SPECIAL COMPENSATION FOR ASSISTANCE WITH ACTIVITIES OF DAILY LIVING (SCAADL) ELIGIBILITY

PRIVACY ACT STATEMENT

AUTHORITY: 37 U.S.C. Section 439; DoDD 5154.02; DoDI 1341.12, and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): To allow a licensed physician to certify or recertify that the applicant needs assistance from another person to perform the personal functions required in everyday living or requires constant supervision and in the absence of the provision of such care would require hospitalization, nursing home, or other residential institutional care. To allow the Services to provide certified, detailed monthly listings of individuals with such determinations to the Defense Finance and Accounting Service of the effective start and stop date of payments for special compensation for assistance with activities of daily living.

ROUTINE USE(S): The DoD "Blanket Routine Uses" found at http://dpclo.defense.gov/privacy/SORNs/blanket_routine_uses.html apply to this collection.

DISCLOSURE: Voluntary. However, failure to provide requested information may result in a denial or delay in processing your request for special compensation for assistance with activities of daily living.

In accordance with DoDI 1341.12, the following information is provided to determine the compensation for the referenced Service member.

1. SERVICE MEMBER NAME *(Last, First, Middle)*	**2. DOD ID NUMBER/ SSN** *(Last 4 digits)*	**3. DATE OF BIRTH** *(YYYYMMDD)*

4. SOURCES USED TO COMPLETE THIS TOOL *(X all that apply)*

☐ DIRECT OBSERVATION ☐ CHART REVIEW ☐ REPORT OF PRIMARY FAMILY CAREGIVER

5. FACILITY/LOCATION	**6. SERVICE MEMBER ADDRESS** *(City, State and ZIP Code)*

REFERENCES:

- Katz Basic Activities of Daily Living Scale
- The UK Functional Independence Measure and Functional Assessment Measure
- The Neuropsychiatric Inventory

SCORING GUIDE

4 - Total Assistance (Service member completes less than 25% of the task/activity or is unable to do the task without assistance).

3 - Maximal Assistance (Service member completes 25% - 49% of the task/activity with some hands on help).

2 - Moderate Assistance (Service member completes 50% - 74% of the task/activity with some hands on help).

1 - Minimum Assistance (Service member completes 75% or more of the task/activity with supervision/coaching assistance).

0 - Complete Independence (Service member completes task/activity without help).

TOTAL SCORE: High Dependence: 28 - 21 Moderate Dependence: 20 - 13 Low Dependence: 12 - 1

7. ASSISTANCE WITH ACTIVITIES OF DAILY LIVING (ADL)

(1) AREA	(2) SCORE	(3) DID CLINICIAN OBSERVE? YES	(3) DID CLINICIAN OBSERVE? NO	(4) REASONS FOR SCORE
a. EATING		☐	☐	
b. GROOMING		☐	☐	
c. BATHING		☐	☐	
d. DRESSING		☐	☐	
e. TOILETING		☐	☐	
f. NEEDS ASSISTANCE WITH PROSTHETIC OR OTHER DEVICE *(beyond that of the average person)*		☐	☐	
g. DIFFICULTY WITH MOBILITY *(walking, going up stairs, getting in and out of bed, etc.)*		☐	☐	
h. TOTAL SCORE	0			

8. SUPERVISION/PROTECTION *(Use Scoring Guide on Page 1)*

(1) AREA	(2) SCORE	(3) DID CLINICIAN OBSERVE? YES	(3) DID CLINICIAN OBSERVE? NO	(4) REASONS FOR SCORE
a. REQUIRES SUPERVISION/ ASSISTANCE AS A RESULT OF SEIZURES *(blackouts or lapses in mental awareness, etc.)*		☐	☐	
b. DIFFICULTY WITH PLANNING AND ORGANIZING *(able to adhere to medication regimen, managing financial and other household affairs, etc.)*		☐	☐	
c. SAFETY RISKS *(significant risk of falling, wandering outside the home, leaving cook top/oven on, crossing streets, using electrical appliances, etc.)*		☐	☐	
d. DIFFICULTY WITH SLEEP REGULATION		☐	☐	
e. REQUIRES ASSISTANCE/ SUPERVISION AS A RESULT OF DELUSIONS/HALLUCINATIONS		☐	☐	
f. DIFFICULTY WITH RECENT MEMORY *(forgets what day it is, what happened yesterday, etc.)*		☐	☐	
g. SELF REGULATION *(being able to moderate moods, agitation/ aggression)*		☐	☐	
h. TOTAL SCORE	0			

9. TOTAL SCORES

a. ADL	b. SUPERVISION/PROTECTION	c. TOTAL	d. DEPENDENCE LEVEL
0	0	0	

10. APPLICABLE ICD-09/10 CODES

11.a PERSON COMPLETING FORM *(Name and Signature)*

b. DATE

c. PRINTED NAME OF PHYSICIAN *(Last, First, Middle Initial)*

d. TITLE

e. TELEPHONE *(Include area code)*

f. EMAIL ADDRESS

12. SERVICE MEMBER ACKNOWLEDGEMENT

I acknowledge my PCM's assessment of my dependency level. I ☐ do ☐ do not plan to appeal this decision.

a. PERSON COMPLETING FORM *(Name and Signature)*

b. DATE

c. TELEPHONE *(Include area code)*

d. EMAIL ADDRESS