Adult Services Annual Assessment

Client Name: _____ Date: _____

Case # _____ ID # _____

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

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

B. Changes in the client's/family's social functioning since the last assessment or reassessment *(e.g., changes in the household composition, changes in the dynamics and quality of client's or family's relationships, losses or changes in social support.) Update the Face Sheet as necessary.*

C. Has there been a change in the client's preferred emergency contact person? ☐ **Yes** ☐ **No**
***If yes,** update the Face Sheet.*

II. Environment

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

B. Type of residence

SELECT TYPE

Other - Explain below

Facility/Group Home

Specify shelter below

C. Location

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. What impact have changes in the environment in the past year had on the lives of the client/ family *(May include positive and negative impact.)*

III. Mental/Emotional Assessment

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

B. Have you used any assessment instruments to evaluate the client's mental/cognitive status within the past year, or at this reassessment? **If yes,** list tools, the results, and your evaluation.

☐ **Yes** ☐ **No**

Tools	Results	Evaluation Findings/Conclusions

C. Has the client had hospitalization/treatment for mental/emotional problems since the last annual assessment or reassessment *(include inpatient, outpatient, therapy, substance abuse recovery programs, changes in therapist or other mental health workers)?* ***If yes,*** *give setting(s), length of stay(s) or participation, and reason(s).* ☐ Yes ☐ No

D. What impact have changes in mental/emotional health in the past year had on the lives of the client/family? (*May include positive and negative impact)*

E. 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:			

IV. Physical Health

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

B. Have there been changes/additions in the client's medical providers? *Update the Face Sheet as necessary.*

☐ **Yes** ☐ **No**

C. 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			
Bowel 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:			

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

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

E. 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:

F. Does the client have new or continuing unmet needs for durable medical equipment? ☐ **Yes** ☐ **No**

G. Has the client been hospitalized or had outpatient procedures since the last (re)assessment? **If yes,** describe where, when and why. ☐ Yes ☐ No

H. What impact have changes in physical health in the past year had on the lives of the client/family? *(May include positive and negative impact)*

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)

	Help needed?				
ADL Tasks	**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. What impact have changes in ADLs/IADLs in the past year had on the lives of the client/family? *(May include positive and negative impact)*

VI. Economic

A. Client's/family's perception of changes in the 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		Rent/ Mortgage		Utilities		Other	

Insurance type or Other, please explain:

E. Any changes in house or property ownership? *(E.g., mortgage added/paid off, property sold or inherited)*

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. What impact have changes in the economic domain in the past year had on the lives of the client/ family? *(May include positive or negative impact)*

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

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		
Sheltered Workshops		
Skilled Therapies (PT, OT, ST)		
Telephone Alert/Reassurance		
Transportation		
Other:		
Other:		

Progess on Goals

Goal # and/or Description | Progress | Disposition | Other, Explain

Goal # and/or Description | Progress | Disposition | Other, Explain

Goal # and/or Description | Progress | Disposition | Other, Explain

Goal # and/or Description | Progress | Disposition | Other, Explain

Summary of Findings - including strengths and problems

Documentation of eligibility for specific services:

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

☐ Close case	☐ Revise Goals/Service Plan	☐ Other - Explain below
☐ Make Referral to Another Agency	☐ Transfer Case to another Unit	

Social Worker's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____