Case # _____

SIS ID # _____

North Carolina Department of Health and Human Services

Adult Services Initial Assessment

Client's Name:	**Date:**

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 can he/she most rely on? (person's name/relationship)

C. Dimensions of social functioning (Use a genogram or ecomap if social network or large or complex. Tools available in (***A Guide to Record Keeping for Adult Services Social Workers***).

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? ☐ Yes ☐ No (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.)

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

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

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

B. Type residence	
☐ Home for the aged	☐ Nursing home
☐ Facility/group home	☐ Homeless
☐ House/mobile home	☐ Home for the aged
☐ Boarding room	☐ DD home
☐ Apartment	☐ Rehab treatment/acute facility
	☐ Other
C. Location	
☐ City/town	
☐ Rural	
☐ Isolated	

If other, please explain:

D. If client lives in house, mobile home, or apartment, who is responsible party/head of household?
☐Other family member
☐Client/client's spouse

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	☐ Lighting	☐ Transportation
☐ Access, Exterior	☐ Living area	☐ Trash disposal
☐ Bathing facilities	☐ Lock/security	☐ Ventilation
☐ Cooking appliance	☐ Pest/vermin	☐ Water/plumbing
☐ Cooling	☐ Refrigerator	☐ Yard (or area immediately outside of residence)
☐ Eating area	☐ Shopping (access)	
☐ Electrical outlets	☐ Sleeping accommodations	☐ Other (describe)

Comments:

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? ☐ Yes ☐ No If yes, please explain:

G. Environmental strengths:

II. Economic

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

B. Monthly Income (from all sources – (indicate source).

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

C. Other resources (e.g., FNS benefit, subsidized housing, property, Medicare, Medicaid)

D. Monthly Expenses

Type	Amount
Rent/mortgage	
Food/supplies	
Electricity	
Heat	
Water/sewer	
Transportation	
Clothes/laundry	
Insurance (type)	
Medical	
Phone	
Other	
Other	

E. Home/property ownership

F. Are there any problems/irregularities in the way the client's money is managed (by self or others)? ☐ No ☐ Yes If yes, please explain below:

G. If expenses exceed income, how does the client manage?

H. Client/family 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 the social worker or a mental health professional? ☐ No ☐ Yes (record results below). Assessment tools available in ***A Guide to Record Keeping for Adult Services Social Workers.***

C.

Instrument	**Administered by**	**Findings/Conclusion**

Mental, emotional, and cognitive problems-disease, impairments, and symptoms **Diagnosis/Symptoms**	***Source Code** (see below)	**Notes** (e.g., onset, severity, functional impact, history, untreated condition, needs professional assessment)
Aggressive/abusive behavior		
Agitation/anxiety/panic attacks		

Change in activity level (sudden/extreme)		
Changes in mood (sudden/extreme)		
Change in appetite		
Cognitive impairment/memory impairment (specify)		
Hallucinations/delusions		
Inappropriate affect (flat or incongruent)		
Impaired judgement		
Mental anguish		
Mental illness (specify)		
Orientation impaired: person, self, place time		
Persistent sadness		
Sleep disturbances		
Substance misuse (specify)		
Thoughts of death/suicide		
Wandering		
Other:		

***Source Codes:**
C= Client's statement
F= Family member/guardian/responsible party
M= FL2, MD, Medical/mental health professional
S=Social worker observations/judgement
O= Other collateral (specify)

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

E. Is there a history of mental illness or substance misuse in the client's family or household?

☐ No ☐ Yes If yes, describe

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

IV. ADL/IADL

A. Client's/family's perception 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*	Help Needed? *some*	Help Needed? *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	☐	☐	☐		
To/from chair	☐	☐	☐		
Into/out of car	☐	☐	☐		

IADL Tasks	☐	☐	☐		
Home maintenance	☐	☐	☐		
Housework	☐	☐	☐		
Laundry	☐	☐	☐		
Meal preparation	☐	☐	☐		
Money management	☐	☐	☐		
Shopping/errands	☐	☐	☐		
Telephone use	☐	☐	☐		
Transportation use	☐	☐	☐		

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

D. Client/Family strengths

V. Physical Health

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

B. Physical health problems—diseases, impairments, and symptoms

Diagnosis/Symptoms	***Source Code** (see below)	**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 diseases/conditions		
Headaches		
Hearing difficulty		
Heart disease/angina		
Hypertension/high blood pressure		
Kidney disease/renal failure		
Liver diseases		
Malnourished/dehydrated		
M. Sclerosis/M. Dystrophy/Cerebral Palsy		
Pain		
Paraplegia/quadriplegia/spinal problems		
Parkinson’s disease		
Rapid weight gain/loss		
Seizures		
Sores/Wounds (specify)		

Speech impairment		
Shortness of breath/persistent cough		
Stroke		
Other:		
Other:		

***Source Codes:**
C=Client's statement
F=Family member/guardian/responsible party
M=FL-2, M.D., medical/mental health professional
S=Social worker observation/judgment
O=Other collateral (specify)_____

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

H.

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

I. Medications *(prescribed and over the counter)* and Treatments *(e.g., special diet, massage, therapy)*:

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

Does the client need assistance with medication or treatment? If so, is he/she receiving the assistance needed? ☐ No assistance needed ☐ Assistance needed, but not received.

Assistance received from:

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

K. Durable Medical Equipment/Assistive Devices/Supplies **(<u>Record U if client uses it now</u>, <u>N if client needs it, but does not have it.)</u>**

____ Cane	____ Telephone	____ Incontinence supplies
____ Glasses	____ Alert device	____ Wheelchair
____ Prosthesis	____ Communication devices	____ Dentures
____ Commode (seat beside)	____ Hospital bed	____ Ostomy/colostomy bags
____ Hearing aid	____ Walker	____ Diabetic supplies
____ Ostomy/colostomy bags	____ Oxygen equipment	____ Others – specify below:

Comments/Explanations:

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

Formal Services Currently Received by Client (If none, check here ☐)

Service	Provider	Comments
Adult Day Care/Day Health		
CAP (Community Alternatives)		
Case Management		
Counseling		
Employment Services		
Food Stamps		
In-home Aide/PCS		
Legal Guardian		
Meals (Congregate/Home)		
Medicaid		
Mental Health Services		
Nursing Services		
PACE		

Payee		
Public/Subsidized Housing		
Sheltered Workshops		
Skilled Therapies (PT, OT, ST)		
Telephone Alert/Reassurance		
Transportation		
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

<u>Information obtained from this assessment must be included in the development of the Service Plan with the client.</u>

Documentation of eligibility for specific services:

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

☐ Develop goals/service plan
☐ Transfer case to another unit
☐ Other
☐ Close case
☐ Make referral to another agency

Social worker's signature	Assessment completed	Date
Supervisor's signature	Reviewed	Date