



Name:

Address:

Assessment  
Document Printed on

User Name:  
Assessor Name:  
Program:

Case Filed On\*

Author

### Case Identification

Assessment/Reassessment Date

\*,

Assessor's Name:

Agency/Program Name:

Reason for Assessment/Reassessment:  Event Based  Initial  Routine

Source of Information:

Comments:

Next Assessment Date (mm/dd/yyyy) \*:

### Client Information

Last Name:

First Name:

Middle Name:

Address 1:

Address 2:

City:

State:

Zip:

County:

Email Address:

Phone (Home) (###-###-####):

Social Security No.:

Marital Status:  Divorced  Domestic Partner or Signif Other  Married  Never Married  Separated  Single  Widowed

Sex:  Female  Male  Unspecified

Some people describe themselves as transgender when they experience a different gender identity from their sex at birth. For example, a person born into a male body, but who feels female or lives as a woman. Do you consider yourself to be transgender?

Transgender - Gender Identity or Expression:  No  Yes, transgender male to female  Yes, transgender female to male  Yes, transgender, do not identify as male or female  Did not answer

Birth Date (mm/dd/yyyy):

Name:

Race:  2 or More Races     Amer Ind / Alaskan Native     Asian     Black or African American  
 Native Hawaiian / Other Pacific Islander     Not Available     Other Race     Refused to Answer  
 White Hispanic     White not Hispanic

Ethnicity:  Hispanic / Latino     Missing / Unknown     Not Hispanic / Latino     Refused to Answer

Sexual Orientation:  Heterosexual or Straight     Homosexual or Gay     Lesbian     Bisexual  
 Not Sure     Did Not Answer     Other

Creed:  Christianity     Islam     Hinduism     Buddhism  
 Judaism     Did Not Answer     Other

National Origin:

Primary Language (Check all that apply)

English:  Speaks     Reads     Understands orally

Spanish:  Speaks     Reads     Understands orally

Chinese:  Speaks     Reads     Understands orally

Russian:  Speaks     Reads     Understands orally

Italian:  Speaks     Reads     Understands orally

French/Haitian Creole:  Speaks     Reads     Understands orally

Korean:  Speaks     Reads     Understands orally

Other:  Speaks     Reads     Understands orally

Name: \_\_\_\_\_

Client does not speak English as their primary language and has ONLY a limited ability to read, speak, write or understand English.: ( ) No ( ) Yes

Living-Arrangement: [ ] Alone [ ] Non-Relatives, Domestic Partner [ ] Not Available [ ] Others [ ] Relatives [ ] Spouse & Others [ ] Spouse Only

During the last 6 months have you experienced any of the following forms of abuse?: [ ] Physical Abuse [ ] Active and Passive Neglect [ ] Sexual Abuse [ ] Self Neglect [ ] Emotional Abuse [ ] Domestic Violence [ ] Financial Exploitation [ ] Other (e.g. Abandonment) [ ] None Reported

Was this referred to: [ ] Adult Protective Services [ ] AAA [ ] Police Agency [ ] Other [ ] Domestic Violence Service Provider [ ] Not Referred

Other specify: \_\_\_\_\_

Emergency Contacts

Primary

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone (Home) (###-###-####): \_\_\_\_\_ Phone (Cell) (###-###-####): \_\_\_\_\_

Secondary

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone (Home) (###-###-####): \_\_\_\_\_ Phone (Cell) (###-###-####): \_\_\_\_\_

Client Information

Is the client frail?: ( ) No ( ) Yes Is the client disabled?: ( ) No ( ) Yes

Housing Status

Type of Housing: ( ) Apartment ( ) Condominium ( ) Multi-Unit ( ) Other ( ) Single Family

Housing Status: ( ) Other ( ) Own ( ) Rent

Is Neighborhood Safety an Issue: ( ) No ( ) Yes

Name:

Landlord Name:

Housing Comments:

### Home Safety Checklist

- |   |                          |  |                          |
|---|--------------------------|--|--------------------------|
| Accumulated garbage?:                               | <input type="checkbox"/> | Dirty living areas?:                           | <input type="checkbox"/> |
| Bedroom-bath traffic lane has obstacles?:           | <input type="checkbox"/> | Cluttered stairs/walkways?:                    | <input type="checkbox"/> |
| Cords/wires across walkways?:                       | <input type="checkbox"/> | Doorway widths are inadequate?:                | <input type="checkbox"/> |
| Exposed wiring/electric cords?:                     | <input type="checkbox"/> | Inadequate heating/cooling?:                   | <input type="checkbox"/> |
| Inadequate hot/cold water?:                         | <input type="checkbox"/> | Inadequate lighting in living areas?:          | <input type="checkbox"/> |
| Insects/vermin?:                                    | <input type="checkbox"/> | Loose scatter rugs in one or more rooms?:      | <input type="checkbox"/> |
| No access to phone/emergency numbers?:              | <input type="checkbox"/> | No grab bar at toilet/bathtub?:                | <input type="checkbox"/> |
| No handrails on stairways?:                         | <input type="checkbox"/> | No light or switch in reach of bed?:           | <input type="checkbox"/> |
| No locks on doors/windows?:                         | <input type="checkbox"/> | No rubber mat/decals in bath tub/shower?:      | <input type="checkbox"/> |
| No telephone near bed?:                             | <input type="checkbox"/> | Bad odors?:                                    | <input type="checkbox"/> |
| Carbon Monoxide detectors not present/not working?: | <input type="checkbox"/> | Smoke detectors not present/not working?:      | <input type="checkbox"/> |
| Plumbing problem?:                                  | <input type="checkbox"/> | No lighting in bathroom or hallway?:           | <input type="checkbox"/> |
| Stairs are not well lit?:                           | <input type="checkbox"/> | Stairs are in poor condition?:                 | <input type="checkbox"/> |
| None Apply/Satisfactory:                            | <input type="checkbox"/> | Referral needed for In-home Safety Assessment: | <input type="checkbox"/> |

Housing Safety Comments:

### Health Status

Has Medicaid:     No                       Yes

Medicaid No.:

Medicaid Pending:     No                       Yes

Date Applied (mm/dd/yyyy):

Has Medicare:     No                       Yes

Medicare No.:

Name:

Medicare Type:

- |                                      |   |                                  |                                     |
|--------------------------------------|---|----------------------------------|-------------------------------------|
| <input type="checkbox"/> A and B     | <input type="checkbox"/> A and D        | <input type="checkbox"/> A only  | <input type="checkbox"/> A, B and D |
| <input type="checkbox"/> A, B, and C | <input type="checkbox"/> A, B, C, and D | <input type="checkbox"/> B and D | <input type="checkbox"/> B only     |
| <input type="checkbox"/> D only      |   |                                  |                                     |

Prescription Coverage Plan:

Health Ins Provider:

Health Ins. No.:

Secondary Health Ins. Provider:

Secondary Health Insurance No:

Other Health Ins. Provider:

Other Health Insurance No:

Physician:

Hospital:

Primary Pharmacy Name:

Primary Pharmacy Phone:

Clinic/HMO:

### Medical History/Health History

Chronic Illness/Disability:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Acid Reflux          | <input type="checkbox"/> Alcoholism                                   | <input type="checkbox"/> Allergies                  | <input type="checkbox"/> Alzheimer`s          |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Anorexia                                     | <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Back Problems        | <input type="checkbox"/> Cancer*                                      | <input type="checkbox"/> Cellulitis                 | <input type="checkbox"/> Chronic Constipation |
| <input type="checkbox"/> Chronic Diarrhea     | <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) | <input type="checkbox"/> Chronic Pain               | <input type="checkbox"/> Colitis              |
| <input type="checkbox"/> Colostomy            | <input type="checkbox"/> Congestive Heart Failure                     | <input type="checkbox"/> Decubitus Ulcers           | <input type="checkbox"/> Dehydration          |
| <input type="checkbox"/> Dementia             | <input type="checkbox"/> Dental Problems*                             | <input type="checkbox"/> Developmental Disabilities | <input type="checkbox"/> Diabetes*            |
| <input type="checkbox"/> Dialysis             | <input type="checkbox"/> Diarrhea                                     | <input type="checkbox"/> Digestive Problems*        | <input type="checkbox"/> Diverticulitis       |
| <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Fractures (Recent)                           | <input type="checkbox"/> Frequent Falls             | <input type="checkbox"/> Gall Bladder Disease |
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Hearing Impairment                           | <input type="checkbox"/> Heart Disease*             | <input type="checkbox"/> Hiatal Hernia        |
| <input type="checkbox"/> High Blood Pressure* | <input type="checkbox"/> High Cholesterol                             | <input type="checkbox"/> Hyperglycemia              | <input type="checkbox"/> Hypoglycemia         |
| <input type="checkbox"/> Incontinence         | <input type="checkbox"/> Legally Blind                                | <input type="checkbox"/> Liver Disease              | <input type="checkbox"/> Low Blood Pressure   |
| <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> Muscular Degeneration                        | <input type="checkbox"/> Osteoporosis               | <input type="checkbox"/> Other                |
| <input type="checkbox"/> Oxygen Dependent     | <input type="checkbox"/> Paralysis                                    | <input type="checkbox"/> Parkinson`s                | <input type="checkbox"/> Pernicious Anemia    |
| <input type="checkbox"/> Renal Disease        | <input type="checkbox"/> Respiratory Problems                         | <input type="checkbox"/> Shingles                   | <input type="checkbox"/> Smelling impairment* |
| <input type="checkbox"/> Speech Problems      | <input type="checkbox"/> Stroke                                       | <input type="checkbox"/> Swallowing difficulties    | <input type="checkbox"/> Taste impairment*    |
| <input type="checkbox"/> Thyroid              | <input type="checkbox"/> Traumatic Brain Injury                       | <input type="checkbox"/> Tremors                    | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Ulcer                | <input type="checkbox"/> Urinary Tract Infection                      | <input type="checkbox"/> Visual Impairment          |   |

Name: \_\_\_\_\_

Possible Action:

Insulin Dependent: ( ) No ( ) Yes

Other Diagnosis/Allergies:

Date of last visit to Primary Medical Provider:

Visit Doctor less than once a year: ( ) No ( ) Yes

Require Comprehensive Medical Exam: ( ) No ( ) Yes

Problems with Medication:  Adverse reactions  Allergies  Cost of medication  None  
 Obtaining medications  Other  Sensitivities

If yes to problems with medication, describe:

Medical Information Comments:

**Assistive Devices**

Devices Used:  Accessible vehicle  Bed rail  Braces  Cane  
 Commode  Denture - Full  Denture - Partial  Eyeglasses  
 Grab Bars  Hand Held Shower  Hearing Aid  Other  
 PERS  Prosthesis  Raised Toilet Seat  Scooter  
 Transfer Bench  Tub Seat  Walker  Wheelchair / Transportable folding

Devices Needs:  Accessible vehicle  Bed rail  Braces  Cane  
 Commode  Denture - Full  Denture - Partial  Eyeglasses  
 Grab Bars  Hand Held Shower  Hearing Aid  Other  
 PERS  Prosthesis  Raised Toilet Seat  Scooter

Name: \_\_\_\_\_

Transfer Bench       Tub Seat       Walker       Wheelchair /  
Transportable  
folding

Client/Caregiver needs training to use devices:      ( ) No      ( ) Yes

If Yes, Explain: \_\_\_\_\_

Oxygen Dependent:      ( ) No      ( ) Yes

Dialysis:      ( ) No      ( ) Yes

Assistive Devices Comments: \_\_\_\_\_

**Health Care Events**

Date(mm/dd/yyyy) \*: \_\_\_\_\_

Author: \_\_\_\_\_

Health Care Event\*:      ( ) Alcohol Screening Test      ( ) Clinic Visit      ( ) DMS-1      ( ) Emergency Room  
( ) Hospital Visit      ( ) Other      ( ) Physician Visit      ( ) PRI

Event Date (MM/DD/YYYY)\*: \_\_\_\_\_

Health Care Events Comments: \_\_\_\_\_

**The CAGE Questionnaire (Check all that apply)**

**Alcohol Screening Test**

Have you ever felt you should cut down on your drinking?:

Have people annoyed you by criticizing your drinking?:

Have you ever felt bad or guilty about your drinking?:

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?:

**DMS-1**

DMS-1 Score: \_\_\_\_\_

Name: \_\_\_\_\_

Completed by (Name and Affiliation): \_\_\_\_\_

### PRI

PRI Score: \_\_\_\_\_

Completed by (Name and Affiliation): \_\_\_\_\_

### Legal Information

Power of Attorney:     No                       Yes

Power of Attorney Name: \_\_\_\_\_

Power of Attorney Type:     Durable             Finance             Springing

Do Not Resuscitate (DNR) Request:     No                       Yes

Health Care Proxy: \_\_\_\_\_

Living Will:     No                       Yes

Estate Will:     No                       Yes

Legal Comments: \_\_\_\_\_

### Nutrition

Height - Feet: \_\_\_\_\_

Height - Inches: \_\_\_\_\_

Weight (LBS): \_\_\_\_\_

Body Mass Index(BMI): \_\_\_\_\_

Possible Action: \_\_\_\_\_

Nutrition Problems:

<input type="checkbox"/> Anorexic Behaviors	<input type="checkbox"/> Bulimic Behaviors	<input type="checkbox"/> Compulsive Overeating	<input type="checkbox"/> Decreased Appetite
<input type="checkbox"/> Dehydration	<input type="checkbox"/> Dental Problems	<input type="checkbox"/> Difficulty Chewing	<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Overweight	<input type="checkbox"/> Taste Impairment	<input type="checkbox"/> Underweight

Nutritional Challenges:

<input type="checkbox"/> Has a Physician Diagnosed Food Allergy	<input type="checkbox"/> Has a Physician Prescribed Modified / Therapeutic Diet	<input type="checkbox"/> Inadequate Cooking Facilities	<input type="checkbox"/> Inadequate Freezer
<input type="checkbox"/> Inadequate Refrigerator	<input type="checkbox"/> Requires Nutritional Supplements	<input type="checkbox"/> Unable to Cut up Food	<input type="checkbox"/> Unable to Open Containers / Cartons

Name: \_\_\_\_\_

If Yes to Nutritional Challenges, describe: \_\_\_\_\_

If Yes to Physician Prescribed Modified Diet, indicate diet type: \_\_\_\_\_

- Calorie Controlled
- Diabetic
- Fat Restricted
- High Calorie
- Other
- Renal
- Sodium Restricted
- Texture Modified

Does the person follow this modified diet?:

- No
- Yes

If No to Physician Prescribed Modified Diet, indicate diet type: \_\_\_\_\_

- Diabetic
- Ethnic / Religious
- Regular
- Vegetarian

Weight changes in past 6 months:

- N/A
- No
- Yes

If Yes, How Many Pounds (+ Gained/ - Lost): \_\_\_\_\_

Possible Action:

Number of meals taken daily: \_\_\_\_\_

Does client ever go without food:

- No
- Yes

If Yes, Explain:

Does client have adequate food in home:

- No
- Yes

Nutrition Comments:

**NSI**

I have an illness or condition that made me change the kind and/or amount of food I eat:

- No
- Yes

I eat fewer than 2 meals per day:

- No
- Yes

I eat few fruits for vegetables, or milk products:

- No
- Yes

I have 3 or more drinks of beer, liquor or wine almost every day:

- No
- Yes

I have tooth or mouth problems that make it hard for me to eat:

- No
- Yes

Name:

I don't always have enough money to buy the food I need: ( ) No ( ) Yes

I eat alone most of the time: ( ) No ( ) Yes

I take 3 or more different prescribed or over-the-counter drugs a day: ( ) No ( ) Yes

Without wanting to, I have lost or gained 10 pounds in the last 6 months: ( ) No ( ) Yes

I am not always physically able to shop, cook and/or feed myself: ( ) No ( ) Yes

Total NSI Score:

Conclusion:

Comments:

### Psycho-Social Status

Cognitive/Emotional Status:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Acceptance of Help                 | <input type="checkbox"/> Agitation                                    | <input type="checkbox"/> Alert                    | <input type="checkbox"/> Anxiety                      |
| <input type="checkbox"/> Assertive - Articulates Needs      | <input type="checkbox"/> Cares for Others / Things (pets / neighbors) | <input type="checkbox"/> Confusion                | <input type="checkbox"/> Cooperative                  |
| <input type="checkbox"/> Critical Life Change               | <input type="checkbox"/> Dementia                                     | <input type="checkbox"/> Depression               | <input type="checkbox"/> Diagnosed MH Disorder        |
| <input type="checkbox"/> Disruptive Socially                | <input type="checkbox"/> Friends / Likeable                           | <input type="checkbox"/> Hallucination            | <input type="checkbox"/> Healthy Familial Attachments |
| <input type="checkbox"/> History of Mental Health Treatment | <input type="checkbox"/> Hoarding                                     | <input type="checkbox"/> Impaired Decision Making | <input type="checkbox"/> Lonely                       |
| <input type="checkbox"/> Member of Community Organizations  | <input type="checkbox"/> Memory Deficit                               | <input type="checkbox"/> Oriented                 | <input type="checkbox"/> Other                        |
| <input type="checkbox"/> Physical Aggression                | <input type="checkbox"/> Problem Behavior Reported                    | <input type="checkbox"/> Recent Losses            | <input type="checkbox"/> Self-neglect                 |
| <input type="checkbox"/> Sense of Humor                     | <input type="checkbox"/> Shows Initiative                             | <input type="checkbox"/> Sleeping Problems        | <input type="checkbox"/> Substance Abuse              |
| <input type="checkbox"/> Suicidal Behavior                  | <input type="checkbox"/> Suicidal Thoughts                            | <input type="checkbox"/> Verbal Disruption        |   |

What are the client identified strengths:

Substance Abuse: ( ) No ( ) Yes

Name:

If Yes, Explain:

Problem Behavior Reported:

No

Yes

If Yes, Explain:

Diagnosed Mental Health Problem:

No

Yes

If Yes, Explain:

History of Mental Health Treatment:

No

Yes

If Yes, Explain:

Mental Health Evaluation Needed:

No

Yes

If Yes, Explain:

Are there cultural determinates that may influence needs:

No

Yes

Psych/Social Comments:

Name:

### Medications List

Date Entered	Medication	Dose	Frequency	Related Diagnosis	Status	Comments

### ADLS

#### Bathing

Activity Status:    ( ) Person does not participate; another person performs all aspects of this task    ( ) Requires continual help with all or most of this task    ( ) Requires intermittent supervision and / or minimal assistance    ( ) Totally Able

Need Met By:    [ ] Assistive Devices    [ ] Formal Support    [ ] Informal Support    [ ] Unmet

Name of Person(s):     Formal Support:

Comments:

#### Personal Hygiene

Activity Status:    ( ) Person does not participate; another person performs all aspects of this task    ( ) Requires continual help with all or most of this task    ( ) Requires intermittent supervision and / or minimal assistance    ( ) Totally Able

Need Met By:    [ ] Assistive Devices    [ ] Formal Support    [ ] Informal Support    [ ] Unmet

Name of Person(s):     Formal Support:

Comments:

Name: \_\_\_\_\_

### Dressing

Activity Status:     Person does not participate; another person performs all aspects of this task     Requires continual help with all or most of this task     Requires intermittent supervision and / or minimal assistance     Totally Able

Need Met By:     Assistive Devices     Formal Support     Informal Support     Unmet

Name of Person(s): \_\_\_\_\_ Formal Support: \_\_\_\_\_

Comments: \_\_\_\_\_

### Mobility

Activity Status:     Person does not participate; another person performs all aspects of this task     Requires continual help with all or most of this task     Requires intermittent supervision and / or minimal assistance     Totally Able

Need Met By:     Assistive Devices     Formal Support     Informal Support     Unmet

Name of Person(s): \_\_\_\_\_ Formal Support: \_\_\_\_\_

Comments: \_\_\_\_\_

### Toileting

Activity Status:     Person does not participate; another person performs all aspects of this task     Requires continual help with all or most of this task     Requires intermittent supervision and / or minimal assistance     Totally Able

Need Met By:     Assistive Devices     Formal Support     Informal Support     Unmet

Name of Person(s): \_\_\_\_\_ Formal Support: \_\_\_\_\_

Name: \_\_\_\_\_

Comments: \_\_\_\_\_

**Eating**

Activity Status:    ( ) Person does not participate; another person performs all aspects of this task    ( ) Requires continual help with all or most of this task    ( ) Requires intermittent supervision and / or minimal assistance    ( ) Totally Able

Need Met By:    [ ] Assistive Devices    [ ] Formal Support    [ ] Informal Support    [ ] Unmet

Name of Person(s): \_\_\_\_\_ Formal Support: \_\_\_\_\_

Comments: \_\_\_\_\_

**Transfer**

Activity Status:    ( ) Person does not participate; another person performs all aspects of this task    ( ) Requires continual help with all or most of this task    ( ) Requires intermittent supervision and / or minimal assistance    ( ) Totally Able

Need Met By:    [ ] Assistive Devices    [ ] Formal Support    [ ] Informal Support    [ ] Unmet

Name of Person(s): \_\_\_\_\_ Formal Support: \_\_\_\_\_

Comments: \_\_\_\_\_

Are changes in ADL functional capacity expected within 6 mths?:    ( ) No    ( ) Yes

If yes, describe.: \_\_\_\_\_

Overall ADLs Comments: \_\_\_\_\_

Name: \_\_\_\_\_

\_\_\_\_\_

**Totals**

Informal Support: \_\_\_\_\_

Formal Support: \_\_\_\_\_

Assistive Devices: \_\_\_\_\_

Unmet Needs: \_\_\_\_\_

**IADLS**

**Housework/Cleaning**

Activity Status: ( ) Person does not participate; another person performs all aspects of this task ( ) Requires continual help with all or most of this task ( ) Requires intermittent supervision and / or minimal assistance ( ) Totally Able

Need Met By: [ ] Assistive Devices [ ] Formal Support [ ] Informal Support [X] Unmet

Name of Person(s): \_\_\_\_\_

Formal Support: \_\_\_\_\_

Comments: \_\_\_\_\_

**Self Administration of Medications**

Activity Status: ( ) Person does not participate; another person performs all aspects of this task ( ) Requires continual help with all or most of this task ( ) Requires intermittent supervision and / or minimal assistance ( ) Totally Able

Need Met By: [ ] Assistive Devices [ ] Formal Support [ ] Informal Support [ ] Unmet

Name of Person(s): \_\_\_\_\_

Formal Support: \_\_\_\_\_

Comments: \_\_\_\_\_

**Shopping**

Activity Status: ( ) Person does not participate; another person performs all ( ) Requires continual help with all or most of this task ( ) Requires intermittent supervision and / or minimal assistance ( ) Totally Able

Name: \_\_\_\_\_

aspects of this task

Need Met By:  Assistive Devices  Formal Support  Informal Support  Unmet

Name of Person(s):  Formal Support:

Comments:   
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Laundry

Activity Status:  Person does not participate; another person performs all aspects of this task  Requires continual help with all or most of this task  Requires intermittent supervision and / or minimal assistance  Totally Able

Need Met By:  Assistive Devices  Formal Support  Informal Support  Unmet

Name of Person(s):  Formal Support:

Comments:   
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Transportation

Activity Status:  Person does not participate; another person performs all aspects of this task  Requires continual help with all or most of this task  Requires intermittent supervision and / or minimal assistance  Totally Able

Need Met By:  Assistive Devices  Formal Support  Informal Support  Unmet

Name of Person(s):  Formal Support:

Comments:   
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Prepare and Cook Meals

Activity Status:  Person does not participate; another person  Requires continual help  Requires intermittent supervision  Totally Able

Name: \_\_\_\_\_

performs all aspects of this task      with all or most of this task      and / or minimal assistance

Need Met By:     Assistive Devices     Formal Support     Informal Support     Unmet

Name of Person(s): \_\_\_\_\_ Formal Support: \_\_\_\_\_

Comments: \_\_\_\_\_

**Handle Personal Business/Finances**

Activity Status:    ( ) Person does not participate; another person performs all aspects of this task    ( ) Requires continual help with all or most of this task    ( ) Requires intermittent supervision and / or minimal assistance    ( ) Totally Able

Need Met By:     Assistive Devices     Formal Support     Informal Support     Unmet

Name of Person(s): \_\_\_\_\_ Formal Support: \_\_\_\_\_

Comments: \_\_\_\_\_

**Telephone**

Activity Status:    ( ) Person does not participate; another person performs all aspects of this task    ( ) Requires continual help with all or most of this task    ( ) Requires intermittent supervision and / or minimal assistance    ( ) Totally Able

Need Met By:     Assistive Devices     Formal Support     Informal Support     Unmet

Name of Person(s): \_\_\_\_\_ Formal Support: \_\_\_\_\_

Comments: \_\_\_\_\_

Are changes in IADL functional capacity expected within 6 mths?:    ( ) No      ( ) Yes

Name:

If yes, describe.:

Overall IADLs Comments:

**Totals**

Informal Support:

Formal Support:

Assistive Devices:

Unmet Needs:

**Services Receiving**

What formal services does the person currently receive?	(Check all that apply)	Provider
None Utilized	( ) No ( ) Yes	
Adult Day Health Care	( ) No ( ) Yes	
Caregiver Support	( ) No ( ) Yes	
Case Management	( ) No ( ) Yes	
Community-Based Food Program	( ) No ( ) Yes	
Consumer Directed In-home Services	( ) No ( ) Yes	
Congregate Meals	( ) No ( ) Yes	
Equipment/Supplies	( ) No ( ) Yes	
Escort	( ) No ( ) Yes	
Friendly Visitor/Telephone Reassurance	( ) No ( ) Yes	
Health Promotion	( ) No ( ) Yes	
Health Insurance Counseling	( ) No ( ) Yes	

Name:

Home Health Aide	( )No ( )Yes	
Home Delivered Meals	( )No ( )Yes	
Homemaking/Personal Care	( )No ( )Yes	
Hospice	( )No ( )Yes	
Housing Assistance	( )No ( )Yes	
Housekeeping/Chore	( )No ( )Yes	
Legal Services	( )No ( )Yes	
Mental Health Services	( )No ( )Yes	
Nutrition Counseling	( )No ( )Yes	
Occupational Therapy	( )No ( )Yes	
Outreach	( )No ( )Yes	
Personal Emergency Response System (PERS)	( )No ( )Yes	
Protective Services	( )No ( )Yes	
Respite	( )No ( )Yes	
Respiratory Therapy	( )No ( )Yes	
Senior Center	( )No ( )Yes	
Senior Companions	( )No ( )Yes	
Services For The Blind	( )No ( )Yes	
Shopping	( )No ( )Yes	

Name:

Skilled Nursing	( ) No ( ) Yes	
Social Adult Day Care	( ) No ( ) Yes	
Speech Therapy	( ) No ( ) Yes	
Transportation	( ) No ( ) Yes	
Other	( ) No ( ) Yes	

### Informal Support Status

Does the person have a family, friends and/or neighbors who help or could help with care?: ( ) No ( ) Yes

Primary Contact Name:

Degree of involvement (Type of help/frequency):

Does the person appear to have a good relationship with this person?: ( ) No ( ) Yes

Explain/Describe:

Would the person accept help, or more help, from this person in order to remain at home and/or maintain independence?: ( ) No ( ) Yes

Explain/Describe:

Any factors that might limit this person's involvement?:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Emotional Burden | <input type="checkbox"/> Family Responsibilities | <input type="checkbox"/> Finances        | <input type="checkbox"/> Health Problems |
| <input type="checkbox"/> Job              | <input type="checkbox"/> Living Distance         | <input type="checkbox"/> Physical Burden | <input type="checkbox"/> Reliability     |
| <input type="checkbox"/> Transportation   |  |  |  |

Would this person be considered the caregiver?: ( ) No ( ) Yes

Is caregiver relief needed for respite?: ( ) No ( ) Yes

Name: \_\_\_\_\_

If Yes, when?:

- |  |  |                                    |                                  |
|--|--|------------------------------------|----------------------------------|
| <input type="checkbox"/> Afternoon                               | <input type="checkbox"/> Day & Evening | <input type="checkbox"/> Evening   | <input type="checkbox"/> Morning |
| <input type="checkbox"/> Needs relief and would take it any time | <input type="checkbox"/> Other         | <input type="checkbox"/> Overnight | <input type="checkbox"/> Weekend |

Which of these services could be provided as respite for the caregiver?:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Adult Day Services | <input type="checkbox"/> Personal Care Level 1 | <input type="checkbox"/> Personal Care Level 2 | <input type="checkbox"/> In Home Contact & Support (Paid Supervision) |
|---|--|--|---|

Would the caregiver like to receive information about other caregiver services?:

- ( ) No                      ( ) Yes

Secondary Contact Name:

\_\_\_\_\_

Degree of involvement (Type of help/frequency):

\_\_\_\_\_

Does the person appear to have a good relationship with this person?:

- ( ) No                      ( ) Yes

Explain/Describe:

\_\_\_\_\_

Would the person accept help, or more help, from this person in order to remain at home and/or maintain independence?:

- ( ) No                      ( ) Yes

Explain/Describe:

\_\_\_\_\_

Any factors that might limit this person's involvement?:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Emotional Burden | <input type="checkbox"/> Family Responsibilities | <input type="checkbox"/> Finances        | <input type="checkbox"/> Health Problems |
| <input type="checkbox"/> Job              | <input type="checkbox"/> Living Distance         | <input type="checkbox"/> Physical Burden | <input type="checkbox"/> Reliability     |
| <input type="checkbox"/> Transportation   |  |  |  |

Would this person be considered the caregiver?:

- ( ) No                      ( ) Yes

Is caregiver relief needed for respite?:

- ( ) No                      ( ) Yes

If Yes, when?:

- |  |  |                                    |                                  |
|--|--|------------------------------------|----------------------------------|
| <input type="checkbox"/> Afternoon                               | <input type="checkbox"/> Day & Evening | <input type="checkbox"/> Evening   | <input type="checkbox"/> Morning |
| <input type="checkbox"/> Needs relief and would take it any time | <input type="checkbox"/> Other         | <input type="checkbox"/> Overnight | <input type="checkbox"/> Weekend |

Name:

Which of these services could be provided as respite for the caregiver?:

Adult Day Services

Personal Care Level 1

Personal Care Level 2

In Home Contact & Support (Paid Supervision)

Would the caregiver like to receive information about other caregiver services?:

No

Yes

Can other informal support(s) provide temporary care to relieve the caregiver(s)?:

No

Yes

If yes, describe.:

Does the person have any community, neighborhood or religious affiliations that could provide assistance?:

No

Yes

If yes, describe who might be available, when they might be available and what they might be willing to do.:

Comments:

Overall Evaluation of Informal Support:

Adequate, can expand if needed

Adequate, could not expand

Inadequate / Limited

Other

Temporarily Unavailable

## Monthly Income

Name:

Poverty Level			# of people in household	
<b>Sources of Income</b>				
Source	Individual Being Assessed	Person's Spouse	Other Family/ Household Income	Total Family/Household Income (Total Month / Total Year)
SS Income				
Pension				
Rental				
Supp. SS Income				
Interest Income				
Dividend Income				
Salary Income				
Other Income				
<b>Total Income</b>				
<b>Total Annual Income</b>				
Comments				
Is client a veteran?	( ) No		( ) Yes	
Check if person will provide no financial information?	[ ]			
If checked, describe?				

**Benefits/Entitlements**

**Income Related Benefits**

Social Security:

SSI (\*):

Railroad Retirement:

SSD:

Veteran's Benefits:

**Entitlements**

Medicaid Number:

Food Stamps (SNAP):

Public Assistance:

**Health Related Benefits**

Medicare Number:

QMB:

SLIMB/QI-1:

EPIC:

Medicare Part D:

Medigap Insurance/HMO:

Long Term Care Insurance:

Health Insurance:

Private Health Insurance:

**Housing Related Benefits**

Name:

SCRIE:

Section 8:

IT 214:

Veteran Tax Exemption:

Reverse Mortgage:

Real Property Tax Exemption (STAR):

HEAP:

WRAP:

Telephone Discount:

Aged STAR Exemption:

Cable Discount:

Lifeline/PERS:

Other:

(\*) Persons receiving SSI is categorically eligible for Medicaid and should have a Medicaid card.

Require Counseling on Benefits/Entitlements: ( ) No ( ) Yes

Benefits/Entitlements Comments:

### Contacts List

Contact	Relation	Address	Home Phone	Work Phone	Mobile Phone	C-Giver	E-Contact	Status	Type