Special Assistance In Home (SAIH)

Program Assessment

Date of Face-to-Face Home Visit: Enter date here

Adult Name: Enter first and last name here

Type of Assessment: Select one

# 

|  |
| --- |
| DEMOGRAPHICS |

**DOB:** Enter date here **Race:** Select one **Ethnicity:** Select one

**Gender:** Select one

**Primary Language:** Select one **Marital Status:** Select one

Physical Address: Enter text here Phone: Enter text here

City: Enter text here State: NC Zip Code: Enter text here

Mailing Address (if different than above): Enter text here

City: Enter text here State: NC Zip Code: Enter text here

**SOCIAL**

Does the adult have a Guardian, POA, Representative Payee or Authorized Representative? Yes  No

If yes, what is the type of authority: Select one

Name of Representative: Enter name here

Representative’s Physical Address: Enter text here

City: Enter text here State: Enter text here Zip Code: Enter text here

Phone: Enter text here

Is there more than one individual that has authority for the adult? If so, list the additional person’s information below.

What is the type of authority: Select one

Name of Representative: Enter name here

Representative’s Physical Address: Enter text here

City: Enter text here State: Enter text here Zip Code: Enter text here

Telephone Number: Enter text here

**Household Members and Significant Informal Supports**

Check here if the adult lives alone.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Is this person an Emergency POC?** | **First and Last Name** | **Living Arrangement** | **Relationship** | **Telephone Number** | **Frequency of Contacts** |
| Select one | Enter text | Select one | Select one | Enter text | Select one |
| Select one | Enter text | Select one | Select one | Enter text | Select one |
| Select one | Enter text | Select one | Select one | Enter text | Select one |
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| Select one | Enter text | Select one | Select one | Enter text | Select one |
| Select one | Enter text | Select one | Select one | Enter text | Select one |

**Agency /Community Support Services**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Business Name** | **Agency Point of Contact First/Last Name** | **Telephone Number** | **Services Provided** | **Dates Service Began & Ended (as applicable)** | **Frequency of Services** |
| Enter text | Enter text | Enter text | Enter text | Enter text | Enter text |
| Enter text | Enter text | Enter text | Enter text | Enter text | Enter text |
| Enter text | Enter text | Enter text | Enter text | Enter text | Enter text |
| Enter text | Enter text | Enter text | Enter text | Enter text | Enter text |
| Enter text | Enter text | Enter text | Enter text | Enter text | Enter text |
| Enter text | Enter text | Enter text | Enter text | Enter text | Enter text |

* Have there been significant history/changes in the adult’s social support or functioning?

Yes  No

* Does the adult feel their relationships are supportive and consistent to meet their needs?

Yes  **No**

* Are there any considerations regarding the adult’s social support that pose a threat to their overall safety, well-being, or ability to receive services?

**Yes**  No

* If needed, does the adult utilize community resources/services available to strengthen their support system?

Yes  **No**

* Are there any community resources/services the adult needs to reduce risk related to social isolation that are not currently in place?

**Yes**  No

If any checkboxes in bold above are marked or if there are any changes or concerns noted, please clarify your assessment of the adult's strengths and areas of need within this domain here: Enter text here

**DETERMINATION OF CASE MANAGEMENT NEEDS (Social):**

* This domain area presents a risk or safety concern that poses a threat to the adult’s overall safety and/or well-being, impacting their ability to remain safely in their PLA. The adult requires assistance to access resources to mitigate these risks.

**Yes**  No

If yes, describe here: Enter text here

* The adult has an unmet need in this domain area that cannot be addressed with available supports, making their PLA unsafe.

**Yes**  No

If yes, describe here: Enter text here

**ENVIRONMENT**

* Adult’s living arrangement:  Owns Home  Rents  Lives with family/others
  + Type of Residence:  Private Residence  Congregate Living
  + Private Residence: House Mobile Home Apartment Camper/Permanent Housing Camper/Temporary Housing Other
  + **Congregate Living Situations**: Boarding Home/Room

Multi-Unit Assisted Housing with Services Other

* + If other, describe here: Enter text here.
* Describe the adult’s emergency exit: Enter text here.
* Is the adult’s emergency exit plan realistic, allowing them to both explain and demonstrate it

effectively? Yes  No

Environmental risk factors (Check all that apply)

|  |  |  |
| --- | --- | --- |
| Threatened eviction | No electricity | Household areas inaccessible |
| Inadequate heating/cooling source | Accumulated debris | No water/safe supply |
| Deteriorating structure | Vermin/pest infested PLA | Unsanitary conditions |
| Neighborhood | Animal infested PLA | Telephone |
| Accessibility issues | No food storage facilities | Transportation |
| Mobility barriers | Fire hazards | Internal hazards |
| Other Enter text here. | | |

* Are there any community resources/services the adult needs to reduce risk related to their environmental conditions? Yes  No

If any checkboxes in bold above are marked or if there are any changes or concerns noted, please clarify your assessment of the adult's strengths and areas of need within this domain here: Enter text here

**DETERMINATION OF CASE MANAGEMENT NEEDS (Environment):**

* This domain area presents a risk or safety concern that poses a threat to the adult’s overall safety and/or well-being, impacting their ability to remain safely in their PLA. The adult requires assistance to access resources to mitigate these risks.

**Yes**  No

If yes, describe here: Enter text here

* The adult has an unmet need in this domain area that cannot be addressed with available supports, making their PLA unsafe.

**Yes**  No

If yes, describe here: Enter text here

**ECONOMIC**

* What is the adult’s primary source of income? Enter text here
* Does the adult manage their own finances?

Yes  **No**

Economic risk factors (Check all that apply)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Food | Utilities | Fuel | Shelter | Medicine | Clothing |
| Other: Enter text here | | | | | |

* Are there any considerations regarding the adult’s economic situation that pose a threat to their overall safety, well-being, or ability to receive services?

**Yes**  No

* Are there any community resources/services the adult needs to reduce risk related to their economic situation that are not currently in place?

**Yes**  No

If any checkboxes in bold above are marked or if there are any changes or concerns noted, please clarify your assessment of the adult's strengths and areas of need within this domain here: Enter text here

**DETERMINATION OF CASE MANAGEMENT NEEDS (Economic):**

* This domain area presents a risk or safety concern that poses a threat to the adult’s overall safety and/or well-being, impacting their ability to remain safely in their PLA. The adult requires assistance to access resources to mitigate these risks.

**Yes**  No

If yes, describe here: Enter text here

* The adult has an unmet need in this domain area that cannot be addressed with available supports, making their PLA unsafe.

**Yes**  No

If yes, describe here: Enter text here

**MENTAL/EMOTIONAL**

Mental health indicators (Check all that apply)

|  |  |
| --- | --- |
| **Diagnosis/Symptoms** | **Describe diagnosis/symptom and their impact on the adult** (onset, severity, history, current treatment). |
| Aggressive/abusive behavior | Enter text here |
| Agitation/anxiety/panics attacks | Enter text here |
| Change in activity levels (sudden/extreme) | Enter text here |
| Change in appetite | Enter text here |
| Dementia/Alzheimer’s Related Disease | Enter text here |
| Intellectual and Developmental Disability (IDD) | Enter text here |
| Hallucinations/delusions | Enter text here |
| Mental illness | Enter text here |
| Impaired judgement | Enter text here |
| Substance misuse | Enter text here |
| Thoughts of death/suicide | Enter text here |
| Orientation impaired: person, self, place, time | Enter text here |
| Wandering | Enter text here |
| Other | Enter text here |

* Are there any considerations regarding the adult’s mental health that pose a threat to their overall safety, well-being, or ability to receive services?

Yes  No

* Are there any community resources/services the adult needs to reduce risk related to their mental health that are not currently in place?

Yes  No

If any checkboxes in bold above are marked or if there are any changes or concerns noted, please clarify your assessment of the adult's strengths and areas of need within this domain here: Enter text here

**DETERMINATION OF CASE MANAGEMENT NEEDS (Mental/Emotional):**

* This domain area presents a risk or safety concern that poses a threat to the adult’s overall safety and/or well-being, impacting their ability to remain safely in their PLA. The adult requires assistance to access resources to mitigate these risks.

**Yes**  No

If yes, describe here: Enter text here

* The adult has an unmet need in this domain area that cannot be addressed with available supports, making their PLA unsafe.

**Yes**  No

If yes, describe here: Enter text here

**ACTIVITIES OF DAILY LIVING (Check any ADL or IADLs for which the adult requires assistance)**

|  |  |
| --- | --- |
| **Activity of Daily Living Task** | **Assistance Provided by** (Name of Support Person and / or Support Equipment) |
| Ambulation | Enter text here |
| Bathing | Enter text here |
| Eating | Enter text here |
| Grooming | Enter text here |
| Toileting | Enter text here |
| Transfer to/from bed | Enter text here |
| Transfer to/from chair | Enter text here |
| Transfer into/out car | Enter text here |

|  |  |
| --- | --- |
| **Instrumental Activity of Daily Living (IADL) Task** | **Assistance Provided by** (Name of Support Person and / or support equipment) |
| Home maintenance | Enter text here |
| Housework | Enter text here |
| Laundry | Enter text here |
| Meal preparation | Enter text here |
| Medication management | Enter text here |
| Money management | Enter text here |
| Shopping/errands | Enter text here |
| Telephone use | Enter text here |
| Transportation | Enter text here |

**Highest Completed Grade:**  Select one.

**Able to Read?** Yes  No  **Able to Write?** Yes  No

**Vision/Hearing/Communication Barriers?** Yes  No

If accommodations are needed to promote effective communication, describe adaptations.

Enter text here

* Are there any considerations regarding the adult’s ADL/IADL that pose a threat to their overall safety, well-being, or ability to receive services?

Yes  No

* Are there any community resources/services the adult needs to reduce risk related to ADL/IADL that are not currently in place?

Yes  No

If any checkboxes in bold above are marked or if there are any changes or concerns noted, please clarify your assessment of the adult's strengths and areas of need within this domain here: Enter text here

**DETERMINATION OF CASE MANAGEMENT NEEDS (ADL/IADL):**

* This domain area presents a risk or safety concern that poses a threat to the adult’s overall safety and/or well-being, impacting their ability to remain safely in their PLA. The adult requires assistance to access resources to mitigate these risks.

**Yes**  No

If yes, describe here: Enter text here

* The adult has an unmet need in this domain area that cannot be addressed with available supports, making their PLA unsafe.

**Yes**  No

If yes, describe here: Enter text here

**PHYSICAL HEALTH**

Physical health indicators (Check all that apply)

|  |  |
| --- | --- |
| **DIAGNOSIS/SYMPTOMS** | **Describe diagnosis/symptom and their impact on the adult** (onset, severity, history, current treatment). |
| Arthritis/osteoporosis/gout | Enter text here |
| Asthma/emphysema/other respiratory | Enter text here |
| Bladder/urinary problems or incontinence | Enter text here |
| Bowel problems or incontinence | Enter text here |
| Cancer | Enter text here |
| Dental problems | Enter text here |
| Diabetes | Enter text here |
| Dizziness/falls | Enter text here |
| Eye disease | Enter text here |
| Hypertension/high blood pressure | Enter text here |
| Heart disease/angina | Enter text here |
| Kidney disease/renal failure | Enter text here |
| Liver disease | Enter text here |
| Multiple sclerosis/muscular dystrophy/cerebral palsy | Enter text here |
| Pain | Enter text here |
| Paraplegia/quadriplegic/spinal problems | Enter text here |
| Parkinson’s Disease | Enter text here |
| Rapid weight gain/loss | Enter text here |
| Seizures | Enter text here |
| Shortness of breath/persistent cough | Enter text here |
| Skin condition | Enter text here |
| Speech impairment | Enter text here |
| Stroke | Enter text here |
| Other | Enter text here |

Durable Medical Equipment/Assistive Devices/Supplies

(Select “Has” if the adult currently has this assistance and “Needs” if the assistance is needed)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Select | Cane | Select | Glasses | Select | Prothesis |
| Select | Catheter | Select | Grab bars | Select | Ramp |
| Select | Bedside commode | Select | Hearing aid | Select | Telephone |
| Select | Crutches | Select | Alert device | Select | Walker |
| Select | Dentures | Select | Hospital bed | Select | Wheelchair |
| Select | Diabetic supplies | Select | Incontinence supplies | Select | Oxygen equipment |
| Select | Communications devices | Select | Ostomy/colostomy bags | Select | Shower Chair |
|  | Other: Enter text here. | | | | |

**Medical/Mental Health Providers**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Provider Name** | **Type (include specialists)** | **City of Location** | **Telephone Number** | **Frequency of Care** | **Date of Last Visit** | **Date of Next Visit** | **Up to date?** |
| Enter text | Enter text | Enter text | Enter text | Select | Enter date | Enter date |  |
| Enter text | Enter text | Enter text | Enter text | Select | Enter date | Enter date |  |
| Enter text | Enter text | Enter text | Enter text | Select | Enter date | Enter date |  |
| Enter text | Enter text | Enter text | Enter text | Select | Enter date | Enter date |  |
| Enter text | Enter text | Enter text | Enter text | Select | Enter date | Enter date |  |
| Enter text | Enter text | Enter text | Enter text | Select | Enter date | Enter date |  |
| Enter text | Enter text | Enter text | Enter text | Select | Enter date | Enter date |  |

* **What is the date of the adult’s most recent FL2?** Enter text here.

Medications (Medical, Psychiatric, OTC), Treatments (Special Diet, Massage)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medication Name** | **Medication Dosage** | **Prescribing Physician** | **Reason for Medication** | **Side Effects** | **Is medication current and accessible?** |
| Enter text | Enter text | Enter text | Enter text | Enter text | Yes  No |
| Enter text | Enter text | Enter text | Enter text | Enter text | Yes  No |
| Enter text | Enter text | Enter text | Enter text | Enter text | Yes  No |
| Enter text | Enter text | Enter text | Enter text | Enter text | Yes  No |
| Enter text | Enter text | Enter text | Enter text | Enter text | Yes  No |
| Enter text | Enter text | Enter text | Enter text | Enter text | Yes  No |
| Enter text | Enter text | Enter text | Enter text | Enter text | Yes  No |
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| Enter text | Enter text | Enter text | Enter text | Enter text | Yes  No |
| Enter text | Enter text | Enter text | Enter text | Enter text | Yes  No |
| Enter text | Enter text | Enter text | Enter text | Enter text | Yes  No |
| Enter text | Enter text | Enter text | Enter text | Enter text | Yes  No |

* Pharmacy Name: Enter text here
* Pharmacy Location: Enter text here
* How does the adult obtain their medications? Select one
* Is the adult able to communicate verbally?

Yes  No

* Does the adult have any sensory or health problems that impair their ability to make or communicate responsible decisions?

Yes  No

* Have there been any recent changes/additions to the adult’s medical providers?

Yes  No

* Has the adult been recently hospitalized?

Yes  No

If yes, provide date and reason: Enter text here

* Are there any factors/barriers that affect the adult’s medication compliance?

Yes  No

If any checkboxes in bold above are marked or if there are any changes or concerns noted, please clarify your assessment of the adult's strengths and areas of need within this domain here: Enter text here

**DETERMINATION OF CASE MANAGEMENT NEEDS (Physical):**

* This domain area presents a risk or safety concern that poses a threat to the adult’s overall safety and/or well-being, impacting their ability to remain safely in their PLA. The adult requires assistance to access resources to mitigate these risks.

**Yes**  No

If yes, describe here: Enter text here

* The adult has an unmet need in this domain area that cannot be addressed with available supports, making their PLA unsafe.

**Yes**  No

If yes, describe here: Enter text here

**\*\*ADULT AND FAMILY SERVICE PLAN \*\***

**Prior to personalizing the Case Management Support Plan, please complete an Adult and Family Service Plan. If this is a re-assessment, a new service plan should be completed.**

Check all domain areas where needs have been identified, and ensure that the clarifying sections explain what the needs are:

**S**ocial

**E**conomic

**E**nvironmental

**M**ental / Emotional Health

**A**ctivities of Daily Living / Instrumental Activities of Daily Living

**P**hysical Health

Does the adult have any needs that have been identified during the assessment that cannot be addressed adequately on the service plan and is not suitable for the SAIH Program?

Yes No

Explain why or why not:Enter text here

**\*\* CASE MANAGEMENT SUPPORT PLAN \*\***

**SAIH clients will receive the following annual requirements:**

* A Minimum of two contacts per year: At least one contact must be face-to-face and occur in the client’s PLA.
* Annual Re-Assessments: Conducted during a face-to-face home visit.
* Annual completion of a new Adult and Family Service Plan.

**Personalized Case Management Support Plan Development**

Each SAIH client will receive a personalized Case Management Support Plan based on their person-centered assessment. This plan should be directly informed by the strengths and needs identified in the client’s Adult and Family Service Plan.

**Process for Developing the Personalized Case Management Support Plan:**

1. **Assessment Review**:
   * Review the completed assessment, focusing on the sections labeled **“Determination of Case Management Needs.”**
   * Identify any areas marked "Yes" and confirm that the Adult and Family Service Plan addresses these identified needs.
2. **Evaluating and Establishing Support Levels**:
   * Once the Adult and Family Service Plan is completed, the Adult Services Case Manager and Supervisor should evaluate the level of support required to meet the client's needs and ensure their safety within their PLA.
3. **Plan Development and Finalization**:
   * Based on the needs identified in the Adult and Family Service Plan, develop a Case Management Support Plan that provides tailored support to best address the client's individual requirements. Document in section “**Individualized Case Management Support Plan**” the required activities and frequency of contacts necessary to meet the client’s needs.

This process ensures the Case Management Support Plan is person-centered and effectively supports the client's stability and well-being.

**Individualized Case Management Support Plan**

Document required activities and frequency of contacts needed: Enter text here.

**Annual Reassessment Due Date:** Enter date.

**Important Notices for the Social Worker and Supervisor:**

* If changes occur that impact risk/safety, a home visit should be completed without delay, a new assessment form completed, and the service plan updated to reflect changes/needs identified within the new assessment. The service plan must show how identified needs are being met.
* The social worker and supervisor should staff and review the Case Management Support Plan assignments for approval and any changes.
* If an agency determines that a client needs more or less frequent contact based on assessed/identified risk concerns, the agency may increase or reduce the frequency of visits and should document the rationale for their decision here:Enter text here.

**Updates/Changes to Situation:** Document any updates/changes needed if services outlined within the adult’s service plan are not being met: Enter text here.

Social Worker Name: Type Social Worker/Case Manager’s Name

Social Worker Signature Enter signature here Date: Date of Signature

Supervisor Name: Type Supervisor’s Name

Supervisor SignatureEnter signature here Date: Date of Signature