



Rhode Island Department of Human Services Rhode Island Department of Elderly Affairs

CASE MANAGEMENT ASSESSMENT

REFERRAL

Assessment Date: _____ Referral Type: HCBS Nursing Preventive Initial
 Effective Date: _____ Re-Assess Sherlock Plan Other
 Location: Home NH Other (specify: _____)
 Social Caseworker: _____ Tel. No.: _____
 Agency/Unit: _____

CLIENT IDENTIFYING DATA

Name: _____ DOB: _____ SSN: _____
 Address: _____ Apt#: _____ Floor: _____
 City/Town: _____ Zip: _____ Telephone Number: _____
 Primary Language: _____ Interpreter Needed: Yes No
 Primary Contact Person: _____ Caregiver: Yes No
 Relationship _____ Contact Telephone Number _____
 Address: _____ City/Town _____ State _____ Zip _____

LIVING ARRANGEMENTS

Lives Alone Nursing Home _____ Admission Date
 Subsidized Housing Group Home _____ Admission Date
 With Others Residential/Assisted Living _____ Admission Date

Please specify relationship: _____

FUNCTIONAL ABILITY**A. HOMEMAKING CAPABILITIES** (Please use Functional Codes)**Functional Codes***** Explain Limitations/Extra Needs**

_____ Cleaning _____

_____ Laundry _____

_____ Shopping _____

_____ Meal Preparation _____

B. PHYSICAL FUNCTIONAL ABILITIES (Please use Functional Codes)**Functional Codes***** Explain Limitations/Extra Needs**

_____ Ambulation _____

_____ Transfers _____

_____ Bathing _____

_____ Dressing _____

_____ Eating _____

_____ Toileting _____

_____ Medication Management _____

Comments: _____

CODE KEY To Be Used When Completing Assessment Forms**Code for individual's actual level of involvement in self-care over 24 hours for the last 7 days.**

0 = Independent -No help or oversight – **OR** – help/oversight provided only 1 or 2 times during the last seven days.

1 = Supervision - Oversight, encouragement or cueing provided 3 or more times –**OR-** Supervision (3 or more times) plus limited physical assistance provided only 1 or 2 times during the last seven days.

2 = Limited Assistance -Individual highly involved in activity, received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 3 or more times –**OR-** Limited assistance (3 or more times) plus extensive assistance provided only 1 or 2 times in the last 7 days.

3 = Extensive Assistance -While individual performed part of activity, weight-bearing support or full caregiver performance 3 or more times over part (but not all) of the last seven days.

4 = Total Dependence -Full caregiver performance of the activity each time the activity occurred during the entire seven-day period. There is complete non-participation by the individual in all aspects of the ADL definition task. If the caregiver performed an activity for the individual during the entire observation period, but the individual performed part of an activity him/herself, it would **NOT** be coded as a "4" Total Dependence.

Equipment Needed: _____

Comments: _____

C. MENTAL STATUS (Check all that apply)

- Alert Disoriented Forgetful Verbally abusive or threatening
- Agitated Depressed Withdrawn Confused
- Anxious Disruptive Pleasant and cooperative

SCW Observation/Source of Information: _____

D. HEARING, SPEECH & VISION

Hearing Impaired: Yes No Speech Impaired: Yes No Vision Impaired: Yes No

Comments: _____

E. ENVIRONMENTAL/SAFETY CONCERNS: Please check off those that apply:

- Dangerous stairs or floors Poor lighting and/or electrical wiring
- Heating or cooling Problems with water, plumbing or septic system
- Major appliances (including refrigerator) Odor or pests
- Stairs to enter or leave house Obstacles within home
- Obstruction to entrance of home Inadequate locks on doors and/or windows

Other (please describe other safety concerns): _____

RECENT ACCIDENTS/FALLS: _____

F. INFORMAL SUPPORTS (FAMILY, FRIENDS, ETC.)

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>CONTACT INFORMATION</u>
_____	_____	_____
_____	_____	_____

Pet(s): Yes No Type(s): _____

HEALTH CARE AND COMMUNITY SUPPORTS

Services

Provider(s)

Physician

Specialist

Dentist

Skilled Nursing / P.T. / O.T. / Speech

Medical Equipment

Mental Health/Substance Abuse

Out-Patient Treatment
(Radiation/Chemotherapy/Dialysis)

Medication Reminder/Cueing

Adult Day Care

Senior Center

Meal Site

Transportation

Other

SUMMARY / RECOMMENDATIONS (Give reasons for level of care/need for services). Include caregiver's participation in care plan.

Signature of Social Caseworker

Date