Appendix A

The Record-Keeping Tools

Adult Services Intake/Inquiry Information

Use for all adult services intakes except APS referrals.

Client's name ______________________________ Date ________

If assigned: Case # ______________ ID # ______________

Date of Birth ____________ Social Security Number ______________

Type of contact

- ❑ Office visit
- ❑ Phone call
- ❑ Home intake
- ❑ Other: ________

Persons other than client involved in initial referral/contact: (check all that apply)

- ❑ Family member(s) ______________
- ❑ Neighbor(s)/friend(s) ______________
- ❑ Physician ______________
- ❑ Agency ______________
- ❑ Facility ______________
- ❑ Other: ______________

Client's level of involvement in referral/contact:

- ❑ client was present and participating
- ❑ client not present, but desires referral/contact
- ❑ client not present, but aware of referral/contact
- ❑ client was present but did not participate (explain) ______________
- ❑ client unaware of contact (explain) ______________
- ❑ uncertain (e.g. telephone contact) ______________

Presenting problem(s) ______________________________

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Additional history (duration/efforts/outcomes) ______________________________

____

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____

Expectation of person(s) at intake interview, including services requested

____

____

Urgent?

- ❑ Yes
- ❑ No

Preliminary information in functional domains

Social ______________________________

____

____

Environmental ____

____

Mental health ____

____

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Physical health ____

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ADL/IADL ____

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Economic ____

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DISPOSITION (check all that apply)

- ❑ Opened case/accepted referral (specify) ____________________
- ❑ Wrote/phoned referral to other agency (specify) ____________________
- ❑ Advised of food stamp program
- ❑ Advised of Medicaid application procedure
- ❑ FL-2 given
- ❑ Application for eye exam
- ❑ Application for transportation
- ❑ Application for fuel assistance
- ❑ Other: ____
- ❑ Application for emergency financial assistance
- ❑ Application for senior nutrition/home-delivered meals
- ❑ Family planning information
- ❑ Explained other DSS services (specify) ____________________
- ❑ Bus ticket provided
- ❑ Closed/handled at intake
- ❑ Unable to assist client (reason) ____________________

Did anything during the initial interview suggest that the client may live in an environment dangerous to the social worker visiting? (Check all that apply and explain below.) Be sure to note dangers in the directions to home section of the face sheet.

- ❑ Dangerous neighborhood
- ❑ Violence in home
- ❑ Guns/weapons in home
- ❑ Biting dog/other dangerous pets
- ❑ Drug use/transactions in home
- ❑ Other: ____

Describe (include source of information and impression of the seriousness of the danger)

____

____

Additional comments (if needed) ____

____

____

____

Intake social worker's signature ____

Case # ____________________
ID # ____________________

Face Sheet

(begun at intake, continued at assessment, updated as necessary)

Client name(s)	Sex	Race	DOB	Marital Status	Education completed	Social Security #

Address		
City	State	Zip
Is this address a facility? Yes No If yes, level of care:	Client's phone number(s):	
Directions to client's residence/potential dangers/other notes:		

Emergency Contact:	Relationship to client:
address	Phone number(s):

Others in client's household (or significant persons in group settings)

Name	Year of Birth	Relationship to Client	Daytime Phone

Significant others not in client's household

Name	Relationship	Address	Phone(s)

Notes/Comments:

Professional contacts			
Name	Profession	Address	Phone

Medicaid # MQB	Medicare # A B
Medicaid Worker	Phone/ext.
Other IM CaseWorker	Phone/ext.
Is client/spouse a veteran? Yes No	
Private Insurance: Yes No	Type(s): Medical Long Term Care Life Burial
Insurance information:	
Advance directives/ living will/ burial arrangements:	
Does the client have a guardian, payee, or a person with power of attorney? If yes, complete below.		

Name	status	Phone number(s)
address		
Name	status	Phone number(s)
address		

History of services requested/received:

Notes *(Counties may wish to identify additional information to be recorded here.)*

Case # ____________________
ID # ____________________

Adult Services Functional Assessment

Client's name ______________________________ Date ______________

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

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

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

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

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

2. Does the client have a caregiver/caretaker? __ 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.)* ______________________________

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.* ______________________________

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

II. Environment

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

____

____

B. Type of residence
- __house/mobile home
- __apartment
- __boarding room
- __homeless
- __other ______________

facility/group home
- __ nursing home
- __ family care home
- __ home for the aged
- __ DD home
- __ rehab/treatment/acute facility
- __ shelter (specify)____________________________________

C. Location
- __ town/city
- __ rural community
- __ isolated

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.

- __Access within home
- __Access, exterior
- __Bathing facilities
- __Cooking appliance
- __Cooling
- __Eating area
- __Electrical outlets
- __Fire hazards/no smoke detectors
- __Heating
- __Laundry
- __Lighting
- __Living area
- __Locks/security
- __Pests/vermin
- __Refrigerator
- __Shopping (access)
- __Sleeping accommodations
- __Structural integrity
- __Telephone
- __Toilet
- __Transportation
- __Trash disposal
- __Ventilation
- __Water/plumbing
- __Yard (or area immediately outside of residence)
- __Other (describe)

____

____

____

Comments ____

____

____

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

____

G. Environmental strengths ____

____

III. Mental/Emotional Assessment

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

____

____

B. Were any mental/cognitive assessment instruments used by social worker or a mental health professional? ___ 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**

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)		
Changes in mood (sudden/extreme)		
Change in appetite		
Cognitive impairment/memory impairment (specify)		
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		
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)________________________

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

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

___ No ___ Yes If yes, describe: ________________________

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

____

IV. Physical Health

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

____

____

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

Diagnosis/Symptom	Source*	Notes (e.g., onset, severity, history, functional impact, untreated condition, needs professional assessment)
Arthritis/osteoporosis/gout		
Asthma/emphysema/other respiratory		
Bladder/urinary problems/incontinence		
Bowel problems/incontinence		
Bruises		
Burns		
Cancer		
Dental problems		
Diabetes		
Dizziness/falls		
Eye diseases/conditions		
Headaches		
Hearing difficulty		
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:
C=client's statement
F=family member/guardian/responsible party
M=FL-2, M.D., other medical professional
S=Social worker observation/judgment
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? ______________________

____

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

Medical Providers	Notes

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

Name	Comments (*dosage, compliance issues, side effects, other*)

F. Does the client need assistance with medication or treatment? 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.*)

___cane
___catheter
___commode (seat/bedside)
___communications devices
___crutches
___dentures
___diabetic supplies
___glasses
___grab bars
___hearing aid
___hospital bed
___incontinence supplies
___ostomy/colostomy bags
___oxygen equipment
___prosthesis
___ramp
___telephone alert device
___walker
___wheelchair
___other ______________

____

Comments/explanations ______________________

____

____

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

____

V. ADL/IADL

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

____

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

ADL Tasks	Help needed? none	some	total	Need met? 1-yes 2-partial 3-no	**Comments** (*e.g., who assists, equipment used, problems or issues for caregivers*)
Ambulation					
Bathing					
Dressing					
Eating					
Grooming					
Toileting					
Transfer					
to/from bed					
to/from chair					
into/out of car					
IADL Tasks					
Home maintenance					
Housework					
Laundry					
Meal preparation					
Money management					
Shopping/errands					
Telephone use					
Transportation use					

C. ***[For APS use only]*** Is the client incapacitated, and without someone able, willing, and responsible to provide assistance? ___No ___Yes ____________________

____

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

E. Client/family strengths ____________________

____

VI. Economic

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

____

____

B. Monthly Income (from all sources)

Social Security/SSI ____________

retirement/VA/RR ____________

other ____________

____

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

____

____

____

____

D. Monthly Expenses

rent/mortgage ____________

food/supplies ____________

utilities ____________

heat ____________

water/sewer ____________

transportation ____________

clothes/laundry ____________

insurance (type) ____________

medical ____________

other ____________

____

E. Home/property ownership: ____

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

____

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

____

H. Client/family strengths ____

____

VII. Formal Services Currently Received by Client (If none, check here ___.)

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

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

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

____

____

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____

Summary of Findings—including strengths and problems

____

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____

Documentation of eligibility for specific services:

____

____

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

___develop goals/service plan

___complete APS disposition

___transfer case to another unit

___close case

___make referral to another agency

___other ______________________________

Social worker's signature/date ______________________________/__________

Supervisor's signature/date ______________________________/__________

Adult and Family Service Plan

Client: ________________________________

__ Initial __Update __Quarterly __Reassessment

(Use additional sheets as necessary.)

Case # ______________________

ID # ______________________

Date initiated ______________________

Checklist for Change (Problem/Need)	Goal	Target Date	Activities/Services	Person/Agency Responsible	Activity Done	Goal Met

DSS-6221 (8-1-94)

Checklist for Change (Problem/Need)	Goal	Target Date	Activities/Services	Person/Agency Responsible	Activity Done	Goal Met

Social Worker

Date

Client

Date

Other (optional)

Date

Contact/Activity Log

Client ______________________
Case # ______________________
Id # ______________________

Date	Contact or Activity	Results of Contact/Activity

Interim or Quarterly Client Review

Client ____ Date ______________________
Case# ______________ ID# _________________________

Review was conducted
(check more than one, if applicable)
- ☐ in client's home
- ☐ at DSS
- ☐ by telephone
- ☐ in client's relative's home
- ☐ hospital
- ☐ nursing home/domiciliary care
- ☐ adult day care center
- ☐ other (explain) __________________________

Information was obtained during the review period from
(check all that apply):
- ☐ client
- ☐ primary caregiver
- ☐ guardian
- ☐ other family ________________________________
- ☐ friends
- ☐ aide or other paid assistant
- ☐ facility staff
- ☐ other professionals __________________________
- ☐ other _____________________________________

Have there been any changes/events since the last review which have a SUBSTANTIAL impact on the client's/family's life or need for services? If yes, summarize briefly.

____
____
____

Update face sheet to reflect any changes such as address, phone, or household composition.

Review of the functional domains

Please include in your summary new problems, worsening conditions, improvements, and new resources or accomplishments. (Include information that documents the continuing need for services.)

Social ____
____
____

Environment (home and neighborhood) ____
____
____

Mental/Emotional health ____
____
____

Physical health ____
____
____

ADLs and IADLs ____
____
____

Economic ____

____

____

Summarize below any other significant events, contacts, or activities during the quarter (include dates) or attach relevant sections of your log notes.

____

____

____

____

Progress on Goals

Goal # &/or description	Progress	Disposition
____________	____________________	☐ goal met/discontinue ☐ goal being met, ongoing ☐ continue working toward goal ☐ try new strategy ☐ revise goal ☐ Other: ____________
____________	____________________	☐ goal met/discontinue ☐ goal being met, ongoing ☐ continue working toward goal ☐ try new strategy ☐ revise goal ☐ Other: ____________
____________	____________________	☐ goal met/discontinue ☐ goal being met, ongoing ☐ continue working toward goal ☐ try new strategy ☐ revise goal ☐ Other: ____________
____________	____________________	☐ goal met/discontinue ☐ goal being met, ongoing ☐ continue working toward goal ☐ try new strategy ☐ revise goal ☐ Other: ____________

Update service plan as needed.

Social worker's signature ____

Case # ____________________
ID # ____________________

Adult Services Annual Reassessment

Client's name ____ Date ______________

I. Social

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

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.*
____
____
____
____
____
____
____
____
____
____

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 ____________________
____
____

B. Type of residence
__house/mobile home
__apartment
__boarding room
__homeless
__other ______________

facility/group home
__ nursing home
__ family care home
__ home for the aged
__ DD home
__ rehab/treatment/acute facility
__ shelter (specify)________________________________

C. Location
__ town/city
__ rural community
__ isolated

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.

__Access within home
__Access, exterior
__Bathing facilities
__Cooking appliance
__Cooling
__Eating area
__Electrical outlets
__Fire hazards/no smoke detectors
__Heating
__Laundry
__Lighting
__Living area
__Locks/security
__Pests/vermin
__Refrigerator
__Shopping (access)
__Sleeping accommodations
__Structural integrity
__Telephone
__Toilet
__Transportation
__Trash disposal
__Ventilation
__Water/plumbing
__Yard (or area immediately outside of residence)
__Other (describe)
____
____
____

Comments ____
____

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

G. 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)*? ______________________________
____
____

III. Mental/Emotional Assessment

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

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*.)
____
____

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)*? ______________________________
____

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)		
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		
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______________________________________
____
____

B. Have there been changes/additions in the client's medical providers? __ No __ Yes (*Update the Face Sheet as necessary.*) ____
____
____
____
____
____

C. 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		
Asthma/emphysema/other respiratory		
Bladder/urinary problems/incontinence		
Bowel problems/incontinence		
Bruises		
Burns		
Cancer		
Dental problems		
Diabetes		
Dizziness/falls		
Eye diseases/conditions		
Headaches		
Hearing difficulty		
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: C=client's statement F=family member/guardian/responsible party		M=FL-2, M.D., other medical professional S=Social worker observation/judgment O=Other collateral (specify)__________________________

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

Name	**Comments (*dosage, compliance issues, other*)**

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?*) ____
____

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)*? ____
____
____

V. ADL/IADL

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

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

ADL Tasks	**Help needed?** *none*	*some*	*total*	**Need met?** 1-yes 2-partial 3-no	**Comments** (*e.g., who assists, equipment used, problems or issues for caregivers*)
Ambulation					
Bathing					
Dressing					
Eating					
Grooming					
Toileting					
Transfer					
to/from bed					
to/from chair					
into/out of car					
IADL Tasks					
Home maintenance					
Housework					
Laundry					
Meal preparation					
Money management					
Shopping/errands					
Telephone use					
Transportation use					

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)*? ______

______

______

V. Economic

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

______

______

B. Monthly Income (from all sources)
- Social Security/SSI ______
- retirement/VA/RR ______
- other ______

______

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

______

______

______

______

D. Monthly Expenses
- rent/mortgage ______
- food/supplies ______
- utilities ______
- heat ______
- water/sewer ______
- transportation ______
- clothes/laundry ______
- insurance (type) ______
- medical ______
- other ______

______

E. Any changes in house or property ownership (*e.g., mortgage added/paid off, property sold or inherited*)?

______

______

F. Are there any problems/irregularities in the way the client's money is managed (*by self or others*)?

___ No ___Yes ______

______

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

______

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)*? ______

______

______

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

______

______

______

______

______

VII. Formal Services Currently Received by Client

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

Progress on Goals

Goal # &/or description
____
____
____

Progress ____
____
____
____
____

Disposition
- ☐ goal met/discontinue
- ☐ goal being met, ongoing
- ☐ continue working toward goal
- ☐ try new strategy
- ☐ revise goal
- ☐ Other: __________________

Goal # &/or description
____
____
____

Progress ____
____
____
____
____

Disposition
- ☐ goal met/discontinue
- ☐ goal being met, ongoing
- ☐ continue working toward goal
- ☐ try new strategy
- ☐ revise goal
- ☐ Other: __________________

Goal # &/or description
____
____
____

Progress ____
____
____
____
____

Disposition
- ☐ goal met/discontinue
- ☐ goal being met, ongoing
- ☐ continue working toward goal
- ☐ try new strategy
- ☐ revise goal
- ☐ Other: __________________

Goal # &/or description
____
____
____

Progress ____
____
____
____
____

Disposition
- ☐ goal met/discontinue
- ☐ goal being met, ongoing
- ☐ continue working toward goal
- ☐ try new strategy
- ☐ revise goal
- ☐ Other: __________________

Summary of Findings—including strengths and problems

Documentation of eligibility for specific services:

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

___revise goals/service plan
___transfer case to another unit
___close case
___make referral to another agency
___other ______________________________

Social worker's signature/date ____/________

Supervisor's signature/date ____/________

Case Closing/Transfer Summary

Client Name ______________________________ Date __________

Case # ______________ ID # ______________

Case is being . . . ☐ closed/withdrawn ☐ transferred to ______________ Effective ________

If closed, reason for closing:

☐ client refused services
☐ client requested termination of services
☐ client moved out of county
☐ client cannot be located
☐ Other: ______________________________
☐ client died
☐ DSS unable to continue services
☐ goals met/no services needed

If transferred, reason for transfer:

☐ Redistribution of cases for administrative purposes
☐ Revised service plan calls for other worker/unit
☐ Other: ______________

Date of most recent review or (re)assessment ______________

Significant changes since most recent review ______________________________

____

____

____

____

Pending or recently completed social work activities on client's/family's behalf since the most recent review

____

____

____

____

____

Unresolved concerns ____

____

____

____

____

____

____

Client's/family's response to case closing or transfer ______________________

____

____

____

____

Social worker's signature ______________________________________