**North Carolina Department of Health and Human Services**

**Division of Aging and Adult Services**

**Adult Services Annual Assessment**

**Client Name:****Date Assessment Begun**Click or tap to enter a date.

**Case #**        **ID#** **Social *(****update face sheet as needed.*)

1. Client’s /family’s perception of client’s social functioning.
2. 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.)
3. Has there been a change in the client’s preferred emergency contract person? [ ]  Yes [ ]  No

Please explain:

1. **Environment**
2. Client’s/family’s perceptions of the home and neighborhood environment.

|  |  |  |
| --- | --- | --- |
| 1. Type residence
 | Facility/group home | 1. Location
 |
|  |  |  |

Other – explain:

If in a shelter, specify shelter here:

1. If client lives in a house, mobile home, or apartment, who owns/rents (list person who is head of household?)

or if other, please explain:

1. Inadequate, unsafe, or unhealthy conditions in client’s environment (space for comments/explanations below provided if needed.) If client is in a facility, record environmental issues/concerns user 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 appliances | [ ]  Heating | [ ]  Pest/vermin | [ ]  Telephone  | [ ]  Water/plumbing |
| [ ]  Cooling | [ ]  Laundry | [ ]  Refrigerator | [ ]  Toilet | [ ]  Yard or other area immediately outside residence |

List comments/explanations and/or describe **other** below.

1. 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

Please explain

1. 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.) [ ] Yes [ ]  No

Please explain

1. **Economics**
2. Client’s/family’s perception of changes in the client’s financial situation and ability to manage finances.

1. **Monthly income from all sources – (indicate source)**

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

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

Please explain:

1. **Monthly Expenses**

|  |  |
| --- | --- |
| Clothes/laundry |        |
| Heat |        |
| Medical |        |
| Transportation |        |
| Water/sewer |        |
| Food/supplies |        |
| Insurance |        |
| Rent/mortgagee |        |
| Electricity |        |
| Other |        |

Insurance type or Other, please explain:

1. Any changes in house or property ownership? (e.g. mortgage added/paid off, property sold or inherited?) [ ]  Yes [ ]  No. If yes, please explain:
2. Are there any problems/irregularities in the way the client’s money is managed? (by self or others?) [ ]  Yes [ ]  No. If yes, please explain:
3. If expenses exceed income, what does the client do to manage? Please explain:
4. 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). Please explain:
5. **Mental/Emotional Assessment**
6. Client’s/family perception of client’s mental/emotional health. Please explain:
7. 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** |
|       |       |       |
|       |       |       |

1. 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 stays(s) or participation, and reason(s) [ ]  Yes [ ]  No

 Please explain:

1. 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.) Please explain:
2. Mental, Emotional, and Cognitive problems, disease, impairments and symptoms.

|  |  |  |  |
| --- | --- | --- | --- |
| **Diagnosis/Symptom** | **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 or extreme) |  |        |        |
| Changes in mood (sudden or extreme |  |        |        |
| Changes in appetite |  |        |        |
| Cognitive impairment/memory impairment (specify) |  |        |        |
| Developmental disability/IDD (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 |  |        |        |
| Other |  |        |        |

**Source Codes:**

**C=**Client’s statement **M=**FL-2, M.D.,medical/mental health professional

**F=**Family member/guardian/responsible party **O=**Other collateral (specify)

1. **ADLs/IADLs**
2. **Client’s/fam**ily’s perceptions of the client’s ability to perform activities of daily living (basic and instrumental) Please explain:
3. Review of activities of daily living (basic and instrumental.)

|  |  |  |  |
| --- | --- | --- | --- |
| **ADL Tasks** | **Help Needed?** | **Need Met?** | **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 |  |  |       |

1. What impact have changes in ADLs/IADLs in the past year had on the lives of the client/family? Please explain:
2. **Physical Health**
3. Client’s/family perception of client’s health status. Please explain:
4. Have there been changes/additions in the client’s medical providers? [ ]  Yes [ ]  No

 Please explain:

1. Does the client need assistance with medication or treatment? [ ]  Yes [ ]  No

1. If yes, is he/she receiving the assistance needed? [ ]  Yes [ ]  No Please explain:
2. Does the client have new or continuing unmet needs for durable medical equipment

 [ ]  Yes [ ]  No

1. Physical health problems: diseases, impairments and symptoms.

|  |  |  |  |
| --- | --- | --- | --- |
| **Diagnosis/Symptom** | **\*Source Code** | **Other-specify** | **Notes(e.g. onset, severity, functional impact, history, untreated condition, needs professional assessment)** |
| Arthritis/osteoporosis/gout |  |       |       |
| Asthma/emphysema/COPD/other  |  |       |       |
| Bladder/urinary problems/incontinence |  |       |       |
| Bowel problems/incontinence |  |       |       |
| Bruises |  |       |       |
| Cancer |  |       |       |
| Dental problems |  |       |       |
| Diabetes |  |       |       |
| Dizziness/falls |  |       |       |
| Eye disease/conditions |  |       |       |
| Headaches |  |       |       |
| Hearing difficulty |  |       |       |
| Heart disease/angina |  |       |       |
| Hypertension |  |       |       |
| 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 **M**=FL-2, M.D., medical/mental health

**F**= Family member/guardian/responsible party **O**=Other collateral (specify)

1. Medications (prescription and over the counter) and treatments (e.g. special diet, massage)

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

1. Has the client been hospitalized or had outpatient procedures since the last (re)assessment? [ ]  Yes [ ]  No If yes, describe where, when and why.
2. 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) Please explain:

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

1. **Formal Services currently received by client, if none check here** **[ ]**

|  |  |  |
| --- | --- | --- |
| **Service** | **Provider** | **Comments** |
| Adult day care/Day health |       |       |
| 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 |       |       |
| PACE |       |       |
| Payee |       |       |
| Public/subsidized housing |       |       |
| Sheltered workshops |       |       |
| Skilled therapies (PT,OT,ST) |       |       |
| Telephone alert/reassurance |       |       |
| Transportation |       |       |
| Other |       |       |

**A new Service Plan must be completed annually and include all goals, progress and disposition of goals, as well as strengths and needs identified during Annual Assessment**

**List Goals(s) completed and resolved from previous Service Plan and indicate how resolved:**

**Current Assessment Summary of Findings** – including strengths and needs:

**Documentation of eligibility for specific services:**

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

|  |  |
| --- | --- |
| [ ]  Close case | [ ]  **\***Other – Explain below\* |
| [ ]  Make referral to another agency | [ ]  Transfer case to another unit |

**\*** Other

|  |  |  |
| --- | --- | --- |
|       |  | Click or tap to enter a date. |
| **Social Worker’s signature** |  | **Date assessment completed** |
|  |  |  |
|  |  | Click or tap to enter a date. |
| **Supervisor’s signature** |  | **Date** |