

NORTH CAROLINA

HOME CARE INDEPENDENCE PROGRAM

SERVICE ASSESSMENT/REASSESSMENT FORM

Initial____ or Annual____ or Other____

DATE_____

Participant_____

Address_____

Tele:_____

Date of Birth_____

Marital Status: M_ S_ D_ W_ If married, name of spouse_____

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I. Health StatusAsk the following of the Participant and note any observations relative to mental agility:

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

Are you currently receiving treatment for any of the above or for any other condition? Yes____ No____

If Yes, for what? _____

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

Participant does not take daily medications_____

Primary Physician: Name_____

Address_____ Telephone_____

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

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

Comments regarding ADLS:

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

Comments regarding IADLs:

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

IV. Social

Who has been involved in the care of this Participant?

Agency caregiver____
Family member____ Specify_____
Friend____ Specify_____
Privately hired person____

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

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

Does the Participant engage in social activities in the community? Yes____ No____

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

V. Economic

Total monthly income of Participant and Spouse, if married_____
Sources of income: Soc.Sec.____ SSI____ VA pension____ other____

Financial Affairs managed by:
Participant____ Relative____ Guardian____ Trust____
Power of Attorney____ Other____(specify)_____

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

VI. Summary Comments by Assessor:

Signature of Assessor_____ Title_____
Date_____