COMMUNITY SERVICES
Senior Services

☐ #1 ☐ #2 ☐ #3

☐ C-2 HOME-DELIVERED MEALS
☐ CASE MANAGEMENT ☐ PERSONAL CARE
☐ HOMEMAKER ☐ CHORE CLIENT REASSESSMENT

TERMINATION DATE:	***TERMINATION REASON:***

CLIENT INFORMATION

GENDER

☐ MALE ☐ FEMALE ☐ OTHER ☐ DECLINED TO STATE

NAME*			CLIENT PHONE*
LAST	FIRST	MI	

EMERGENCY CONTACT NAME*	RELATIONSHIP	EMERGENCY CONTACT PHONE*

CLIENT ASSESSMENT

ASSESSMENT DATE	TYPE OF COMMUNICATION
	☐ HOME VISIT (Pink) ☐ PHONE CALL (Yellow)

REASON FOR HOME DELIVERED MEALS/CARE MANAGEMENT SERVICES	DAYS OF SERVICE REQUESTED
☐ 60+ ☐ DISABLED ☐ CAREGIVER ☐ INABILITY TO SHOP ☐ POOR EATING HABITS	☐ MON ☐ TUE ☐ WED
☐ INABILITY TO COOK MEALS ☐ OTHER ______	☐ THU ☐ FRI

HAS A CAREGIVER	HOURS/WK	ASSISTIVE DEVICES
☐ YES ☐ NO		☐ CANE ☐ WALKER ☐ WHEELCHAIR ☐ NONE

PRESENTING PROBLEMS (Check all that apply)

☐ BREATHING/O2 ☐ LANGUAGE BARRIERS ☐ COGNITIVE LOSS ☐ MILD ☐ MODERATE ☐ SEVERE
☐ CARE GIVING ☐ LOW VISION ☐ EMOTIONAL
☐ DENTAL ☐ MOBILITY ☐ AGITATED ☐ ANXIOUS ☐ HOMICIDAL ☐ LONELY ☐ PARANOID
☐ FINANCIAL ☐ PHYSICAL ☐ ANGRY ☐ CONFUSED ☐ LETHARGIC ☐ SAD ☐ SUICIDAL
☐ HOH ☐ SLEEP ☐ SMOKES ☐ HOUSEHOLD SAFETY ______
☐ LEGAL ☐ TRANSPORTATION ☐ SMOKE ALARM ☐ OTHER ______

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	CARE MGMT	EMERG. RESPONSE	FRIENDLY VISITOR/ CALLER	HANDY MAN	HOME MAKER/ CHORE	IADHS	IMOW	MENTAL HEALTH/ OAS	PERSONAL CARE	SENIOR CENTER	SHOPPING	TRANS-PORTATION	VETERANS AFFAIRS	MEDICAL	LEGAL

☐ OTHER / UNMET NEEDS ______

C-2 CLIENT REASSESSMENT

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

Rate the following activities:
1=Independent
3=Some Human Help
4=Lots of Human 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#	________

COMMENTS / RECOMMENDATIONS

I CERTIFY THE ABOVE INFORMATION IS CORRECT.

PARTICIPANT SIGNATURE* ________ DATE ________

FOR OFFICE USE ONLY

ID# ________ COMPLETED BY ________ DATE ________