COMMUNITY SERVICES
Senior Services

CARE MANAGEMENT ASSESSMENT

REFERRED BY: ☐ SELF ☐ FAMILY/FRIEND/NEIGHBOR ☐ APS ☐ IPD ☐ COUNTY AGENCY ☐ MEDICAL FACILITY/HEALTH CARE PROVIDER ☐ FOR FAMILIES ☐ OTHER: _____

REFERRAL DATE:	***INITIAL ASSESSMENT DATE:***
TERMINATION DATE:	***TERMINATION REASON:***

CLIENT INFORMATION

NAME*			***DATE OF BIRTH***
LAST	FIRST	MI	
ADDRESS*			MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ SIGNIFICANT OTHER/PARTNER ☐ DIVORCED ☐ WIDOWED
CITY	STATE	***ZIP***	PHONE*
EMERGENCY CONTACT NAME*	RELATIONSHIP		EMERGENCY CONTACT PHONE*

RACE/ETHNICITY

RACE (Select all that apply): ☐ DECLINED/NOT STATED

☐ WHITE/CAUCASIAN
☐ BLACK/AFRICAN AMERICAN
☐ AMERICAN INDIAN/ALASKA NATIVE
☐ ARAB
☐ PACIFIC ISLANDER

Asian:

☐ AFGHAN
☐ ASIAN INDIAN
☐ CHINESE
☐ FILIPINO
☐ JAPANESE
☐ KOREAN
☐ PERSIAN
☐ VIETNAMESE
☐ OTHER ASIAN

ETHNICITY:

☐ NOT HISPANIC/LATINO
☐ HISPANIC/LATINO
☐ DECLINED/NOT STATED

DEMOGRAPHICS

WHAT IS YOUR GENDER?

☐ MALE ☐ FEMALE ☐ DECLINED/NOT STATED
☐ NOT LISTED; SPECIFY: _____
☐ **LGBTQ*:** _____

NUMBER IN HOUSEHOLD: _____
☐ DECLINED/NOT STATED

FEMALE HEAD OF HOUSEHOLD: ☐ YES ☐ NO

LIVING ARRANGEMENT(Check all that apply):

☐ LIVES ALONE
☐ LIVES WITH OTHERS (FAMILY/FRIEND)
☐ HOMEOWNER
☐ RENTER
☐ INDEPENDENT LIVING/ ASSITED LIVING FACILITY
☐ RISK OF HOMELESSNESS
☐ HOMELESS
☐ DECLINED/NOT STATED

CASE MANAGEMENT ASSESSMENT

CLIENT ASSESSMENT

ASSESSMENT DATE	TYPE OF COMMUNICATION
	☐ HOME VISIT ☐ PHONE CALL

LANGUAGE SPOKEN

PRIMARY: SECONDARY:

HOUSEHOLD INCOME ☐ DECLINED TO STATE

ANNUAL INCOME (ESTIMATED): _____

INCOME SOURCE: ☐ SS ☐ SSI ☐ SSDI ☐ PENSION ☐ OTHER: _____

REASON FOR CARE MANAGEMENT SERVICES (Check all that apply)

☐ COGNITIVE OR PHYSICAL DECLINE/ISSUES ☐ ISOLATION ☐ CAREGIVER STRESS ☐ EMOTIONAL WELLNESS/HEALTH
☐ LACK OF FAMILY SUPPORT/SUPPORT SYSTEM ☐ LANGUAGE BARRIER ☐ OTHER: _____

SUPPORT FROM	ASSISTIVE DEVICES	OWNS A PET
☐ FAMILY ☐ NEIGHBOR ☐ NONE ☐ FRIEND ☐ PAID CAREGIVER: _____ HOURS/WEEK	☐ CANE ☐ WALKER ☐ ERS ☐ WHEELCHAIR	☐ YES ☐ NO

TRANSPORTATION USED	DRIVES
☐ SELF ☐ FRIEND ☐ ACCESS/OCTA ☐ OTHER: _____ ☐ FAMILY ☐ NEIGHBOR ☐ TRIPS ☐ NONE	☐ YES ☐ NO

ALLERGIES (Food or Medications)	DIABETIC	LTC INSURANCE	POLST	AHCD
☐ YES If YES, please list: ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

VETERAN STATUS	MULTIPLE MEDICATIONS	MEDICAL MANAGEMENT METHOD
☐ VETERAN ☐ FAMILY OF VETERAN	☐ YES ☐ NO	☐ NONE ☐ VERBAL REMINDER FROM FAMILY/CAREGIVER ☐ MEDICATION PILL BOX ☐ AUTOMATIC MEDICATION DISPENSER

PRESENTING PROBLEMS (Check all that apply)

☐ BREATHING/O2
☐ CARE GIVING
☐ COGNITIVE LOSS
- ☐ MILD
- ☐ MODERATE
- ☐ SEVERE

☐ DENTAL
☐ FINANCIAL
☐ HOH
☐ HOUSEHOLD SAFETY: _____
☐ ISOLATED

☐ LEGAL
☐ LANGUAGE BARRIERS
☐ LOW VISION
☐ MOBILITY
☐ PHYSICAL

☐ SLEEP
☐ SMOKE ALARM
☐ SMOKES
☐ TRANSPORTATION
☐ OTHER: _____

CASE MANAGEMENT ASSESSMENT

EMOTIONAL/MENTAL HEALTH (Check all that apply)

☐ EMOTIONAL ☐ AGITATED ☐ CONFUSED ☐ LONELY ☐ SUICIDAL; HISTORY: _____

☐ ANGRY ☐ HOMICIDAL ☐ PARANOID WEAPON(S): _____

☐ ANXIOUS ☐ LETHARGIC ☐ SAD RISK ASMT COMPLETED: _____

☐ SUBSTANCE USE ☐ YES; TYPE: _____

☐ NO

SIGNIFICANT CHANGES (In the last 3 months)

☐ ER/HOSPITALIZED ☐ FALLEN ☐ OTHER: WHEN: LENGTH OF TIME:

SUGGESTED SERVICES (Mark all that apply - RECOMMENDED [+]; IN PLACE [O])

APS	ERS	FRIENDLY VISITOR/ CALLER	HANDY MAN	HOME MOD	CHORE	PERSONAL CARE	HOME MAKER	IADHS	IMOW	MENTAL HEALTH/ OAS	FOR FAMILIES	SENIOR CENTER/ REC	TRANS-PORTATION	VETERANS AFFAIRS	MEDICAL	LEGAL

☐ OTHER/UNMET NEEDS:

ACTIVITIES OF DAILY LIVING (ADL) / INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

Rate the following activities:

1=Independent
2=Verbal Assistance
3=Some Help
4=Lots of Help
5=Dependent
6=Declined to State

ACTIVITIES OF DAILY LIVING:

EATING	_____	TRANSFER (CHAIR/BED)	_____
BATHING	_____	WALKING	_____
TOILETING	_____	DRESSING	_____
		TOTAL ADL#	_____

INSTRUMENTAL ACTIVITIES OF DAILY LIVING:

MEAL PREP	_____	USE OF PHONE	_____
SHOPPING	_____	HEAVY HOUSEWORK	_____
MEDICATION MGMT	_____	LIGHT HOUSEWORK	_____
MONEY MGMT	_____	TRANSPORTATION	_____
		TOTAL IADL#	_____

KEEN CENTER SUPPORT IN PLACE

☐ ASSISTANCE PROGRAMS: _____

☐ SUPPORT GROUP: _____

☐ TRANSPORTATION SERVICE: _____

I CERTIFY THE ABOVE INFORMATION IS CORRECT.

_____ _____
SIGNATURE* (REQUIRED) DATE

FOR OFFICE USE ONLY COMPLETED BY: _____ DATE: _____