

# Adult Services Functional Assessment

Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

Case # \_\_\_\_\_

ID # \_\_\_\_\_

## I. Social *(Complete or modify face sheet as needed.)*

A. Client's/family's perception of client's *social* functioning.

B. When the client has a problem, who is the person he/she can most rely on? *(name, relationship)*

C. Dimensions of social functioning *(Use a genogram or ecomap if social network is large or complex. See appendix of social worker's recordkeeping guide.)*

1. Client's abilities/preferences/barriers in forming and maintaining relationships *(e.g., isolated, likes daily contacts, prefers solitude, shy, unable to communicate)*

2. Does the client have a caregiver/caretaker? *(If yes, describe dynamics, e.g., satisfaction of client and of caregiver, other responsibilities and strains on caregiver, evidence of burnout, strains on client, rewarding relationship for caregiver/client.)*  **Yes**       **No**

3. Dynamics of relationships with and among family, friends, and others *(e.g., neighbors, facility staff, past or present coworkers, church and other organizations, pets). Include pertinent information on cultural values, family roles, sources of strain and satisfaction.*

4. Significant history/changes in client's/family's social functioning.

## II. Environment

A. Client's/family's perceptions of the home and neighborhood environment.

B. Type of residence

Other - Explain below

Facility/Group Home

Specify shelter below

C. Location

D. If client lives in a house, mobile home, or apartment, who is head of household?

List below head of household or if Other - Explain

E. Inadequate, unsafe, or unhealthy conditions in client's environment (*space for comments/ explanations below if needed.*) If client is in a facility, record environmental issues/concerns under comments.

<input type="checkbox"/> Access within Home	<input type="checkbox"/> Eating Area	<input type="checkbox"/> Lighting	<input type="checkbox"/> Shopping, access	<input type="checkbox"/> Transportation	
<input type="checkbox"/> Access, exterior	<input type="checkbox"/> Electrical Outlets	<input type="checkbox"/> Living Area	<input type="checkbox"/> Sleeping Accommodations	<input type="checkbox"/> Trash Disposal	
<input type="checkbox"/> Bathing facilities	<input type="checkbox"/> Fire Hazards/ No Smoke Detectors	<input type="checkbox"/> Locks/ Security	<input type="checkbox"/> Structural Integrity	<input type="checkbox"/> Ventilation	
<input type="checkbox"/> Cooking Appliance	<input type="checkbox"/> Heating	<input type="checkbox"/> Pests/Vermin	<input type="checkbox"/> Telephone	<input type="checkbox"/> Water/Plumbing	
<input type="checkbox"/> Cooling	<input type="checkbox"/> Laundry	<input type="checkbox"/> Refrigerator	<input type="checkbox"/> Toilet	<input type="checkbox"/> Yard or other area immediately outside of residence	<input type="checkbox"/> Other - Describe below

List Comments/Explanations and/or Describe Other below.

F. Is there anything in the home or neighborhood that poses a threat to the client's mental or physical health, safety, or ability to receive services?

G. Environmental Strengths

## III. Mental/Emotional Assessment

A. Client's/family's perception of client's mental/emotional health

B. Were any mental/cognitive assessment instruments used by Social Worker or a mental health professional? **If yes, record results below.** *Sample assessment instruments are included in the appendix of the Social Worker's record keeping guide.*  **Yes**  **No**

Instrument	Given By	Findings/Conclusions

C. Mental, emotional, and cognitive problems, diseases, impairments and symptoms

Diagnosis/Sympton	Source Code	Other - Specify	Notes (e.g., onset, severity, functional impact, history, untreated condition, needs professional assessment)
Aggressive/abusive behavior			
Agitation/anxiety/panic attack			
Change in activity level (sudden/extreme)			
Changes in mood (sudden/extreme)			
Change in appetite			
Cognitive impairment/memory impairment <b>(SPECIFY)</b>			
Developmental disability/mental retardation <b>(SPECIFY)</b>			
Hallucinations/delusions			
Inappropriate affect (flat or incongruent)			
Impaired judgment			
Mental anguish			
Mental illness <b>(SPECIFY)</b>			
Orientation impaired: person, self, place, time			
Persistent sadness			
Sleep disturbances			
Substance abuse <b>(SPECIFY)</b>			
Thoughts of death/suicide			
Wandering			
Other:			
Other:			

D. Past and present hospitalizations/treatments for mental/emotional problems (*Include patient, outpatient, therapy, and substance abuse recovery programs and names of current therapists or other involved mental health professionals.*)

E. Is there a history of mental illness or substance abuse in the client's family or household? **If yes, describe below.**  **Yes**  **No**

F. Strengths in the mental or emotional status of the client/family.

#### IV. Physical Health

A. Client's/family's perception of client's health status.

B. Physical health problems: diseases, impairments and symptoms

Diagnosis/Sympton	Source Code	Other - Specify	Notes (e.g., onset, severity, functional impact, history, untreated condition, needs professional assessment)
Arthritis/osteoporosis/gout			
Asthma/emphysema/other respiratory			
Bladder/urinary problems/incontinence			
Bruises			
Burns			
Cancer			
Dental Problems			
Diabetes			
Dizziness/Falls			
Eye Disease/Conditions			
Headaches			
Hearing difficulty			
Heart disease/angina			
Hypertension/high blood pressure			
Kidney disease/renal failure			
Liver diseases			
Malnourished/dehydrated			
M. Sclerosis/M.Dystrophy/Cerebal Palsy			
Pain			
Paraplegia/quadriplegia/spinal problems			
Parkinson's Disease			
Rapid weight gain/loss			
Seizures			
Sores ( <b>Specify</b> )			
Speech Impairment			
Shortness of breath/persistent cough			
Stroke			
Other:			
Other:			

C. Does the client have any sensory or health problems that impair his/her ability to make or communicate responsible decisions?

D. Medical Providers	Notes (type provider, regular or as needed, etc.)

E. Medications (prescription and over-the-counter) and Treatments (e.g., special diet, massage)	Name	Comments (dosage, compliance issues, side effects, other)

F. Does the client need assistance with medication or treatment?  **Yes**  **No**  
**If yes, is he/she receiving the assistance needed.**  
 No Assistance needed  Assistance received from:   
 Assistance needed, but not received

G. Other significant client/family history, including hospitalizations and outpatient procedures.

H. Durable Medical Equipment/Assistive Devices/Supplies  
 (Record **U** if client uses it now, **N** if client needs it but does not have it. )

<input type="checkbox"/>	Cane	<input type="checkbox"/>	Crutches	<input type="checkbox"/>	Grab bars	<input type="checkbox"/>	Ostomy/ Colostomy Bags	<input type="checkbox"/>	Telephone Alert Device
<input type="checkbox"/>	Catheter	<input type="checkbox"/>	Dentures	<input type="checkbox"/>	Hearing Aid	<input type="checkbox"/>	Oxygen Equipment	<input type="checkbox"/>	Walker
<input type="checkbox"/>	Commode (seat/ bedside)	<input type="checkbox"/>	Diabetic Supplies	<input type="checkbox"/>	Hospital Bed	<input type="checkbox"/>	Prosthesis	<input type="checkbox"/>	Wheelchair
<input type="checkbox"/>	Communication Devices	<input type="checkbox"/>	Glasses	<input type="checkbox"/>	Incontinence Supplies	<input type="checkbox"/>	Ramp	<input type="checkbox"/>	Other - Describe Below

**Comments/Explanations/Other:**

I. Strengths in client's/family's physical health.

**V. ADL/IADL**

A. Client's/family's perceptions of the client's ability to perform the activities of daily living (basic and instrumental)

B. Review of activities of daily living (basic and instrumental)

	Help needed?			Need met? 1 - Yes 2 - Partial 3 - No	Comments (e.g., who assists, equipment used, problems or issues for caregivers)
	None	Some	Total		
<b>ADL Tasks</b>					
Ambulation					
Bathing					
Dressing					
Eating					
Grooming					
Toileting					
Transfer					
to/from bed					
into/out of car					
<b>IADL Tasks</b>					
Home maintenance					
Housework					
Laundry					
Meal Preparation					
Money management					
Shopping/errands					
Telephone use					
Transportation use					

C. **(For APS use only)** Is the client incapacitated, and without someone able, willing and responsible to provide assistance?  Yes  No

Comments/Explanation

D. Is the client able to read?  Yes  No    Is the client able to write?  Yes  No

E. Client/family strengths

**VI. Economic**

A. Client's/family's perception of client's financial situation and ability to manage finances.

B. Monthly income (from all sources)

Social Security/ SSI		Retirement/VA/RR		Other - Type		Other - Amount	
-------------------------	--	------------------	--	-----------------	--	-------------------	--

C. Other resources (e.g., food stamps, subsidized housing, property, Medicare, Medicaid)

D. Monthly Expenses

Clothes/ Laundry		Heat		Medical		Transportation		Water/ Sewer	
Food/ Supplies		Insurance Type		Rent/ Mortgage		Utilities		Other	

**Insurance type or Other explain:** \_\_\_\_\_

E. Home/property ownership: \_\_\_\_\_

F. Are there any problems/irregularities in the way the client's money is managed (*by self or others*)  
 Yes       No

**If yes, please explain:** \_\_\_\_\_

G. If expenses exceed income, what does the client do to manage?  
 \_\_\_\_\_

H. Client/family strengths  
 \_\_\_\_\_

**VII. Formal Services Currently Received by Client. *If none, check here:***

Service	Provider	Comments
Adult Day Care		
CAP (Community Alternative)		
Case Management		
Counseling		
Employment Services		
Food Stamps		
In-home aide/PCS		
Legal Guardian		
Meals (Congregate/Home)		
Medicaid		
Mental Health Services		
Nursing Services		
Payee		
Public/Subsidized Housing		
Shelter Workshops		
Skilled Therapies (PT, OT, ST)		
Telephone Alert/Reassurance		
Transportation		
Other:		
Other:		

**Information from collateral contacts, if appropriate.** (*Include date, name, relationship or position. Attach additional sheets if needed.*)

**Additional notes (optional)** *This space provided for any relevant information that needs documentation and does not fit elsewhere on the tool.*

**Summary of Findings - Including strengths and problems**

**Documentation of eligibility for specific services:**

**Next step(s)** *(Check all that apply)*

<input type="checkbox"/> Close case	<input type="checkbox"/> Develop Goals/Service Plan	<input type="checkbox"/> Transfer Case to Another Unit
<input type="checkbox"/> Complete APS Disposition	<input type="checkbox"/> Make Referral to Another Agency	<input type="checkbox"/> Other - Explain below

**If other, explain:**

Social Worker's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_