NORTH CAROLINA

HOME CARE INDEPENDENCE PROGRAM

SERVICE ASSESSMENT/REASSESSMENT FORM

Initial____ or Annual____ or Other____

DATE_____

Participant_____
Address_____
_____ Tele:_____
Date of Birth_____
Marital Status: M_ S_ D_ W_ If married, name of spouse_____

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I. <u>Health Status</u> …..Ask the following of the Participant and note any observations relative to mental agility:

	Yes	No	Comments
✓ High blood pressure	___	___	_____
✓ Any heart related concerns	___	___	_____
✓ Ever had a stroke	___	___	_____
✓ Diabetes	___	___	_____
✓ Bone/Joint problems	___	___	_____
✓ Cancer	___	___	_____
✓ Respiratory problems	___	___	_____
✓ Allergies	___	___	_____
✓ Short term memory issues	___	___	_____
✓ Long term memory issues	___	___	_____
✓ Ever had mental disorder	___	___	_____
✓ Vision problems	___	___	_____
✓ Hearing problems	___	___	_____
✓ Speech problems	___	___	_____
✓ Dental problems	___	___	_____
✓ Incontinent	___	___	_____

Are you currently receiving treatment for any of the above or for any other condition? Yes___ No___
If Yes, for what? _____

What medications do you take on daily basis? Please specify……

Participant does not take daily medications_____

Primary Physician: Name_____
Address_____ Telephone_____

II. Activities and Instrumental Activities of Daily Living…..

ADLs	Independent	Needs Some Help	Needs Total Help
Eating			
Dressing			
Bathing			
Toileting			
Ambulation			
Transfers			

Comments regarding ADLS:

_____

_____

_____

IADLs	Independent	Needs Some Help	Needs Total Help
Meals			
Cleaning			
Money Mngmt.			
Tele. Usage			
Laundry			
Reading			
Writing			
Shopping			
Transportation			

Comments regarding IADLs:

_____

_____

_____

III. Environmental

Home Type: House___ Apt.___ Mobile___
Home Ownership: Owns___ Rents___
Condition of Home: Clean___ Cluttered___ Needs repairs___
Adequate cooking and/or plumbing facilities: Yes___ No___
Any comments about the condition of the home:

_____

IV. Social

Who has been involved in the care of this Participant?
Agency caregiver___
Family member___ Specify_____
Friend___ Specify_____
Privately hired person___

Does the Participant have family members who attend to needs of this person as they arise? Yes___ No___

Does the person seem to have a good support system of both friends and relatives? Yes___ No___

Does the Participant engage in social activities in the community?
Yes___ No___

What community agencies provide assistance to this person?
None___
Specify those they do assist, if any_____

V. Economic

Total monthly income of Participant and Spouse, if married_____
Sources of income: Soc.Sec.__ SSI___ VA pension___ other___

Financial Affairs managed by:
Participant___ Relative___ Guardian___ Trust___
Power of Attorney___ Other____(specify)_____

If person manages his/her own finances, does it appear that there are problems? Yes___ No___

VI. Summary Comments by Assessor:

_____
_____
_____
_____
_____
_____
_____

Signature of Assessor_____ Title_____
Date_____