Adult Services Functional Assessment

Client Name: c _____ Date: _____

Case # _____ ID # _____

I. Social *(Complete or modify face sheet as needed.)*

A. Client's/family's perception of client's *social* functioning.

B. When the client has a problem, who is the person he/she can most rely on? *(name, relationship)*

C. Dimensions of social functioning *(Use a genogram or ecomap if social network is large or complex. See appendix of social worker's recordkeeping guide.)*

1. Client's abilities/preferences/barriers in forming and maintaining relationships *(e.g., isolated, likes daily contacts, prefers solitude, shy, unable to communicate)*

2. Does the client have a caregiver/caretaker? *(**If yes**, describe dynamics, e.g., satisfaction of client and of caregiver, other responsibilities and strains on caregiver, evidence of burnout, strains on client, rewarding relationship for caregiver/client.)* ☐ **Yes** ☐ **No**

3. Dynamics of relationships with and among family, friends, and others *(e.g., neighbors, facility staff, past or present coworkers, church and other organizations, pets). Include pertinent information on cultural values, family roles, sources of strain and satisfaction.*

4. Significant history/changes in client's/family's social functioning.

II. Environment

A. Client's/family's perceptions of the home and neighborhood environment.

B. Type of residence

SELECT TYPE

Facility/Group Home

C. Location

Other - Explain below

Specify shelter below

D. If client lives in a house, mobile home, or apartment, who is head of household?

List below head of household or if Other - Explain

E. Inadequate, unsafe, or unhealthy conditions in client's environment (*space for comments/ explanations below if needed*.) If client is in a facility, record environmental issues/concerns under comments.

☐ Access within Home	☐ Eating Area	☐ Lighting	☐ Shopping, access	☐ Transportation	
☐ Access, exterior	☐ Electrical Outlets	☐ Living Area	☐ Sleeping Accommodations	☐ Trash Disposal	
☐ Bathing facilities	☐ Fire Hazards/ No Smoke Detectors	☐ Locks/ Security	☐ Structural Integrity	☐ Ventilation	
☐ Cooking Appliance	☐ Heating	☐ Pests/Vermin	☐ Telephone	☐ Water/Plumbing	
☐ Cooling	☐ Laundry	☐ Refrigerator	☐ Toilet	☐ Yard or other area immediately out side of residence	☐ Other - Describe below

List Comments/Explanations and/or Describe Other below.

F. Is there anything in the home or neighborhood that poses a threat to the client's mental or physical health, safety, or ability to receive services?

G. Environmental Strengths

III. Mental/Emotional Assessment

A. Client's/family's perception of client's mental/emotional health

B. Were any mental/cognitive assessment instruments used by Social Worker or a mental health professional? **If yes, record results below.** *Sample assessment instruments are included in the appendix of the Social Worker's record keeping guide.* ☐ **Yes** ☐ **No**

Instrument	Given By	Findings/Conclusions

C. Mental, emotional, and cognitive problems, diseases, impairments and symptoms

Diagnosis/Sympton	**Source Code**	**Other - Specify**	**Notes (e.g., onset, severity, functional impact, history, untreated condition, needs professional assessment)**
Aggressive/abusive behavior			
Agitation/anxiety/panic attack			
Change in activity level (sudden/extreme)			
Changes in mood (sudden/extreme)			
Change in appetite			
Cognitive impairment/memory impairment **(SPECIFY)**			
Developmental disability/mental retardation **(SPECIFY)**			
Hallucinations/delusions			
Inappropriate affect (flat or incongruent)			
Impaired judgment			
Mental anguish			
Mental illness **(SPECIFY)**			
Orientation impaired: person, self, place, time			
Persistent sadness			
Sleep disturbances			
Substance abuse **(SPECIFY)**			
Thoughts of death/suicide			
Wandering			
Other:			
Other:			

D. Past and present hospitalizations/treatments for mental/emotional problems *(Include patient, outpatient, therapy, and substance abuse recovery programs and names of current therapists or other involved mental health professionals.)*

E. Is there a history of mental illness or substance abuse in the client's family or household? **If yes, describe below.** ☐ **Yes** ☐ **No**

F. Strengths in the mental or emotional status of the client/family.

IV. Physical Health

A. Client's/family's perception of client's health status.

B. Physical health problems: diseases, impairments and symptons

Diagnosis/Sympton	Source Code	Other - Specify	Notes (e.g., onset, severity, functional impact, history, untreated condition, needs professional assessment)
Arthritis/osteoporosis/gout			
Asthma/emphysema/other respiratory			
Bladder/urinary problems/incontinence			
Bruises			
Burns			
Cancer			
Dental Problems			
Diabetes			
Dizziness/Falls			
Eye Disease/Conditions			
Headaches			
Hearing difficulty			
Heart disease/angina			
Hypertension/high blood pressure			
Kidney disease/renal failure			
Liver diseases			
Malnourished/dehydrated			
M. Sclerosis/M.Dystrophy/Cerebal Palsy			
Pain			
Paraplegia/quadriplegia/spinal problems			
Parkingson's Disease			
Rapid weight gain/loss			
Seizures			
Sores **(Specify)**			
Speech Impairment			
Shortness of breath/persistent cough			
Stroke			
Other:			
Other:			

C. Does the client have any sensory or health problems that impair his/her ability to make or communicate responsible decisions?

D.

Medical Providers	Notes *(type provider, regular or as needed, etc.)*

E. Medications *(prescription and over-the-counter)* and Treatments *(e.g., special diet, massage)*

Name	**Comments** *(dosage, compliance issues, side effects, other)*

F. Does the client need assistance with medication or treatment? ☐ **Yes** ☐ **No**

If yes, is he/she receiving the assistance needed.

☐ No Assistance needed

☐ Assistance needed, but not received

☐ Assistance received from:

G. Other significant client/family history, including hospitalizations and outpatient procedures.

H. Durable Medical Equipment/Assistive Devices/Supplies

*(Record **U** if client uses it now, **N** if client needs it but does not have it.)*

	Cane		Crutches		Grab bars		Ostomy/ Colostomy Bags		Telephone Alert Device
	Catheter		Dentures		Hearing Aid		Oxygen Equipment		Walker
	Commode (seat/ bedside)		Diabetic Supplies		Hospital Bed		Prosthesis		Wheelchair
	Communication Devices		Glasses		Incontinence Supplies		Ramp		Other - Describe Below

Comments/Explanations/Other:

I. Strengths in client's/family's physical health.

V. ADL/IADL

A. Client's/family's perceptions of the client's ability to perform the activities of daily living *(basic and instrumental)*

B. Review of activities of daily living (basic and instrumental)

ADL Tasks	Help needed? None	Some	Total	Need met? 1 - Yes 2 - Partial 3 - No	Comments *(e.g., who assists, equipment used, problems or issues for caregivers)*
Ambulation					
Bathing					
Dressing					
Eating					
Grooming					
Toileting					
Transfer					
to/from bed					
into/out of car					
IADL Tasks					
Home maintenance					
Housework					
Laundry					
Meal Preparation					
Money management					
Shopping/errands					
Telephone use					
Transportation use					

C. ***(For APS use only)*** Is the client incapacitated, and without someone able, willing and responsible to provide assistance? ☐ Yes ☐ No

Comments/Explanation

D. Is the client able to read? ☐ Yes ☐ No Is the client able to write? ☐ Yes ☐ No

E. Client/family strengths

VI. Economic

A. Client's/family's perception of client's financial situation and ability to manage finances.

B. Monthly income (from all sources)

Social Security/ SSI		Retirement/VA/RR		Other - Type		Other - Amount	

C. Other resources *(e.g., food stamps, subsidized housing, property, Medicare, Medicaid)*

D. Monthly Expenses

Clothes/ Laundry		Heat		Medical		Transportation		Water/ Sewer	
Food/ Supplies		Insurance Type		Rent/ Mortgage		Utilities		Other	

Insurance type or Other explain: _____

E. Home/property ownership: _____

F. Are there any problems/irregularities in the way the client's money is managed *(by self or others)*

☐ Yes ☐ No

If yes, please explain:

G. If expenses exceed income, what does the client do to manage?

H. Client/family strengths

VII. Formal Services Currently Received by Client. *If none, check here:* ☐

Service	Provider	Comments
Adult Day Care		
CAP (Community Alternative)		
Case Management		
Counseling		
Employment Services		
Food Stamps		
In-home aide/PCS		
Legal Guardian		
Meals (Congregate/Home)		
Medicaid		
Mental Health Services		
Nursing Services		
Payee		
Public/Subsidized Housing		
Shelter Workshops		
Skilled Therapies (PT, OT, ST)		
Telephone Alert/Reassurance		
Transportation		
Other:		
Other:		

Information from collateral contacts, if appropriate. *(Include date, name, relationship or position. Attach additional sheets if needed.)*

Additional notes (optional) *This space provided for any relevant information that needs documentation and does not fit elsewhere on the tool.*

Summary of Findings - Including strengths and problems

Documentation of eligibility for specific services:

Next step(s) *(Check all that apply)*

☐ Close case	☐ Develope Goals/Service Plan	☐ Transfer Case to Another Unit
☐ Complete APS Disposition	☐ Make Referral to Another Agency	☐ Other - Explain below

If other, explain:

Social Worker's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____