

# The Reassessment

Reassessment completes the cycle envisaged in the Family Assessment and Change Process, in that it measures the effect of the client's, family's, and social worker's actions against the client's initial circumstances, and, depending on the results, reinitiates the process of identifying and prioritizing items for change, specifying goals, developing and implementing the family plan, and monitoring the client's change or response (based on *A Model for Excellence*, p. 42).

When you reach this stage in the process, you are likely very knowledgeable about the client, the family, and their circumstances. *A Model for Excellence* recommends that social workers conduct reassessments at least annually. While some aspects of monitoring sometimes can be performed over the telephone, the reassessment, which replaces the quarterly review at least every fourth quarter, is something the client and social worker do face to face. You may need to conduct a formal reassessment more frequently than annually if your client's circumstances change radically. For example, if your client is hospitalized in the course of the year, you may need to reassess to see what effect the situation that caused the hospitalization has had on his or her functioning. Are the services you had in place still appropriate? Are there new problems? Are there new goals to be set? Are new interventions or services necessary? These, of course, are the same questions you will be asking if the reassessment falls at the "normal" time.

## The Social Work behind the Record

### Why Is It Important to Do a Thorough Reassessment?

We've just said that by the time you need to reassess your client and family you know them fairly well, so why go to all this trouble? One reason has to do with empowerment. Both for you and for the client, it helps to set a formal time to take stock of the situation globally and measure and take pride in your successes. One success often makes others possible, because it allows clients and families to see that their efforts are effective and that they have some measure of control over their lives. Just as we suggest that you help clients identify strengths before problems, we suggest that you identify successes and savor them together before you turn to new areas for change or to unfinished business—things that didn't work out so well.

Reassessment also provides an opportunity to look at the client's and family's situation with "new eyes," to identify aspects of their lives and functioning that might not have been apparent when you were first getting to know and understand them.

In examining both your successes and the problems that remain, try to identify why you got the results you did. Apart from the practical aspects—the intervention fit the goal, or didn't quite—were there things in the attitude of the client or of another involved party that helped things along, or conversely, that made it harder to succeed? Also, be generous in how you measure success. Remember that among the possible types of goals were maintenance goals. For some things, holding level or minimizing the rate of decline are successes.

### Using the Adult Services Annual Reassessment

The Adult Services Annual Reassessment has many elements in common with the original Adult Services Functional Assessment and others more like the Interim or Quarterly Client Review. This re-

## **Mrs. Johnson's Story Continues: What Happened after the First Quarter**

After the first quarterly review, Mrs. Johnson showed progress in a number of areas. Her doctor had arranged one home visit from an occupational therapist, and between that and good modeling by the in-home aide, she had learned ways to complete her household tasks up to her own standards and felt good about it. The "Sunshine" committee of her church women's group volunteered to do spring housecleaning once a year—windows, turning mattresses, cleaning rugs and slipcovers, and other tasks that were too much for her to handle by herself. The aide was still helping with her hair.

To improve her financial situation, Mrs. Johnson sold her house to her son. The financial advisor at Kudzu Women's Center helped them find a lawyer whom they could afford, and Mr. Johnson signed a contract to pay his mother \$25 every two weeks, pay for major upkeep of the house and property, and allow her to live there for her lifetime. As part of the agreement, they made arrangements for Mrs. Johnson's care should she become physically or mentally incapacitated.

She was resolving her grief issues fairly well, but she and some of the other widows in the support group liked the group so much they were thinking of continuing to meet to support each other in coping with such other issues as aging and dealing with adult children. She had a regular ride to church on Sunday mornings and rarely missed a service. Her social worker anticipated being able to close the case after the second quarterly review. Then, about two weeks before her review was scheduled, she slipped on a wet spot on her porch and broke her right arm.

The social worker rescheduled the re-

view as soon as possible on learning about the broken arm. Because Mrs. Johnson is right-handed and the arthritis is worse in her left hand and arm, she was now impaired in all ADLs except toileting. She needed more in-home aide services than she had been getting. Mrs. Gooch was not able to work enough additional hours on the schedule that was needed, so a new in-home aide was assigned. Mrs. Johnson really missed Mrs. Gooch and had trouble adjusting to Ms. DeShields, who was younger and had fewer of the same interests. The social worker helped Mrs. Johnson understand that she had other friends and that the aide was doing her job adequately. Mrs. Johnson's attitude remained good through this event. She saw it as a temporary setback that others had dealt with. "It could happen to anyone."

Nothing very eventful happened after this. Mrs. Johnson had another visit from the occupational therapist and got some advice and devices to help her dress and bathe herself, and she very slowly resumed most of her personal care and a little bit of the housework. By the third review the arm had not finished healing. Dr. Shepard confirmed that this was a little slow but nothing to worry about in a woman of Mrs. Johnson's age. The doctor also reported that Mrs. J. was doing a "fair" job of keeping her blood pressure under control. She continued to show progress in ADLs over the third quarter, and made progress on goals to take her blood pressure medicine daily, and to follow her food plan at least 25 days each month.

flects two philosophies of reassessment—a focus on documenting *change* (that is, what’s the difference between the client’s status now and what it was before, and what has happened to produce this change?) and a focus on “looking at the client and family situation with new eyes” (for example, what does the bigger picture look like now?). Social workers will differ in the emphasis they give these two pieces, but most will agree that some elements of both should be included. Before we look at the details, you might examine the summary of what has happened to Mrs. Johnson since the first quarterly review. The completed Reassessment tool reflecting these changes is at the end of the chapter.

### **Social**

The first two spaces of this domain reflect the two purposes of reassessment. The first provides space for you to record the client’s and family’s perceptions of social functioning, which is consistent with the “looking with new eyes” philosophy of reassessment. The second allows you to document *changes* in the client’s household and network of family and friends—who’s new, who’s still there, who’s gone—and changes in the dynamics of those relationships. If there has been a change in the emergency contact, you would update that information on the Face Sheet.

The example shows that Mrs. Johnson’s social contacts have increased. She is attending church regularly and is involved with a group of friends. She is less dependent on her family for emotional support.

### **Environment**

In the assessment, you documented how well the client fit in his or her environment. Here again you can reflect a new picture of the client’s overall situation, as well as specific small changes. As in every domain, you have space to record the client’s and family’s current perceptions of the client’s environment. Checklists for type of residence, location, head of household, and conditions in the home are similar to those in the assessment so that you can document the

current picture and the small changes in a familiar format. The section concludes with a space to document how environmental changes have affected the client and family over the period since the last assessment or reassessment.

Mrs. Johnson is doing better in her environment than before. She keeps the house to her own standards, and she is able to use the resources in the community more frequently. Her son is firmly enlisted in helping her keep the place up because he now has a stake in it.

### **Mental/Emotional Assessment**

Again we begin with a place to record the client’s and family’s current perceptions of mental/emotional health. Space is provided to list any mental health assessment instruments used since the assessment or last reassessment and to record any hospitalizations or treatments in the past year. The next space allows you to record the impact of changes in mental and emotional health on the lives of client and family. This question may be especially important for clients with severe disabilities whose families care for them, since it is here that you might note signs of “caregiver burn-out.” The grid that follows allows you to record diagnoses and symptoms that have continued since the assessment or to make note of any new problems, to provide the source of that information, and to make any additional comments.

For Mrs. J. we find the interesting situation that her mental health symptoms are exactly that, symptoms of returning emotional well-being. The comments make it clear that her appetite has improved, and her activity level reflects improvement as well.

### **Physical Health**

The client’s and family’s perceptions of health status start this set of questions and are still reliable indicators of how things are going. There is space to record changes and additions to the list of medical providers, and you are reminded to update the face sheet as necessary. We have

provided the same grid containing diagnoses and symptoms that you used to document similar information on the assessment. You will want to check off conditions that persist since the assessment or any new conditions that may have arisen so that you portray a current picture of the client's physical health. Recording a date of onset is one easy way to mark any new conditions. If the client has symptoms that remain since the assessment, you may want to know if they have been unchanging and whether further medical evaluation is necessary. Here's a place for your judgment—some diseases have symptoms that continue even when the disease itself is being treated effectively. What you are looking for is “mystery” symptoms for which you still don't know a cause, or a change, whether sudden or gradual, in the client's feeling of well-being.

Medications and treatments remain important to document. The doctor has added Prinivil to help Mrs. J. control her blood pressure. With her, as with other clients, look out for new problems as new medications are added. The next two questions allow you to record whether the client is getting necessary assistance in complying with prescriptions and to note any unmet needs for durable medical equipment.

You are probably aware of any hospitalizations or outpatient treatments the client has had in the past year. Recording them here allows other colleagues who use this record to find this information easily. In Mrs. J.'s case, cataracts may never have appeared on her list of medical diagnoses, since they were identified and treated between assessment and reassessment. Recording her outpatient treatment here preserves this information for others who might need to consult her case record. The last question allows you to note the impact of changes in physical health on the client and family.

### **ADL/IADL**

This section almost speaks for itself. Because the ability to perform these activities is so critical to the client's independence, it is important to record the client's current level of functioning, as well as any changes since the assessment or last reassessment. This domain, like the others, begins with space to record the client's and family's perceptions of the client's functioning and ends with space to document the impact of changes in ADL/IADL functioning on the client and family.

Although Mrs. J. still has some disabilities, she takes care of most things with a little help from family and church group members. If we imagine for a moment, though, that the forgetfulness that brought her son to see you in the first place was the beginning of dementia rather than part of depression, by now you might see changes in her ability to do IADLs successfully—she might get sidetracked in the midst of household tasks or perhaps not be managing her affairs as well as previously.

### **Economic**

As with the other domains, there is space here to record the client's and family's current perceptions of economic functioning. Sections B, C, and D are identical to those sections in the assessment. Section E allows you to document changes in property ownership since the assessment. Question F gives you space to note problems and irregularities in the way money is managed, and question G, to report what clients do when expenses exceed income. As usual, the domain concludes with space for you to record the impact of changes in economic functioning on clients and families over the past year.

During the year, Mrs. Johnson and her family found a way to make her more financially secure. We acknowledge that this is a fairly rosy outcome for her, although a debilitating illness could change the picture quickly. For clients in worse straits, you may be exercising all your best talents as case manager to help them receive the

benefits to which they are entitled and to stretch their resources as far as possible.

### **Additional Notes**

At the bottom of page six, after you have recorded information on all six domains, there is a space for additional notes. This optional space is provided for you to write anything that you wish to document that has not been recorded elsewhere.

### **Services Currently Received**

Just as you considered the formal resources the client was already using when you made your assessment, list them again here. Be sure to note cases where your DSS is providing services (including yourself as counselor and/or case manager). In the comments section you might note whether the client is satisfied with the services from these sources, and if not, why not. Making this list here should give you information for the new Checklist for Change, goals, and family plan that might come out of the reassessment.

#### **Another Example: Mr. Kent**

Mr. Kent is a client with developmental disabilities for whom you are payee. He has difficulty managing his spending money and was coming nearly every day to ask for more. You and he set the goal that he would budget his money well enough that he would come to the DSS only once a week. You and he developed strategies to accomplish this—that he would put each day’s pocket money in a sealed envelope at the beginning of each week, mark the date it could be opened across the flap, store the envelopes in the drawer of his bedside table with a calendar, open the envelope first thing in the morning on the right date, and check the date off when he opened the envelope. He is still coming to see you twice a week, most weeks, but he is doing better than previously. Celebrate together that he is managing to meet the goal in part.

In Mrs. Johnson’s case, she is receiving two DSS services—in-home aide services and the case management services of her social worker. Because Mrs. Johnson has become self-sufficient in these areas now, the social worker notes that these services will be terminated at the beginning of the next month.

### **Progress on Goals**

This sheet duplicates the ones you’ve been using to track the progress toward meeting goals over the course of the year. In one sense, it is part of the normal monitoring that you would do at least each quarter. At the reassessment, though, you will step back a bit to look at the goals globally—not only in terms of what has been happening recently, but also in terms of the goals you set at the assessment (or previous reassessment). Are there problems you deferred that should or can have goals now?

Mrs. Johnson has met or made progress on all of her goals. However, she needs to keep working on maintaining her diet to keep her blood pressure down, even after services are discontinued. The only goal that she had deferred when she, her family, and the social worker made the original plan was her financial concerns. That goal had been added in the second quarter and met by her arrangement to sell her house to her son. Note that under the goal abbreviated “grief/outlook,” the social worker had already written in some detail about Mrs. Johnson’s progress in the mental health domain, so she simply cross-referenced that note rather than repeating the information needlessly.

### **Summary of Findings at Reassessment**

You wrote a summary for the initial assessment, and many of the suggestions given in Chapter 4 are relevant here. However, you do not need to repeat what you said there—the focus of this summary is on now. You made a snapshot of the client’s condition about a year ago; here’s the opportunity to paint a new picture of his or her

circumstances, including the problems and strengths that are currently most relevant.

As with the original summary, we don't offer a set way of writing it—you will develop your own style. Here is a brief critique of the example. The worker has reviewed the progress made in the course of the year, noting services from the DSS and elsewhere that have been used to meet the goals. The focus is on the changes that have been made in Mrs. J.'s life and the effect they have had on her functioning across domains: socialization has improved her IADLs, medical care has also improved IADLs, socialization has improved her mental outlook and seems to have reduced her forgetfulness by reducing her depression. The worker notes the family's improved attitude—some of the burden on them is decreased, but they feel able to help in vital ways.

In a case that doesn't have a happy ending at this point, you should still celebrate the successes you and the client have had, even while you identify functional problems that will serve as the basis for a new Checklist for Change, goal list, and service plan (see the example on the previous page).

Finally, note the space at the end of the reassessment for recording documentation of eligibility for specific services and noting your next steps.

## Frequently Asked Questions

*Question: Why is it necessary to take the time to go through the whole assessment again?*

*Answer:* Reassessment provides the opportunity to get a new picture of the client and family. The reassessment tool is not meant for needless repetition of everything you found in the initial assessment but to provide space for the new picture of the client, which may include some elements that you documented the first time.

You have already captured a lot of information on the client and family that is available in the Adult Services Func-

tional Assessment. The Reassessment tool allows you several options. You may choose to record some key information even if it repeats previous information, you may write "no change," or you may record only what has changed for clients and families since the assessment or last reassessment. However, if you choose not to record still-current information that is on the assessment tool, you will need to look simultaneously at both tools to see the current picture of the client.

*Question: Why do I need to record clients' and families' perceptions of all the domains all over again?*

*Answer:* These questions allow you to note how the client and family currently feel about important aspects of their lives. You may also record any changes in the ways clients and families view their situations since the last time you assessed these domains. Perceptions may have changed for a variety of reasons, such as successful service interventions, new illnesses, increased or decreased functional abilities in clients, or changes in stress level for families. Recording clients' and families' perceptions can help you stay focused on their strengths and problems as they see them.

## Key Points

- The focus of the reassessment is both to document changes since the last assessment and to give a new picture of the client.
- The reassessment process provides you with the opportunity to measure your progress and celebrate your successes.
- The reassessment process offers you and the client a time to look with fresh eyes at the client's state of affairs, to identify new and continuing problems, to set new goals, and to implement new strategies to meet them.

Case # 95-10019

ID # 18937485368

## Adult Services Annual Reassessment

Client's name Mary Foster Johnson

Date 2/6/96

### I. Social

A. Client's/family's perception of the client's social functioning Client says she's "blessed with a lot of sweet friends." Son also pleased with her relationships with others.

B. Changes in the client's/family's social functioning since the last assessment or reassessment (e.g., changes in the household composition, changes in the dynamics and quality of client's or family's relationships, losses or changes in social support). Update the Face Sheet as necessary.  
Clt. attending church regularly now. Has made friends in Widows' Support Group. She is less isolated and happier with her social life. Her family is feeling less worried about her and less burdened; they are not worried about her safety, and she relies on them less for emotional support.

C. Has there been a change in the client's preferred emergency contact person?  No  Yes (If yes, update the Face Sheet.) \_\_\_\_\_

### II. Environment

A. Client's/family's perceptions of the home and neighborhood environment Client feels even more positive about her home. Son is more satisfied w/spending time and money to maintain it since he owns it (see economic domain).

B. Type of residence	facility/group home	C. Location
<input checked="" type="checkbox"/> house/mobile home	<input type="checkbox"/> nursing home	<input checked="" type="checkbox"/> town/city
<input type="checkbox"/> apartment	<input type="checkbox"/> family care home	<input type="checkbox"/> rural community
<input type="checkbox"/> boarding room	<input type="checkbox"/> home for the aged	<input type="checkbox"/> isolated
<input type="checkbox"/> homeless	<input type="checkbox"/> DD home	
<input type="checkbox"/> other _____	<input type="checkbox"/> rehab/treatment/acute facility	
	<input type="checkbox"/> shelter (specify) _____	

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 type="checkbox"/> Lighting                | <input checked="" type="checkbox"/> Transportation                       |
| <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 type="checkbox"/> Cooking appliance               | <input type="checkbox"/> Pests/vermin            | <input type="checkbox"/> Water/plumbing                                  |
| <input type="checkbox"/> Cooling                         | <input type="checkbox"/> Refrigerator            | <input type="checkbox"/> Yard (or area immediately outside of residence) |
| <input type="checkbox"/> Eating area                     | <input type="checkbox"/> Shopping (access)       | <input type="checkbox"/> Other (describe)                                |
| <input type="checkbox"/> Electrical outlets              | <input type="checkbox"/> Sleeping accommodations | _____  |
| <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 Although Mrs.J. now has a regular ride to church, she is still dependent on her son or daughter-in-law for most transportation. Their other obligations sometimes make this a problem.

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. What impact have changes in the environment in the past year had on the lives of the client/family (*may include positive and negative impact*)? Son is much more invested in maintaining property now that he owns it. Clt. feels more satisfied with housekeeping and secure in her home.

### III. Mental/Emotional Assessment

A. Client's/family's perception of client's current mental/emotional health Client says she is generally happy and enjoys her friends and family. The family is pleased that she has become so much happier. They are no longer concerned about her memory.

B. Have you used any assessment instruments to evaluate the client's mental/cognitive status within the past year, or at this reassessment?  No  Yes (*If yes, list tools, the results, and your evaluation.*) GDS went from 12 to 9 to 7 over first 2 quarters. Clt.'s "log" of good days and bad days (on kitchen calendar) shows an average of 5 good days a week compared to less than 1 per week when she began keeping a record.

C. Has the client had hospitalization/treatment for mental/emotional problems since the last annual assessment or reassessment (*include in-patient, out-patient, therapy, substance abuse recovery programs, changes in therapist or other mental health workers*)?  No  Yes (*If yes, give setting(s), length of stay(s) or participation, and reason(s).*) \_\_\_\_\_

D. What impact have changes in mental/emotional health in the past year had on the lives of the client/family (*may include positive and negative impact*)? Clt. & family both say how much more they are enjoying spending time together, even if they don't spend as much as one year ago. Mrs. J.'s new friendships make it so that she doesn't rely on family exclusively, and this seems to have made things easier.

E. 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)		
Changes in mood (sudden/extreme)		
Change in appetite		
Cognitive impairment/memory impairment (specify)	C/F	<i>Occasional memory probs., clt./family don't see as problem</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>Substantially reduced—nearly entirely gone</i>
Sleep disturbances		
Substance abuse (specify)		
Thoughts of death/suicide		
Wandering		
Other:		
Other:		
*Source Codes: C=client's statement F=family member/guardian/responsible party		M=FL-2, MD, medical/mental health professional S=Social worker observation/judgment O=Other collateral (specify)_____

IV. Physical Health

A. Client's/family's perceptions of client's current health status Clt. & family believe physical health is generally good, report no new problems. Daughter-in-law has some lingering concerns about clt.'s compliance with blood pressure diet and medications.

B. Have there been changes/additions in the client's medical providers?  No  Yes (Update the Face Sheet as necessary.) Clt. now seeing Dr. May Shepard at Metro Family Practice (see address/phone on FS)

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

Diagnosis/Symptom	Source*	Notes (e.g., onset, severity, history, functional impact, untreated condition, needs professional assessment)
<del>Arthritis</del> osteoporosis/gout	C	<i>Somewhat better pain management. Condition same.</i>
Asthma/emphysema/other respiratory		
Bladder/urinary problems/incontinence		
Bowel problems/incontinence	C	<i>occasional constipation, no changes</i>
Bruises		
Burns		
Cancer		
Dental problems		
Diabetes		
Dizziness/falls		
Eye diseases/conditions	M/C	<i>vision restored since cataract surgery</i>
Headaches		
Hearing difficulty	F	<i>slightly worse than last year, esp. on phone</i>
Heart disease/angina		
Hypertension/high blood pressure	M	<i>Diet &amp; meds. —some compliance problems</i>
Kidney disease/renal failure		
Liver diseases		
Malnourished/dehydrated		
M. Sclerosis/M. Dystrophy/C. Palsy		
Pain		
Paraplegia/quadruplegia/spinal problems		<i>See arthritis</i>
Parkinsons disease		
Rapid weight gain/loss		
Seizures		
Sores (specify)		
Speech impairment		
Shortness of breath/persistent cough		
Stroke		
Other: <i>Fracture of right radius</i>	M	<i>Healed by reassessment</i>
Other:		
*Source Codes: <i>Dr. Shepard</i> M=FL- <del>X</del> <u>M.D.</u> other medical professional		
C=client's statement S=Social worker observation/judgment		
F=family member/guardian/responsible party O=Other collateral (specify) _____		

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

Name	Comments ( <i>dosage, compliance issues, other</i> )
<i>Motrin</i>	
<i>Lasix</i>	<i>* new since last year, 40 mg. b.i.d.</i>
<i>Prinivil</i>	<i>*new since last year, 20 mg./day; aggravating constipation?</i>
<i>Milk of Magnesia</i>	
<i>Metamucil</i>	
<i>Prune juice</i>	
<i>Low fat/low salt diet</i>	<i>Clt. has had some difficulty changing her cooking habits and staying on diet. Says, "I feel so good, I can't imagine a little salt can hurt."</i>

E. 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 \_\_\_\_\_

F. Does the client have new or continuing unmet needs for durable medical equipment?  
 No  Yes \_\_\_\_\_

G. Has the client been hospitalized or had outpatient procedures since the last (re)assessment?  
 No  Yes (Describe—Where? When? Why?) Cataract surgery at Kudzu Co. Hosp. 4/3/95 left eye; 4/18/95, right eye. Clt. satisfied with results. Fractured radius set (outpatient) 8/19/95

H. What impact have changes in physical health in the past year had on the lives of the client/family (may include positive and negative impact)? Clt. able to keep house, read as she used to because of cataract surgery. Pain meds. fairly effective w/arthritis. Family no longer needs to help with personal care.

**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 & family pleased with her ability to do ADLs and more IADLs. Son more comfortable w/help he provides.

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	<input checked="" type="checkbox"/>				} Aide helped before; now self-reliant
Bathing	<input checked="" type="checkbox"/>				
Dressing	<input checked="" type="checkbox"/>				
Eating	<input checked="" type="checkbox"/>				
Grooming	<input checked="" type="checkbox"/>				
Toileting	<input checked="" type="checkbox"/>				
Transfer	<input checked="" type="checkbox"/>				
to/from bed					
to/from chair					
into/out of car					
<b>IADL Tasks</b>					
Home maintenance		<input checked="" type="checkbox"/>		1	Son
Housework					
Laundry		<input checked="" type="checkbox"/>		1	Family
Meal preparation		<input checked="" type="checkbox"/>		1	Aide helping show cooking for high bp
Money management					
Shopping/errands		<input checked="" type="checkbox"/>		1	Family and friends
Telephone use					
Transportation use		<input checked="" type="checkbox"/>		1	Friends from support group help sometimes

C. What impact have changes in ADLs/IADLs in the past year had on the lives of the client/family (may include positive and negative impact)? Client more self-sufficient; family says they feel less pressure to help, can enjoy her company more than before.

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**V. Economic**

A. Client's/family's perception of changes in the client's financial situation and ability to manage finances. Client & family say they are managing well.

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B. Monthly Income (from all sources)  
 Social Security/SSI \$380.00  
 retirement/VA/RR \_\_\_\_\_  
 other annuity 50.00  
money from son 50.00

D. Monthly Expenses  
 rent/mortgage \_\_\_\_\_  
 food/supplies \$75  
 utilities 100  
 heat 45  
 water/sewer 30  
 transportation \_\_\_\_\_  
 clothes/laundry 30  
 insurance (type) home 0 (son pays)  
 medical 40  
 other telephone 30  
taxes 0 (son pays)  
TOTAL \$350

C. Other resources TOTAL \$ 480.00  
 (e.g., food stamps, subsidized housing, property, Medicare, Medicaid)  
Medicare, burial plan

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E. Any changes in house or property ownership (e.g., mortgage added/paid off, property sold or inherited)? Son now owns the home; clt. has lifetime right to remain.

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

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G. If expenses exceed income, what does the client do to manage? N/A

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H. What impact have changes in the economic domain in the past year had on the lives of the client/family (may include positive and negative impact)? Client feels more secure in the event of a financial emergency. She has saved a little money. Son is more willing to pay to keep house up.

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

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## VII. Formal Services Currently Received by Client

Service	Provider	Comments
Adult day care		
CAP (community alternatives)		
Case management	DSS	Discontinue as of 3/1
Counseling		
Employment services		
Food Stamps		
In-home aide/PCS	DSS	Discontinue as of 3/1
Legal guardian		
Meals (congregate/home)		
Medicaid		
Mental health services		
Nursing services		
Payee		
Public/subsidized housing		
Sheltered workshops		
Skilled therapies (PT, OT, ST)		
Telephone alert/reassurance		
Transportation		
Other: _____		
Other: _____		

### Progress on goals

Goal # &/or description <u>Diet for blood pressure</u> _____ _____	Progress <u>Client is having fewer slips, but still "cheats" on her diet several times per week.</u> <u>Blood pressure has been within acceptable limits on last 2 exams.</u> _____ _____	Disposition <input type="checkbox"/> goal met/discontinue <input checked="" type="checkbox"/> goal being met, ongoing <input type="checkbox"/> continue working toward goal <input type="checkbox"/> try new strategy <input type="checkbox"/> revise goal <input type="checkbox"/> Other: _____
Goal # &/or description <u>Autonomy in housework</u> _____ _____	Progress <u>Client can do dishes, dust, and vacuum. Still has some trouble with laundry, but can get some help from family members.</u> _____ _____	Disposition <input checked="" type="checkbox"/> goal met/discontinue <input type="checkbox"/> goal being met, ongoing <input type="checkbox"/> continue working toward goal <input type="checkbox"/> try new strategy <input type="checkbox"/> revise goal <input type="checkbox"/> Other: _____
Goal # &/or description <u>Grief/outlook</u> _____ _____	Progress <u>See item III-B under mental health.</u> _____ _____	Disposition <input checked="" type="checkbox"/> goal met/discontinue <input type="checkbox"/> goal being met, ongoing <input type="checkbox"/> continue working toward goal <input type="checkbox"/> try new strategy <input type="checkbox"/> revise goal <input type="checkbox"/> Other: _____
Goal # &/or description _____ _____ _____	Progress _____ _____ _____	Disposition <input type="checkbox"/> goal met/discontinue <input type="checkbox"/> goal being met, ongoing <input type="checkbox"/> continue working toward goal <input type="checkbox"/> try new strategy <input type="checkbox"/> revise goal <input type="checkbox"/> Other: _____

