the Capital Area
6800 Burleson Rd., Bldg. 310, Ste. 165
Austin, Texas 78744

4. You have the right to participate in the development of a care plan to address unmet needs.
5. You have the right to be informed in writing of available services and the applicable charges if the services are not covered or are unavailable by Medicare, Medicaid, health insurance, or Older Americans Act funding.
6. You have the right to make an independent choice of service providers from the list furnished by the Area Agency on Aging where multiple service providers are available and change service providers when desired.
7. You have the right to be informed of any change in service(s).
8. You have the right to make a voluntary, confidential, contribution for services received through the Area Agency on Aging. Services will not be denied if an eligible participant is unable or chooses not to make a contribution. All contributions will be kept confidential and will be utilized to expand or enhance the service(s) for which they were provided.
9. You have the responsibility to inform the Area Agency on Aging or its service provider(s) of your intent to withdraw from the program or any known periods of absenteeism when services will not be utilized.
10. You have the responsibility to provide the Area Agency on Aging or its services provider(s) with complete and accurate information.

I hold harmless this Area Agency on Aging program, its parent organization, funders, and the sponsoring state agencies for any liability arising out of the services provided in accordance with program guidelines.

_____ _____

Consumer Signature Date

Area Agency on Aging of the Capital Area

Consumer Information Release

Caregiver/Consumer Name:	**Care Recipient:**
By signing this authorization, you are giving the Area Agency on Aging (AAA) CAP permission to release all or part of your information provided, which includes health information. Failure to provide this authorization will result in limited service by the AAA. This release includes access to a continuum of service(s) available through the AAA or its providers.	

PARTS A, B & C TO BE COMPLETED BY CONSUMER OR PERSONAL REPRESENTATIVE

I authorize the Area Agency on Aging to release my information to the following person or agency for the purpose(s) stated in Part A. My information will remain available to the person or agency indicated in accordance with the expiration event or date in Part B.

PART A – Release of Information
I understand that my information may contain protected health information. Release my information to the following person or agency: ☐ Any person, agency or medical professional necessary to meet my service needs.
☐ Only the persons or entities identified:
Check one of the following: ☐ Release all of my information. ☐ Release only the following information:

PART B – Purpose of Release
☐ General: To assist in assessing, arranging, and meeting individual service needs.
☐ Specific:
☐ Expiration: This authorization expires at point of reassessment, where applicable, or within three years of effective date.

PART C – Signature	
Print Name:	
(Representative)	(Date)
☐ Check if you are signing for the consumer and please describe your authority to act for the consumer on the following line:	
Note: If the person requesting the release of information cannot sign his/her name, two witnesses to his/her mark (X) must sign below. Accept one witness signature in circumstances where it is not possible to obtain two witness signatures. Document the reason in the consumer file.	
Witness:	Date:
Witness:	Date:

Notice to Consumer:

- ✓ Once the authorization to release your information is granted, the AAA is not responsible for any redisclosure of the information by the recipient.
- ✓ You can withdraw permission you have given the AAA to use or disclose health information that identifies you, unless the AAA has already taken action based on your permission. You must withdraw your permission in writing.