

**ASSESSMENT TOOL**

Organization/Provider/SDC		Phone Number		Date			
Referral Date		<input type="checkbox"/> Initial Assessment		<input type="checkbox"/> Reassessment			
				<input type="checkbox"/> Status Review			
6. Client Name (Last) (First) (M.I.)		DOB	Sex	SS Number			
9. Client Address(Street) (Town/City) (State) (Zip Code)		Marital Status	Race	Home Tel. #			
Primary Language		Able to communicate? <input type="checkbox"/> Yes <input type="checkbox"/> No					
		Explain: <input type="checkbox"/> Language Understanding <input type="checkbox"/> Aphasia <input type="checkbox"/> Dementia					
Emergency Contact Name		Emergency Contact Address		Emergency Contact Phone			
Conservator/POA Name		Conservator/POA Address		Conservator/POA Phone			
T19 Number		Medicare Number	Other Insurance				
Living Arrangements: <input type="checkbox"/> Alone <input type="checkbox"/> With Spouse <input type="checkbox"/> With Children <input type="checkbox"/> With Others							
Availability of family and/or informal community support on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Housing: <input type="checkbox"/> Own Home <input type="checkbox"/> With Others <input type="checkbox"/> Apartment <input type="checkbox"/> Elderly Housing							
<input type="checkbox"/> Low Income Housing <input type="checkbox"/> Retirement Home <input type="checkbox"/> Boarding Home							
Patient Has		Patient receives:					
<input type="checkbox"/> Supervision <input type="checkbox"/> Social Services		<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Veterans Benefits					
<input type="checkbox"/> Skilled Services <input type="checkbox"/> Financial Svcs		<input type="checkbox"/> SSI <input type="checkbox"/> Food Stamps <input type="checkbox"/> State Supplement					
		<input type="checkbox"/> Fuel Assistance <input type="checkbox"/> Rental Rebate					
Category of Service		Current Service Component		<input type="checkbox"/> Assisted Living: <input type="checkbox"/> Care Managed <input type="checkbox"/> SDC			
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		Type of Assisted Living:		<input type="checkbox"/> Demo <input type="checkbox"/> Congregate/HUD <input type="checkbox"/> Pal			
		Service Level Package		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4			
13. Dates of last inpatient stay							
Admission _____		Discharge _____		Type of facility _____			
12. Does client meet nursing home level of care? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Updated information: New orders/treatment /clinical facts/summary from each discipline							
Physician Name		Physician Address		Phone Number: Fax Number:			
<u>Diagnosis:</u>							
Personal Needs							
<b>ADLs</b>		Ind	Assisted	Toc	<b>IADLs</b>		
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel	<input type="checkbox"/>	
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shopping	<input type="checkbox"/>	
Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laundry	<input type="checkbox"/>	
Meal Prep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transportation	<input type="checkbox"/>	
Eating/Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Money Management	<input type="checkbox"/>	
Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Housework	<input type="checkbox"/>	
Transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Telephone	<input type="checkbox"/>	
		Code: 1 Independent		2 Assist		3 Total Assist	

\_\_\_\_\_  
Screener's Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date