COMMUNITY SERVICES
Senior Services

☐ #1 ☐ #2 ☐ #3

CARE MANAGEMENT REASSESSMENT

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*

DEMOGRAPHICS

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

FEMALE HEAD OF HOUSEHOLD: ☐ YES ☐ NO

CLIENT ASSESSMENT

ASSESSMENT DATE	TYPE OF COMMUNICATION
	☐ HOME VISIT ☐ PHONE CALL

LANGUAGE SPOKEN

PRIMARY: SECONDARY:

REASON FOR CARE MANAGEMENT SERVICES (Check all that apply)

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

CASE MANAGEMENT REASSESSMENT

SUPPORT FROM	ASSISTIVE DEVICES	DRIVES
☐ FAMILY ☐ NEIGHBOR ☐ NONE ☐ FRIEND ☐ PAID CAREGIVER: _____ HOURS/WEEK	☐ CANE ☐ WALKER ☐ ERS ☐ WHEELCHAIR	☐ YES ☐ NO
ALLERGIES (Food or Medications)	**MULTIPLE MEDICATIONS**	**DIABETIC**
☐ YES If YES, please list: ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

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: _____

EMOTIONAL/MENTAL HEALTH (Check all that apply)

☐ EMOTIONAL ☐ AGITATED ☐ ANGRY ☐ ANXIOUS ☐ CONFUSED ☐ HOMICIDAL ☐ LETHARGIC ☐ LONELY ☐ PARANOID ☐ SAD

☐ SUICIDAL; HISTORY: _____
WEAPON(S): _____
RISK ASMT COMPLETED: _____

☐ SUBSTANCE USE ☐ YES; TYPE: _____ ☐ NO

SIGNIFICANT CHANGES (In the last 3 months)

☐ ER/HOSPITALIZED ☐ FALLEN ☐ OTHER (Describe below) 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:

CASE MANAGEMENT REASSESSMENT

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 GROUPS: _____
- ☐ TRANSPORTATION SERVICES: _____

I CERTIFY THE ABOVE INFORMATION IS CORRECT.

_____ _____
SIGNATURE* (REQUIRED) DATE