

Assessment: Data Collection

As *A Model for Excellence in Adult Services Administration and Social Work Practice* suggests, the cornerstone of adult services social work is the comprehensive functional assessment. This chapter introduces the “Adult Services Functional Assessment” tool. The Assessment is not designed to be used as an interview tool with clients and families. It is used to record pertinent information gathered during the process of assessment. The Assessment is comprehensive in that it covers six functional domains considered essential to the well-being of clients and families. These domains are social, environmental, mental and emotional health, physical health, ADLs and IADLs, and economic. The term “functional” refers to the importance of assessing how well the client is able to do things in each of the domains. The tool can be used in all program areas funded through Social Services Block Grants (SSBG) and Home and Community Care Block Grants (HCCBG). It is not designed to be used in the work of Adult Homes Specialists and Adult Day Care Coordinators in their monitoring and licensing/certifying activities.

Functional capacity is a better predictor of how much independence the client can maintain than diagnosis. For example, two people with diabetes may show vastly different strengths and limitations in functioning; so, too, may two people who have recently lost a spouse. One

person with diabetes may have the disease under control with medication and/or diet, whereas another may be suffering the complications of visual impairment and fatigue. Similarly, one bereaved person may still be engaged with family and friends and enjoying the support they provide; another person may be despondent and isolated, showing signs of depression and malnourishment.

The Social Work behind the Record

A Model for Excellence makes five key points about excellence in adult services assessments. It suggests that effective social work practice

- distinguishes between functional assessment and diagnosis
- requires a functional assessment in the social, environmental, mental, physical, ADL and IADL, and economic domains
- assesses client’s and family’s strengths and identifies problems and areas in which they want change to occur
- assesses the services the client currently receives, as well as the client’s and family’s values and preferences about new strategies and interventions
- requires awareness of the strengths and limits of the social worker’s own knowledge and when to seek help from others (based on p. 80).

A Model for Excellence makes two other valuable points about the assessment process. First, the collection of information is useful only if it helps you, the client, and the family identify areas where change is desired, and then makes it easy to clarify goals and take action. Helping clients and families identify problems, make sense of them, and perhaps rethink and reframe them is one of your principal roles as a social worker and the key to helping clients become empowered. Second, you can only do this through an effective relationship with the client and family. The assessment process is your first

extended opportunity to develop a collaborative relationship with clients and families. It provides you with the information base you will use together to develop goals and plan actions, but to begin with, it provides a time when clients and families tell you their story. Your attentiveness acknowledges and validates how they feel about their world.

Why Is the Assessment Tool Important?

The most important thing to know first about the assessment tool is what it is not intended to be: a guide for interviewing. Rather, it is a place to start, because it suggests what information should be included in most assessments, and it is a place to end, where “you hang it all up at the end of the day” by recording relevant things you learned during the assessment process. The tool is important because it provides a structure for recording, analyzing, and synthesizing what you learn.

Second, the tool aids supervisors in their support of workers. It allows easy reference to information for a case staffing. It enables your supervisor to see how you have made connections among the bits of information and drawn conclusions.

A third benefit of the tool is that, when completed, it provides a baseline of information. It can then be used in conjunction with the Interim or Quarterly Reviews and the Adult Services Annual Reassessment for monitoring changes in the client’s and family’s status over time.

Using the Assessment Tool

Flexibility should be your watchword in using the assessment tool. The client and family’s needs and your own judgment will determine the order in which you collect information, the level of detail, and type of information you provide for a particular assessment. Let’s consider these three points individually.

First, your clients’ (and their families’) principal concerns and your own style will probably

guide the *order* in which you gather information. The tool is not a questionnaire. It is not meant to provide either the wording of the questions you ask or the order in which you ask them. Having a structured order in which information appears in the record will help you later, but you do not have to gather or record it in that order (that is, nothing says you have to fill out page 2 before you do page 4).

Second, you will need to exercise your social work judgment about how much information is needed in any given area for each client. You are **not** required to fill “every space for every case,” and in some instances it would be inappropriate to do so. For example, if your client is living in a domiciliary care facility, you will probably document sparingly in the area of physical environment unless there is some obvious deficit that poses a problem for your client.

Third, according to your client’s circumstances you will include different kinds of information in the same space. For example, an APS worker will use the space for documenting the caregiver/client relationship according to the specific requirements of the law and their roles in providing services (i.e., whether there is someone who is able, responsible, and willing to provide care), while a social worker doing a more general assessment might write about the quality of the relationship between caregiver and client or document any evidence of strain or burnout in the family.

The identifying information (case number and ID #), recorded in the upper right hand corner, is meant only to assure that the tool can be easily identified when it is removed from the case file. If your system does not file cases this way, you will probably not need to include it. The date space on the first page is meant for the date that the assessment is started. There is space by the signature space on the last page to record the date that the assessment was completed.

The Functional Domains

Social

As emphasized in *A Model for Excellence*, the assessment of social functioning considers both the “quantity” and “quality” of the client’s relationship with family, friends, and the community (p. 69). Demographic information, such as the names and relationships of other people in the home, is recorded on the face sheet and should not be duplicated here. This section of the assessment is more focused on the quality of social relationships, including both positive and negative aspects.

A. Client’s/Family’s Perception

Fundamental to building an effective working relationship and helping the client and family become empowered is valuing their perceptions of the situation. That is why each domain begins with space to record the client’s and family’s opinions about how well the client is functioning in that domain. In this instance, Mrs. Johnson and her family (probably her son) might be asked how they think she is getting along with other people in her family and community. You would then record impressions from what you hear them say and from what you observe. It is useful to identify separately what the client might share from what the family describes, especially if there are important differences, as in the case of Mrs. Johnson and members of her family.

B. Person Client Can Rely On

This space allows you to note a significant resource—the person a client turns to with problems. This may or may not be the same individual the client indicated as an emergency contact person on the face sheet.

C. Dimensions of Social Functioning

This series of four questions allows you to document various aspects of the social functioning of clients and their families. The first space provides a place to record the client’s abilities to engage in social interactions (e.g., engaging, isolated, inhibited, or outgoing), their prefer-

ences for social relationships (e.g., few but intense relationships with one or two people or socializing with a wide variety of friends and family), and the barriers they face in forming or maintaining relationships (e.g., little transportation, caregiving burdens that restrict opportunities, no telephone). In the example, Mrs. Johnson’s social worker has chosen to record her personal preference for privacy and her desire for more contact with her son’s family as the most important aspects of her preferences.

The section labeled C-2 gives you a place to record the presence or absence of a caregiver and to elaborate on the dynamics of the caregiving relationship. For example, are both client and caregiver satisfied with the arrangement, or is the caregiver beginning to feel burdened by responsibilities? APS workers using this tool will fill this out in terms of the meaning of caretaker within the APS law and will document whether the caretaker is willing, able, and responsible to give needed care. Mrs. Johnson does not have a caregiver, and her social worker has checked “no,” but has added a note that her family is providing some assistance with IADLs.

Section C-3 provides space for you to document the dynamics of relationships the client has with family, friends, and others. You may also use this space to record the nature of the relationships these individuals have among themselves. For example, you might record disagreements among family members about their appropriate roles in providing care for their relative or document how well the family pulls together for the benefit of the client. If you use a genogram or ecomap (see appendix) in assessing the social network, you may note the tool you used here. Mrs. Johnson’s social worker has used this space to talk about several different things—the limited involvement of neighbors and the church, the heavy demands on her son’s family, a strained relationship between Mrs. Johnson and her sister, and some tension felt by her daughter-in-law about Mrs. Johnson’s demands on her son and family (amplifying some of the information she

presented in section A about the client's and family's perceptions).

The last space in the social domain of the assessment is for recording significant past aspects of client's and family's social functioning. You might record important milestones that change social functioning such as births, marriages, retirement, or deaths. You could also record strong positive family relationships, family violence or abuse, or other history that seems relevant. Mrs. Johnson's social worker uses this space to mention the deaths of Mrs. Johnson's husband and daughter and describes how her relationship with her church has changed since her husband's final illness. The history may reflect positive changes as well as losses. For example, in another case, a social worker might write about the things the client likes to do, about the client's excitement over the birth of a new grandchild, or about how she has rediscovered old friendships or made new ones recently.

Environment

As explained in *A Model for Excellence*, the focus of an environmental assessment is to determine whether clients' surroundings contribute to or detract from their functioning and well-being. Information from the assessment can also be used to evaluate whether services can be provided safely. The environmental assessment considers the areas of safety, adequacy, and accessibility in clients' homes and surroundings, as well as the importance clients attach to living where they do.

A. Client's/Family's Perception

The first section provides space for you to document how the client and family feel about the client's living arrangements. This space might include their perceptions about safety; how adequate to their needs they consider the housing, furnishings, and neighborhood to be; whether it is accessible to friends and family; and how important this particular housing is to the client. You will see that Mrs. Johnson stated very strongly that her home is very dear to her and that she wants to remain in it.

B, C, and D: General Information

Section B provides space to indicate the type of independent or group living arrangement in which the client resides. Section C allows you to record the location of the client's residence. Noting the location of the residence may help you to think about resources and problems in these areas. Section D allows you to document the head of household. Indicating the head of household may, in some situations, prompt you to consider additional dynamics in family relationships as well as the control the client may have over her environment. It also may have a bearing on the client's economic status. Mrs. Johnson, for example, is head of her household and owns the house itself, which suggests she could use it as a resource.

E. Inadequate, Unsafe, or Unhealthy Conditions

The checklist about the condition of the client's home provides you with an efficient way of compiling information about adequacy, safety, and accessibility. The comments section allows you to record additional information about the client's environment (including information about clients living in facilities). The social worker checking Mrs. Johnson's home noted many things that were not fully adequate. Some were safety issues such as poor lighting on stairs, while others could affect the quality of her life. For example, the refrigerator is very old and therefore could need repair or replacement in the near future.

F. Potential Threats in the Environment

Occasionally something in clients' homes, neighborhoods, or living arrangements is so severely inadequate that it poses a threat to their health or safety or prevents them from receiving needed services. If so, these potential threats should be described here. You should not limit these to the items listed in section E. One example of an inadequacy that could threaten a client's ability to stay in her home is exterior access. If a client had become wheelchair-bound and lived on the second floor without an eleva-

tor, this would be a serious safety issue that would need immediate attention. If a client had family members who were using or selling drugs in his home, this could provide another environmental hazard that would make it difficult or impossible for him to receive services. None of these factors apply in Mrs. Johnson's case. Her home and neighborhood are relatively safe, although the issues checked in section E should be taken seriously.

G. Strengths

These lines provide space for you to describe current and potential assets in the client's home and surroundings. Examples might include a door frame wide enough for a wheelchair or an entrance low enough so that a short ramp can be built. In Mrs. Johnson's case both the structural integrity of the house and Mrs. Johnson's attachment to it were listed as strengths by her social worker.

Mental/Emotional Assessment

As A Model for Excellence reminds us, we must be sensitive to symptoms of cognitive incapacity, psychiatric disorders, and other risks when working with adult services clients (p. 73). Social workers must consider two areas of mental health status especially—cognitive functioning and emotional well-being—and any accompanying behavioral and psychological problems. This section of the Assessment tool provides space to record the feelings and impressions of the client and family, and to report results if you use tools to help you screen for mental and emotional disorders.

A. Client's/Family's Perception

This domain begins, as do all others, by providing you with space to record what you learned about the client's and family's impressions of the client's current mental and emotional status. The most useful records reflect accurately the descriptions they give, sometimes using a short quote, if appropriate, to reflect their overall sentiment. From the case example, you get several impressions. First, Mrs. Johnson's family is worried about her well-being because of her apparent forgetful-

ness. On the other hand, Mrs. Johnson says she is "doing fine overall" but is still saddened over the loss of her husband and is anxious about not having more control over certain aspects of her life. Changes in these reports over time may be particularly revealing.

B. Mental/Cognitive Assessment Instruments

If cognitive or other screening tools are used with the client, record the instruments used, who performed the screenings, and what the findings were. Examples of some screening tools are found in the appendix. In Mrs. Johnson's case, her social worker thought that some of her reported "forgetfulness" might be due to depression, and decided to administer the Geriatric Depression Scale to screen for this possibility. She reports using this instrument and the results (a score of 12, indicating mild depression) in section B.

C. Mental, Emotional, and Cognitive Problems

This grid provided is not to be used as a checklist in which you ask clients about each symptom or condition. Rather, it is for your use in recording what you learn about mental and emotional functioning in the course of your assessment. Becoming familiar with the items on the grid will, however, help you be alert for potential indicators of problems in mental and emotional functioning. We have provided space for you to record other symptoms and conditions that do not appear on the grid. APS workers will use the grid to record mental anguish, when appropriate, and information that contributes to a determination of clients' capacity to make decisions about service needs.

For each diagnosis or symptom, indicate who provided the information. The space for notes should be used to provide additional or clarifying information such as onset, duration, pervasiveness, or severity of symptoms.

In our case example, the social worker shows that the family has seen a decrease in activity in the past year. She notes the family's concern

with memory loss, but also notes that her observation in the interview suggested relatively mild impairment. Finally, she notes that both the client and family have reported that Mrs. Johnson is sad almost all the time, and that both link it to the deaths of her husband and daughter.

D. Past and Present Hospitalizations/Treatments

Space is provided to record ongoing or past treatment of mental/emotional problems. Comments about current treatment may include information about how long treatments have been going on, what progress has been made, any problems associated with them, and what is expected in the future. Past treatment approaches and medications that were once successful are likely to be successful again. Unsuccessful approaches can be modified or avoided. This space could also be used by a creative social worker to record ongoing scheduled appointments, information about a mental health case manager, or other relevant information about involvement of mental health professionals outside the agency. From the assessment interview, Mrs. Johnson did not appear to have any history of this type. Her social worker jotted “none reported,” but she could have chosen to leave this space blank.

E. Family History

Documentation of any history of mental illness or substance abuse in the client’s family or household is relevant for at least two reasons. First, it suggests whether there is anything in the client’s family and social dynamics that might distress the client or jeopardize her health, safety, or well-being. For Mrs. Johnson, her sister’s problem with alcohol may contribute to their strained relations. Second, this information may reveal a genetic predisposition toward some conditions. For example, some types of dementia seem to be familial, as do substance abuse and some of the severe and persistent mental illnesses.

F. Strengths

Use this section to record strengths and positive aspects of the client’s and family’s mental/

emotional functioning. Some examples that you might document include self-esteem, good coping skills, a positive (but realistic) outlook, adaptability, seeking treatment appropriately, or a history of compliance with medications or other professional advice. In Mrs. Johnson’s case the social worker recorded the client’s personal strengths (independence and determination) as well as the concern and support demonstrated by her family.

Physical Health

A Model for Excellence mentions three ways that social workers can assess clients’ physical health status: (1) asking clients for a self-assessment of their overall health, (2) checking symptoms and illnesses, and (3) reviewing clients’ use of medications (p. 73). The tool allows space to record information from all three elements, providing an especially good overview.

A. Client’s/Family’s Perception

The section, like the others, begins by providing space to record the client’s and family’s descriptions of the client’s health status. Their perceptions of the client’s health may correspond closely with the symptoms and diagnoses identified in your assessment or they may seem incongruent with what you would expect. For example, a client might have numerous problems but characterize her health as “pretty good,” or have a minor illness but tell you that her health is “failing.” You may want to record some of what you hear using the client’s own words (for example, “clouded vision” as Mrs. Johnson talks about a source of frustration). While it is always best to get the client’s self-assessment, there is also value in recording family members’ descriptions of the client’s physical health. Significant differences in the perception of health status may suggest the need to spend time reaching a better common understanding, or they may indicate the need to recommend an evaluation by a health professional.

B. Physical Health Problems

A grid is provided for you to check diagnoses and symptoms that you identify during the

assessment with the client and family. Remember that this is not designed to be an interview tool. You will want to ask the client about his or her health, but not about each condition listed.

Use the source of information codes in the second column (or your own abbreviations) to help you keep straight where you learned about the condition. Information about diagnoses can be obtained from a variety of sources, including the client's own comments, those of the family or other responsible party, or an FL-2 or other medical report. An example of an "other" source would be comments and reports from other health professionals, such as a home health nurse. While diagnostic impressions offered by non-medical sources can flag the need for medical evaluation, such information should be viewed with caution and may need to be substantiated by a medical evaluation.

The third column allows you to record notes about the client's condition—such as when it started, how successful treatment has been, what kind of follow-up might be needed, and other pertinent information. With Mrs. Johnson, the social worker used the Notes column to record specifics of sensory changes and that her arthritis has worsened over the past 6 months.

C. Impairment in Ability to Communicate

This section allows documentation of health problems that impair communication or the ability to make responsible decisions. APS workers can use this section to document clients' ability to make or communicate their needs according to APS guidelines. This was not an issue in the case example of Mrs. Johnson.

D. Medical Providers

Although you will be keeping your clients' doctors names and phone numbers on the face sheet, you will want to use this space to remind yourself of anything important about a provider (how often he or she sees the client, what issues there are to be resolved). An issue for Mrs. Johnson is that her primary physician has re-

tired, and she has not seen a physician in nearly two and a half years. The dentist who made her dentures is also recorded here in case that information is needed for her future well-being.

E. Medications and Treatments

The listing of current medications and treatments is another important part of the client's health profile. You will want to record over-the-counter (nonprescription) drugs as well as prescriptions. It is also a good idea to record self-treatments (e.g., drinking prune juice every morning or using a heating pad, as Mrs. Johnson does), as well as treatment regimens prescribed by health professionals. If what the client or family understand about the purpose of medications or treatments is different from what you would expect, the Comments section is the place to note this.

Include other comments that would help you and other users of the record to obtain a good idea of what is going on in the client's use of medications and treatments, such as the client's willingness and ability to use them. Comments about findings that alarm you are very important (for example, your discovery of the frayed cord on the heating pad Mrs. Johnson uses when she sleeps). *A Model for Excellence* (p. 76) gives you other examples of findings that you should note (e.g., inability to afford certain medicines, client's concern about side effects). Listing numerous medications (prescription and over-the-counter) may prompt you to encourage the client and/or family to have a health care professional review what is being taken. Because you may be recording medications for mental illnesses as well as physical conditions, remember to consider this information in your assessment of the emotional/mental health domain. Mrs. Johnson's record, in our example, shows that she has no prescription medicines but is treating herself for constipation and arthritis.

F. Assistance with Medication

This is a space for follow-up to section E. You can use a check to indicate whether assis-

tance with medications is needed and provided. There is also space to identify the person giving assistance, if appropriate. In Mrs. Johnson's case, the social worker reports that no assistance is needed. If Mrs. Johnson needed a more complex set of medications, she might need a person or a system to help her keep her dosage straight, given her possible memory problems.

G. Client/Family Medical History

One more bit of information that helps round out a history of the client's physical functioning is the record of hospitalizations and outpatient procedures for medical treatment for the client and significant family members. (Note that hospitalizations and outpatient treatments for psychiatric care are recorded in the mental health domain rather than here.) Documenting medical history can help you in your assessment of whether current conditions have been adequately evaluated and treated. Also, past experiences with illness of the client or of family members can affect the client's willingness to undergo further evaluation or treatment and the family's support for the client's decisions. The social worker found nothing relevant to report here for Mrs. Johnson, and left the section blank.

H. Durable Medical Equipment/ Assistive Devices/Supplies

This list is designed to help you compile information about medical equipment and supplies. Letters allow you to indicate that clients use (U) equipment or need (N) equipment they do not have. The space for comments gives you a place to record additional information that may be important, such as a piece of equipment the client needs and has, but chooses not to use.

One reason this information is recorded here rather than in the ADL/IADL domain is that a nurse or other professional might be more likely to assist with assessing the physical health domain and could supply information about equipment. However, because this medical equipment is often used to help clients maintain their abilities to perform activities of daily living, you

may learn of this information when you assess the ADL/IADL domain.

In the case example, the social worker has used the letter U to indicate that Mrs. Johnson has dentures and wears glasses. She makes a note that the glasses are an old prescription, which may help explain why Mrs. Johnson is reporting vision problems. She also puts an N with a question mark beside hearing aid. She knows from the physical assessment that Mrs. Johnson is experiencing some hearing loss, but she cannot tell without a professional assessment whether a hearing aid would be useful. Mrs. Johnson and her family have not, up to this point, seemed particularly worried about the level of hearing loss she has, so the social worker will probably not follow up on this during the initial assessment.

I. Strengths

Space is provided for documenting strengths in client's physical health. Examples might include such things as "follows recommendations," "understands the implications of a particular illness," "has good relationships with medical providers," or "has minimal symptoms associated with an illness." In Mrs. Johnson's case the social worker has recorded that she is in good health and not taking prescription medications.

ADL/IADL

A Model for Excellence emphasizes the importance of measuring Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) to determine a client's abilities to be self-sufficient. This domain builds on the information gathered in the physical and mental health sections by moving beyond diagnoses and symptoms to functioning. For example, two people with the diagnosis of arthritis may have very different levels of functioning. One may be very impaired and unable to walk without assistance, while the other has minor stiffness in the morning. By assessing their ADLs and IADLs, you can determine specifically what activities they can do independently and which ones pose problems.

A. Client's/Family's Perceptions

As in other domains, Section A provides a place to record the client's and family's descriptions of the client's ability to perform the activities of daily living. It is very important to know what areas are bothering the client and family when you help them develop their Checklist for Change and goals. In the case example, Mrs. Johnson's social worker uses the client's words to document that while the client and family identify most of the same problems (bathing, transportation) the client emphasizes her basic independence while the family emphasizes the need for more help.

B. Review of Activities

This chart allows you to document information about a client's functioning. Usually this will be done with the client and/or the family and on the basis of the social worker's observations. After marking whether assistance is needed, there is space to give further detail for those activities in which some or total help is needed. The center column is used to indicate whether or not the identified needs are being met and the third gives space to add relevant comments. In the case of Mrs. Johnson, we see that she is having difficulty with bathing and dressing. We also see that, although her daughter-in-law is helping her out, Mrs. Johnson is not very comfortable with her daughter-in-law's assistance with bathing. She is also having difficulties with some IADL tasks. The detail provided by both the "Need Met" and the "Additional Notes" columns shows that Mrs. Johnson has limited sources of transportation for errands, shopping, and church. It also alerts us to the possibility that her family and friends will experience burnout from trying to meet her other IADL needs.

C. Documentation of Physical Incapacity

This space is provided for APS workers to document whether the client is incapacitated and without someone to provide assistance.

D. Client's Ability to Read and Write

The purpose of the questions on reading and writing is to determine if a client possesses basic skills and abilities, such as being able to read a pill bottle or write her address. Reading and writing at this level can help ensure a client's safety and prolong her independence. Mrs. Johnson is literate, but her eyesight has become so bad that she is functionally unable to read. Her social worker uses the "Additional Notes" section at the end of the tool to clarify this issue for herself and others.

E. Strengths

Space is provided for you to list the client's and family's strengths used in accomplishing activities of daily living. Strengths may include such things as having few restrictions on functioning or finding successful ways to accommodate limitations.

Economic

As discussed in *A Model for Excellence*, the purpose of economic assessment is to examine the adequacy of a client's financial resources and sometimes to determine if the client is eligible for additional assistance. To accomplish this, it is necessary to identify the client's expenses as well as her income and other resources. The Assessment tool provides space for a brief review of the client's financial status in questions B through D. For clients for whom a more comprehensive review would be helpful, you might wish to use a worksheet similar to the one included in the appendix of this guide.

A. Client's/Family's Perception

This first space allows you to record the client's and the family's financial situation as they see it. When the social worker asked Mrs. Johnson about her financial situation, Mrs. Johnson initially said that she couldn't think of any concerns, but after talking with her for awhile, the social worker discovered that Mrs. Johnson was quite concerned about unexpected expenses since her husband's death.

B, C, and D: Financial Information

Section B allows you to document the amount of direct resources a client receives in a month. In Mrs. Johnson's case, you will note that she received Social Security and a life insurance annuity. Section C gives you a place to record information on resources that do not provide a monthly income but are important to consider when looking at a client's financial picture. In Mrs. Johnson's case there is a savings account, as well as Medicare, a burial plan, and the ownership of her home. Section D provides a place to record the client's monthly expenses. The most common categories are listed and lines are provided to record other expenses. In Mrs. Johnson's case, this listing reveals that her average monthly expenses are about 5 dollars more than her monthly income, even without any unanticipated expenses.

E. Home/Property Ownership

As part of the financial assessment, it is helpful to document whether the client owns or rents her home and if she owns any additional property. Comments could include approximate value of the property, how ownership might affect eligibility for programs (e.g., Medicaid), and the client's long-term plan for its use or distribution. Although Mrs. Johnson's social worker had already recorded the house as a resource, she used this space to document that the house was owned without mortgage, and that Mrs. Johnson wants to pass it along to her son. This preference may limit the possible uses of the house as a resource to meet some of Mrs. Johnson's needs.

F. Problems/Irregularities in Money Management

If the client is experiencing financial problems in meeting basic needs, you will record that information here. Concerns about irregularities in the client's financial affairs are also detailed here and may serve as a red flag for possible exploitation. APS workers will use this space to document exploitation as part of their evalua-

tion. In the case example, there was nothing to document in this area.

G. If Expenses Exceed Income

Recording how the client is coping when her expenses exceed her income can call attention to the need for a long-term strategy for alleviating financial problems. For example, Mrs. Johnson relied on her son's informal "gifts" of money. Although Mrs. Johnson may not decide to work on improving her financial status right now (see the next chapter on the Checklist for Change and Goals), that problem area is one that concerned the social worker, and thus needed to be documented for later consideration.

H. Strengths

Use this space to record client's and family's strengths in economic functioning. Strengths may include such things as sufficient or comfortable income and resources or the ability to manage with limited resources. In Mrs. Johnson's case, her strengths were her home ownership, that she appears to be frugal, and that her son is able and willing to provide some help when needed.

Other Information

Formal Services Currently Received

A Model for Excellence points out that in addition to assessing clients' strengths and needs, it is also important to learn about what services they are currently receiving. We included this section near the end of the Assessment tool because, while important, we did not want it to drive the assessment process.

The purpose of this section is to show in one place the formal services currently provided to the client. By "formal" we mean the services offered by your agency and other human services professionals and agencies in the community. Record services your agency is providing, whether or not they are a part of the adult services program (for example, food stamps or Medicaid), as well as services provided by others. Having the information in one place can help

you see how to build on the client's and family's existing relationships with service providers. It may also identify both gaps and overlaps, information that is important to meeting needs as well as making best use of available resources.

The grid gives space only sufficient to identify the provider by an abbreviated name, such as DSS for county department of social services, MH for the local mental health program, or PHD for local public health department. Decide within your agency what acronyms or abbreviations you wish to use. Use the space for comments to provide additional and/or clarifying information. For instance, you may want to indicate how long a service has been provided to the client, or how satisfied the client appears to be with a particular service.

Collateral Contacts

You may find it useful to record here information learned from the client's friends and relatives, as well as contacts from other agencies providing services and any other professionals involved with the client, such as doctors and ministers. APS workers will use this space to document pertinent collateral information obtained in the course of conducting APS evaluations. In Mrs. Johnson's case, the social worker felt she had an adequate picture to proceed to the next step, although the lack of recent medical evaluation was a concern.

Additional Notes

This optional section is provided for you to document *anything* important that you didn't find a convenient space to record elsewhere. In Mrs. Johnson's case the social worker elaborated on her difficulties with transportation and on her ability to read and write, from the ADL/IADL section.

Summary of Findings, Documentation of Eligibility, and Next Steps

Please see the next chapter for tips on completing these sections of the Assessment tool.

Frequently Asked Questions

Question: This Assessment tool is long; do you really expect me to complete every question for every client?

Answer: The assessment is long, but we believe you will find that its thoroughness enhances your practice. We don't, however, expect that you will write something after each question. We expect that you will use the spaces provided to record information relevant to the client and family. Some social workers find it helpful to draw a line or write "N/A" in spaces they do not need, to remind themselves and/or indicate to colleagues and supervisors that they have thought about this area but do not believe there is any relevant information to record.

Question: Is this tool applicable to clients living in institutional facilities?

Answer: Yes. The Assessment has been designed to be used with clients in all settings. In some sections, such as the dynamics of relationships in the social domain, the tool prompts you to record information specific to clients in facilities such as relationships with facility staff members. In most cases, however, we assume you will make notes or modifications as needed for clients in facilities.

Question: How does this tool relate to what is expected for an Adult Protective Services evaluation?

Answer: This tool can serve as an Assessment tool for all adult services, including Adult Protective Services. If you use the Assessment tool for APS, answer the questions in a way that satisfies the documentation requirements for that service. For example, APS workers will assess the availability of a caregiver/caretaker according to the definition of the law,

they will document threats to the client's health and safety in the environmental domain, and they will record the client's capacity and the availability of someone to provide assistance.

Question: How do you record information collected after the initial assessment but before the quarterly review or reassessment?

Answer: Information gathered after the initial assessment may be recorded on the assessment tool with a date to indicate when it was added. However, if new assessment material becomes available after the Adult and Family Services Plan is written, the social worker may choose to record it on the contact log to be summarized at the time of the quarterly review (or reassessment). The social worker, perhaps in consultation with the supervisor, should judge where the specific information will be most useful.

Question: A Model for Excellence discusses the benefits of including other professionals (e.g., mental health specialists, physicians, nurses) in conducting multidimensional assessments. Can these other professionals also use this tool, and if so, how?

Answer: The tool is designed for use by DSS social workers. However, this does not mean that the input of other professionals is unimportant. We suggest that you consult other professionals whenever necessary. You can then record the results of the consultation in the appropriate place. If other input comes during the assessment, you may refer to it in the section for "collateral contacts." In a few instances, parts of the tool may actually be completed by a consulting professional. For example, if a nurse is available, she/he might complete sections of the physical health domain. The "appropriate place" may also be a separate section of the case record—the key is to

consider, when available, other input in your overall assessment with the client and family.

Question: My agency already has an assessment form I like; why can't I keep using that?

Answer: You can choose to continue using your agency's form. However, this Assessment tool has been designed to combine the best features of several different ones found in current practice. It probably has many parts similar to your assessment form. We believe that after you and your colleagues have become familiar with it, you will find it makes your practice even more effective.

Question: How do I use this tool in assessing the situation of clients currently residing out of my county or out of state, whom I cannot visit personally?

Answer: This tool makes this situation no less complicated than it has previously been except that it gives you a framework for gathering information from professionals in direct contact with the client and for extracting and organizing information from the records they send.

Key Points

- A comprehensive functional assessment is the cornerstone of the Family Assessment and Change Process.
- Functional capacity is a better predictor of need than diagnosis.
- To assess the client's and family's overall well-being, it is essential to review social functioning, environment, physical health, mental and emotional health, ADLs and IADLs, and economic status.
- Strengths, preferences, and resources are as important to consider as problems and potential risks.
- The Assessment tool is not intended to be an interview tool.

- The Assessment tool provides a structure for recording information, analyzing, and synthesizing what you learn about the client and family.
- The tool is yours to use. We hope you will adapt it to your style and area(s) of practice, but we also hope you, your coworkers, and your supervisor will seek a way of using it consistently enough from case to case to facilitate sharing information and case consultation.

Adult Services Functional Assessment

Client's name Mary Foster Johnson

Date 2/6/95

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

- A. Client's/family's perception of client's social functioning Client wishes she could see son more, but is generally pleased "keeping to myself." Says she misses going to church. Son worries that she's becoming withdrawn & isolated—wants to see her more but has many other responsibilities. Daughter-in-law feels she is becoming too dependent on her son.
- B. When the client has a problem, who is the person he/she can most rely on? (name, relationship)
Robert W. Johnson, son
- 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) Private person, chooses to limit social contacts. Dislikes the thought of having to live with others. Enjoys contact with son & his family & would like more.
2. Does the client have a caregiver/caretaker? No Yes (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.) While Mrs. J. does not have, or need a caregiver, some of her IADL needs are being met by her family (see ADL section).
3. Dynamics of relationships with and among family, friends, and others (e.g., neighbors, facility staff, past or present co-workers, church and other organizations, pets). Include pertinent information on cultural values, family roles, sources of strain and satisfaction. Client is widow whose primary relationships are with son and his family. Son & dau.-in-law work full time & have 3 children, all teenagers. Son calls daily & helps client with her home; daughter-in-law helps with some personal care. Clt. has one sister, Dorothy Smith, talks to her infrequently, strained relationship. Neighbors, Elmer and Mary Rigsbee, were once close, and provided occasional meals and transportation. Although no reported problem, Mrs. J. says she doesn't want to bother the Rigsbees. Her son will take care of things. Clt. is member of First Baptist Church—minister visits monthly. Some strain noted with daughter-in-law, who says "we are doing all we can, but it's not enough."
4. Significant history/changes in client's/family's social functioning Clt.'s husband died 1 yr. ago after 45 years of marriage. Son says that father was dominant but loving person to his mother and that it has been hard for her to talk about him since his death. Clt.'s only daughter died 5 years ago without children. Although reserved, client was always extremely active in church functions (taught Sunday School and vacation church school) until her husband's final illness.

II. Environment

A. Client's/family's perceptions of the home and neighborhood environment Client loves her home & neighborhood—strongly desires to stay there. Son has concerns about money & time to help keep her house in repair and wonders about her safety.

<p>B. Type of residence</p> <p><input checked="" type="checkbox"/> house/mobile home</p> <p><input type="checkbox"/> apartment</p> <p><input type="checkbox"/> boarding room</p> <p><input type="checkbox"/> homeless</p> <p><input type="checkbox"/> other _____</p>	<p>facility/group home</p> <p><input type="checkbox"/> nursing home</p> <p><input type="checkbox"/> family care home</p> <p><input type="checkbox"/> home for the aged</p> <p><input type="checkbox"/> DD home</p> <p><input type="checkbox"/> rehab/treatment/acute facility</p> <p><input type="checkbox"/> shelter (specify) _____</p>	<p>C. Location</p> <p><input checked="" type="checkbox"/> town/city</p> <p><input type="checkbox"/> rural community</p> <p><input type="checkbox"/> isolated</p>
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D. If client lives in house, mobile home, or apartment, who is head of household? _____

client/client's spouse other family member friend/housemate

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 checked="" type="checkbox"/> Lighting <i>inadequate on stairs</i>	<input checked="" type="checkbox"/> Transportation <i>see below</i>
<input type="checkbox"/> Access, exterior	<input type="checkbox"/> Living area	<input type="checkbox"/> Trash disposal
<input type="checkbox"/> Bathing facilities	<input type="checkbox"/> Locks/security	<input type="checkbox"/> Ventilation
<input checked="" type="checkbox"/> Cooking appliance <i>See below</i>	<input checked="" type="checkbox"/> Pests/vermin <i>roaches</i>	<input type="checkbox"/> Water/plumbing
<input checked="" type="checkbox"/> Cooling <i>No AC</i>	<input checked="" type="checkbox"/> Refrigerator <i>works but old</i>	<input type="checkbox"/> Yard (or area immediately outside of residence)
<input type="checkbox"/> Eating area	<input checked="" type="checkbox"/> Shopping (access)	<input checked="" type="checkbox"/> Other (describe)
<input type="checkbox"/> Electrical outlets	<input type="checkbox"/> Sleeping accommodations	<u>throw-rugs, safety hazard</u>
<input type="checkbox"/> Fire hazards/no smoke detectors	<input type="checkbox"/> Structural integrity	_____
<input type="checkbox"/> Heating	<input type="checkbox"/> Telephone	_____
<input type="checkbox"/> Laundry	<input type="checkbox"/> Toilet	_____

Comments 1 stove knob missing—others cracked and hard to turn. The heating pad she uses for her arthritis has a badly frayed cord. Only taxi available if son's family not able to provide transportation, food store not within walking distance.

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? No

G. Environmental strengths House appears structurally sound & in basically good repair. Client loves her home, and family is willing to help her stay.

III. Mental/Emotional Assessment

A. Client's/family's perception of client's mental/emotional health Client misses her husband, but says she's "doing fine overall." However, when she speaks of husband, she gets teary, and son says this happens most of the time. Son concerned about her forgetfulness.

B. Were any mental/cognitive assessment instruments used by social worker or a mental health professional? ___ No Yes (record results below) *Sample assessment instruments are included in the appendix of the social worker's record keeping guide.*

Instrument	Given by	Findings/Conclusions
<i>GDS</i>	<i>Social Worker</i>	<i>12, Mildly depressed</i>

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

Diagnosis/Symptom	Source*	Notes (e.g., onset, severity, functional impact, history, untreated condition, needs professional assessment)
Aggressive/abusive behavior		
Agitation/anxiety/panic attacks		
Change in activity level (sudden/extreme)	<i>F</i>	<i>Moderate decrease in outside activities in past year</i>
Changes in mood (sudden/extreme)		
Change in appetite		
Cognitive impairment/memory impairment (specify)	<i>F/S</i>	<i>Son thinks memory loss, notes she forgets to turn off stove. In interview client appeared to have some mild memory problems, but no serious confusion.</i>
Developmental disability/mental retardation (specify)		
Hallucinations/delusions		
Inappropriate affect (flat or incongruent)		
Impaired judgment		
Mental anguish		
Mental illness (specify)		
Orientation impaired: person, self, place, time		
Persistent sadness	<i>C/F</i>	<i>Misses husband and daughter</i>
Sleep disturbances		
Substance abuse (specify)		
Thoughts of death/suicide		
Wandering		
Other:		
Other:		
*Source Codes:		M=FL-2, MD, medical/mental health professional
C=client's statement		S=Social worker observation/judgment
F=family member/guardian/responsible party		O=Other collateral (specify) _____

D. Past and present hospitalizations/treatments for mental/emotional problems (*include inpatient, outpatient, therapy, and substance abuse recovery programs and names of current therapists or other involved mental health professionals*) *None reported*

E. Is there a history of mental illness or substance abuse in the client's family or household?

___ No Yes If yes, describe: *Clt. says sister drinks alcohol too much; sister's behavior while drinking (especially at Mr. Johnson's funeral) appears to have contributed to the problems in their relationship.*

F. Strengths in the mental or emotional status of the client/family Client coping with change & loss with independence & determination. Family concerned and supportive.

IV. Physical Health

A. Client's/family's perception of client's health status Clt. sees self as "slowing down," especially because of arthritis. She is frustrated with "clouded vision." Family concerned that she doesn't move around as well as she used to, also some problems with hearing.

B. Physical health problems—diseases, impairments, and symptoms

Diagnosis/Symptom	Source*	Notes (e.g., onset, severity, history, functional impact, untreated condition, needs professional assessment)
Arthritis/osteoporosis/gout	C/F	has had 10 yrs.; worse in past 6 mos.
Asthma/emphysema/other respiratory		
Bladder/urinary problems/incontinence		
Bowel problems/incontinence	C	occasional constipation
Bruises		
Burns		
Cancer		
Dental problems		
Diabetes		
Dizziness/falls		
Eye diseases/conditions	C/S	"cloudy" vision; worse in past year, hard to read
Headaches		
Hearing difficulty	F	gradual loss over 2 years; worse over phone
Heart disease/angina		
Hypertension/high blood pressure		
Kidney disease/renal failure		
Liver diseases		
Malnourished/dehydrated		
M. Sclerosis/M. Dystrophy/C. Palsy		
Pain		
Paraplegia/quadriplegia/spinal problems		
Parkinsons disease		
Rapid weight gain/loss		
Seizures		
Sores (specify)		
Speech impairment		
Shortness of breath/persistent cough		
Stroke		
Other:		
Other:		
*Source Codes:		M=FL-2, M.D., other medical professional
C=client's statement		S=Social worker observation/judgment
F=family member/guardian/responsible party		O=Other collateral (specify)_____

C. Does the client have any sensory or health problems that impair his/her ability to make or communicate responsible decisions? No

D. Medical Providers	Notes (type provider, regular or as needed, etc.)
<i>no MD</i>	<i>her MD retired 2 1/2 yrs. ago—hasn't seen anyone since</i>
<i>Dr. Marcus</i>	<i>dentist, for her dentures</i>

E. Medications (prescription and over-the-counter) and Treatments (e.g., special diet, massage):

Name	Comments (dosage, compliance issues, side effects, other)
<i>Aspirin</i>	<i>as needed for arthritis</i>
<i>Milk of Magnesia</i>	<i>constipation</i>
<i>Metamucil</i>	<i>constipation</i>
<i>Prune juice</i>	<i>constipation</i>
<i>Heating pad</i>	<i>arthritis; pad has frayed cord</i>

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

G. Other significant client/family medical 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 checked="" type="checkbox"/> glasses <i>old prescription</i>	<input type="checkbox"/> prosthesis
<input type="checkbox"/> catheter	<input type="checkbox"/> grab bars	<input type="checkbox"/> ramp
<input type="checkbox"/> commode (seat/bedside)	<input checked="" type="checkbox"/> hearing aid	<input type="checkbox"/> telephone alert device
<input type="checkbox"/> communications devices	<input type="checkbox"/> hospital bed	<input type="checkbox"/> walker
<input type="checkbox"/> crutches	<input type="checkbox"/> incontinence supplies	<input type="checkbox"/> wheelchair
<input checked="" type="checkbox"/> dentures	<input type="checkbox"/> ostomy/colostomy bags	<input type="checkbox"/> other _____
<input type="checkbox"/> diabetic supplies	<input type="checkbox"/> oxygen equipment	_____
Comments/explanations	_____	

I. Strengths in client's/family's physical health *Client in generally good physical health; takes no prescription meds.*

V. ADL/IADL

A. Client's/family's perceptions of the client's ability to perform the activities of daily living (basic and instrumental) *Client says she does "o.k. on my own," but admits to some problems with bathing, washing her hair, and transportation. Family says help needed with bathing, sometimes dressing, and transportation.*

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

ADL Tasks	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		
Ambulation	✓				
Bathing		✓		2	Arthritis makes both bathing and dressing difficult,
Dressing		✓		2	especially washing hair. Daughter-in-law helps; clt. not
Eating	✓				comfortable w/this.
Grooming	✓				
Toileting	✓				
Transfer	✓				
to/from bed					
to/from chair					
into/out of car					
IADL Tasks					
Home maintenance		✓		1	Son, grandchildren help
Housework	✓				Uncleaned spills on floor; Mrs. J. says she can't keep
Laundry	✓				house the way she wants any more.
Meal preparation	✓				
Money management	✓				
Shopping/errands		✓		2	family: see comments under "Additional Notes"
Telephone use	✓				
Transportation use			✓	2	

C. [For APS use only] Is the client incapacitated, and without someone able, willing, and responsible to provide assistance? ___ No ___ Yes

See "Additional Notes"

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

E. Client/family strengths Clt. is able to do most things by herself. Family and neighbors available to help some of the time.

VI. Economic

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

Loss of husband's SS income has made a big difference in monthly resources. Clt. worried about unexpected expenses. Son knows little about her financial situation, but feels responsible to help out.

B. Monthly Income (from all sources)

Social Security/SSI \$380.00
retirement/VA/RR _____
other annuity 50.00
TOTAL \$430.00

D. Monthly Expenses TOTAL: \$435.00

rent/mortgage _____
food/supplies \$ 85.00
utilities 100.00
heat 45.00
water/sewer 30.00
transportation _____
clothes/laundry 20.00
insurance (type) life 65.00
medical 10.00
other phone 30.00
taxes 50.00

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

Medicare, burial plan, owns home,
savings account (\$1,000)

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

ADL/IADL, Transportation: Son & his family take her shopping about weekly. Neighbors used to help out, but she doesn't ask them, because she "doesn't want to bother them." She'd like to go to her old church, but son and family involved in a different congregation, so can't take her.

Reading/Writing: Mrs. J. used to enjoy reading, but vision problems keep her from doing it. Now her only writing is to sign her name, also on account of the vision.

Summary of Findings—including strengths and problems

[See the examples in the next chapter.]

Documentation of eligibility for specific services:

[See discussion in the next chapter.]

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

- | | |
|--|--|
| <input checked="" type="checkbox"/> develop goals/service plan | <input type="checkbox"/> close case |
| <input type="checkbox"/> complete APS disposition | <input type="checkbox"/> make referral to another agency |
| <input type="checkbox"/> transfer case to another unit | <input type="checkbox"/> other _____ |

Social worker's signature/date Virginia White / 2/10/95

Supervisor's signature/date Betty Jacobs / 2/12/95