IN-HOME SERVICES ASSESSMENT

Screening Date: ______ Interview Date: ______ Screening Score: ______

Name: ______ Date of Birth: ______ Gender: ☐ Male ☐ Female Other

Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian ☐ American Indian Other: ______

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Single N/M ☐ Unknown

Name of Spouse: ______ Date of Birth: ______

Address: ______

Phone: ______ Cell Phone: ______

Directions to Home:

EMERGENCY INFORMATION

Emergency Contact: ______ Phone: ______

Address: ______

Referral Agency/Contact Person: ______

Referral Date: ______ Phone: ______

☐ Guardian ☐ POA ☐ Conservator Name: ______ Phone: ______

Usual Living Arrangement: ☐ Alone ☐ W/Spouse ☐ W/Family ☐ Supervised Living ☐ Senior Housing ☐ Subsidized Housing ☐ Other: ______

INSURANCE INFORMATION

Social Security #: ______ Medicare ID #: ______

Part A Effective Date: ______ Part B Effective Date: ______

Long Term Care Policy: ☐ Yes ☐ No

Medicaid Status: ☐ Non-MA ☐ MA Pending ☐ MA Active

MA Case #: ______ MA ID #: ______

Other Phone / Necessary Information: ______

DHS Case Worker: ______ Phone: ______

Health Insurance Company & Group #: ______ Company: ______

Phone: ______ Premium Paid By: ☐ Client ☐ Company ☐ Other: ______

ECONOMIC INFORMATION

MONTHLY INCOME

	Participant	Spouse
Social Security:		
Pension:		
VA Benefits:		
SSI (must have):		
Interest Income:		
Railroad Income:		
Rental Income:		
Other:		
Subtotals:		
HOUSEHOLD TOTAL:		

Comments:

IN-HOME SERVICES ASSESSMENT

SOCIAL AND HEALTH SUPPORTS

Family Support : ☐ No Family ☐ Family will help ☐ Family Cannot/Will not help

Informal Support: (This should be family or volunteer services)

Task Code: ☐ 1. Shopping ☐ 2. Transportation ☐ 3. Meals ☐ 4. Housekeeping ☐ 5. Personal Care ☐ 6. Money Management ☐ 8. Other ____________________

Name	Phone	Address	Relationship	Days/Hours Available	Tasks Performed

HOUSING ASSESSMENT

Lives In: ☐ House ☐ Apartment ☐ Other: ____________________

	YES	NO	COMMENTS:
Neighborhood Safe/Secure	☐	☐	
Cooking Facilities & Refrigerator	☐	☐	
Microwave	☐	☐	
Telephone (Home/Cell)	☐	☐	
Washer/Dryer	☐	☐	
Heating & Water Supply Adequate & Safe	☐	☐	
Tub/Shower/Hot Water	☐	☐	
Pets	☐	☐	
Smoke Detector	☐	☐	
Housing Space & Arrangement Adequate	☐	☐	
Barriers Outside Home (inclines, stairway, handicap access)	☐	☐	
Barriers Inside Home (tub, stairs)	☐	☐	
Home repairs Needed (roof, flooring)	☐	☐	
Smokes	☐	☐	

MEDICAL INFORMATION

Primary Diagnosis:____________________

History of Chronic/Acute Illness:

Primary Physician: ____________________ Phone: ____________________

Address:____________________ Date Last Seen: ____________________

RECENT ADMISSIONS				
	Reason:	Facility Name:	Admission Date:	Discharge Date:
Hospital:				
Nursing Facility:				
Emergency Room:				

IN-HOME SERVICES ASSESSMENT

Pharmacy: ______________________________ Phone: ______________

Address: ____

Current Medications (prescribed /Over the Counter) & Other Physician Orders:

Allergies: ____

DIET

Diet: ☐ 1. Regular ☐ 2. Sodium Restricted ☐ 3. Fat Controlled ☐ 4. Diabetic ☐ 5. Mechanical Soft
☐ 6. Bland Low Residue ☐ 7. Calorie Restricted ☐ 8. Other ______________
☐ 9. Dietary Supplements Used: ______________

Participant has Instructions: Written ☐ Yes ☐ No Verbal ☐ Yes ☐ No Needs Instructions ☐ Yes ☐ No

Participant is Following Prescribed Diet: ☐ Yes ☐ No Prescribed Diet is on File: ☐ Yes ☐ No

Pattern of Daily Food Intake (include Source of all meals and special diet):

Appetite/Eating Problems: ______________

Oral Status (condition of teeth, gums, mouth & tongue):

Recent Weight Loss/Gain: ______________ Nutritional Risk: ______________

Participant Wants Milk with HDM? ☐ Yes ☐ No (Necessary for N.S.I.P Reimbursement)

Participant Has: Dentures ☐ Yes ☐ No Eye Glasses ☐ Yes ☐ No Hearing Aides ☐ Yes ☐ No

ACTIVITIES OF DAILY LIVING (MH: Mechanical Help HH: Human Help)

BATHING	TOILETING	WALKING
1. ☐ Without Help	1. ☐ Without Help	1. ☐ Without Help
2. ☐ MH Help Only	2. ☐ MH Help Only	2. ☐ MH Help Only
3. ☐ HH Only, Minimal	3. ☐ HH Only, Minimal	3. ☐ HH Only, Minimal
4. ☐ HH Continuous	4. ☐ HH Continuous	4. ☐ HH Continuous
Describe Help:	Describe Help:	Describe Help:

IN-HOME SERVICES ASSESSMENT

EATING/FEEDING	DRESSING	MOBILITY LEVEL
1. ☐ Without Help	1. ☐ Without Help	1. ☐ Without Help
2. ☐ MH Help Only	2. ☐ MH Help Only	2. ☐ MH Help Only
3. ☐ HH Only, Minimal	3. ☐ HH Only, Minimal	3. ☐ HH Only, Minimal
4. ☐ HH Continuous	4. ☐ HH Continuous	4. ☐ HH Continuous
Describe Help:	Describe Help:	Describe Help:

TRANSFERRING	BLADDER FUNCTION	BOWEL FUNCTION
1. ☐ Without Help	1. ☐ Continent	1. ☐ Continent
2. ☐ MH Help Only	2. ☐ Occasionally Incontinent	2. ☐ Occasionally Incontinent
3. ☐ HH Only, Minimal	3. ☐ Frequently Incontinent	3. ☐ Frequently Incontinent
4. ☐ HH Continuous	4. ☐ Incontinent	4. ☐ Incontinent
Describe Help:	Describe Help:	Describe Help:

COGNITIVE/PSYCHOLOGICAL / SOCIAL STATUS (a brief description):

Is There a Dementia Diagnosis: ☐ Yes ☐ No

SERVICES IN PLACE THE LAST 6 MONTHS (includes DHHS, DHM, HHA, DME, ect.)

Agency Name	Service	Phone	Contact Person	Are Services Current
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Comments:

Participant Signature — Date

Participant Representative Signature — Date

Assessor Signature — Date

Original Assessment Date