

Adult Services Functional Assessment

Client Name: _____

Date: _____

Case # _____

ID # _____

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

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

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

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

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

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

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

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

II. Environment

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

B. Type of residence

Other - Explain below

Facility/Group Home

Specify shelter below

C. Location

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

List below head of household or if Other - Explain

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

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

List Comments/Explanations and/or Describe Other below.

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

G. Environmental Strengths

III. Mental/Emotional Assessment

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

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

| Instrument | Given By | Findings/Conclusions |
|------------|----------|----------------------|
| | | |
| | | |

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

| Diagnosis/Sympton | Source Code | Other - Specify | Notes (e.g., onset, severity, functional impact, history, untreated condition, needs professional assessment) |
|--|-------------|-----------------|---|
| Aggressive/abusive behavior | | | |
| Agitation/anxiety/panic attack | | | |
| Change in activity level (sudden/extreme) | | | |
| Changes in mood (sudden/extreme) | | | |
| Change in appetite | | | |
| Cognitive impairment/memory impairment (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: | | | |

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

| |
|--|
| |
|--|

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

| |
|--|
| |
|--|

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

IV. Physical Health

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

B. Physical health problems: diseases, impairments and symptoms

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

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

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

| | Help needed? | | | Need met? 1 - Yes 2 - Partial 3 - No | Comments (e.g., who assists, equipment used, problems or issues for caregivers) |
|--------------------|--------------|------|-------|---|---|
| | None | Some | Total | | |
| ADL Tasks | | | | | |
| Ambulation | | | | | |
| Bathing | | | | | |
| Dressing | | | | | |
| Eating | | | | | |
| Grooming | | | | | |
| Toileting | | | | | |
| Transfer | | | | | |
| to/from bed | | | | | |
| 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? Yes No

Comments/Explanation

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

E. Client/family strengths

VI. Economic

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

B. Monthly income (from all sources)

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

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

D. Monthly Expenses

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

Insurance type or Other explain: _____

E. Home/property ownership: _____

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

Yes No

If yes, please explain:

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

H. Client/family strengths

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

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

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

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

Summary of Findings - Including strengths and problems

Documentation of eligibility for specific services:

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

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

If other, explain:

Social Worker's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____