State of Alaska DHSS/Division of Senior and Disabilities Services

Senior In-Home Services Grant
CASE MANAGEMENT ASSESSMENT

(Complete sections appropriate to client situation)

Client Information

Date:

Name:			**Phone:**
DOB:	Age:	Race/Ethnicity:	Gender: Male ☐ Female ☐
Mailing Address:			
Residence Address:			
Email:			
Veteran: ☐ Yes ☐ No	Medicaid: ☐ Yes ☐ No		Medicare: ☐ Yes ☐ No
Medicare Part D: ☐ Yes ☐ No			Marital Status:
Living Arrangements:			Hospitalized? Yes ☐ No ☐
Referral Source:			Date of last PCA and/or denied Waiver assessment:

Emergency Contact:	Phone:	Relationship:
Primary Caregiver:	Phone:	Relationship:
Primary Caregiver Address:		
Email:		
Legal Representative:		Type: DPOA ☐ Guardian ☐ Conservator ☐
Person to contact regarding fees/billing:		Phone:
Documentation of Living Will? Yes ☐ No ☐		Comfort One? Yes ☐ No ☐

Primary Physician:	Phone:
Secondary Physician:	Phone:

Medication Allergies	**Other Allergies**

Cognitive and Behavior Status:

Short Term Memory? ☐ okay ☐ problems		Long Term Memory? ☐okay ☐problems
Alzheimer's Disease? ☐ yes ☐ no	Dementia? ☐ yes ☐ no	How long?
Does client wander? ☐yes ☐ no Is client combative? ☐yes ☐ no Does client get agitated or anxious? ☐yes ☐ no Other behavior changes? ☐yes ☐ no What provokes a behavior change?		Comments

Diagnoses

ENDOCRINE/METABOLIC/NUTRITIONAL
- ☐ Diabetes Mellitus
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

HEART/CIRCULATION
- ☐ Arteriosclerosis heart disease
- ☐ Cardiac dysrhythmia
- ☐ Congestive heart failure
- ☐ Hypertension (high blood pressure)
- ☐ Other cardiovascular disease

MUSCULOSKELETAL
- ☐Arthritis
- ☐ Hip fracture
- ☐ Missing limb
- ☐ Osteoporosis

PULMONARY
- ☐ Asthma
- ☐ Emphysema/COPD
  - ☐ Bronchitis
  - ☐ Pneumonia

NEUROLOGICAL
- ☐ Alzheimer's disease
- ☐ Aphasia
- ☐ Dementia other than Alzheimer's disease
- ☐ Hemiplegia/hemiparesis
- ☐ Multiple sclerosis
- ☐ Paraplegia
- ☐ Parkinson's disease
- ☐ Quadriplegia
- ☐ Seizure disorder
- ☐ Stroke
- ☐ Transient ischemic attack (TIA)
- ☐ Traumatic brain injury

PSYCHIATRIC/MOOD
- ☐ Anxiety disorder
- ☐ Depression
- ☐ Manic Depression (bipolar disease)
- ☐ Schizophrenia

OTHER
- ☐ Anemia
- ☐ Cancer
- ☐ Renal failure
- ☐ Tuberculosis
- ☐ HIV
- ☐ Mental retardation (Down's syndrome, autism or other related to MR or DD)
- ☐ Substance Abuse
- ☐ Other psychiatric diagnosis paranoia, phobias disorder)
- ☐Explicit Terminal prognosis

☐ Other: _____

☐ Other: _____

☐ Other: _____

☐ Other: _____

Medications

(Include non-prescription medicines and supplements)

Medication Name	Dosage	Frequency

Emergency Room Visits:	Reason:	Dates:	Comments:
Hospitalizations in past year:			
Nursing Home Admissions			
Surgeries:			
Psycho-social concerns and/or previous psychiatric treatment:			

Sensory

Vision **Glasses? Yes / No** Ability to see in normal light w/ glasses/contacts, if used:		Comments
	Good – *sees regular print in newspapers/books*	
	Fair – *sees headlines but not regular print in newspapers*	
	Poor – *cannot read headlines*	
	Blind - *no functional vision*	
	Glaucoma	
	Cataracts	
	Macular Degeneration	
	Other:	

Hearing **Use hearing aids? Left / Right / Both** Ability to hear with hearing aid if used:		Comments
	Good – *hears normal conversation, TV, phone*	
	Fair – *some problems hearing when not in a quiet setting*	
	Poor – *hears only if volume is turned up or voices raised*	
	Deaf – *no functional hearing*	
	Other:	

Functional Information

What level of assistance is needed? (0 = independent; 1 = supervision (encouragement/cues); 2 = limited assistance/minimal physical; 3 =extensive assistance; or 4 = total dependence)

ADLs	Level of assistance	**IADLs**	Level of assistance
Eating/Drinking		Preparing meals	
Dressing		Shopping for food	
Bathing (*Transfer in/out of tub required)?*		Housekeeping Light	
Toileting		Housekeeping Heavy/laundry	
Transferring in/out of bed or chair		Medication management	
Ambulation/Mobility: *Walking*		Managing money	
Stairs		Using telephone	
Walking Distance		Using available transportation	
Does Caregiver assist with ADLs? ☐yes ☐ no		**Does Caregiver assist with IADLs?** ☐yes ☐ no	

Additional Information:
Safety challenges:

Limitations on activities:
Communication challenges:
Special family support needs:
Additional comments:

Equipment Used and/or Needed

	Uses	Needs		Uses	Needs	Comments
Walker			Cane			
Scooter			Lift			
Raised Toilet Seat			Grab Bars			
Bath Bench or chair			Other Devices			
Special Equipment			Personal Items			

Nutrition and Diet

(check all that apply and include comments as needed)

Eating Issues		Comments
	Chewing	
	Lack/poor fitting dentures	
	Difficulty swallowing	
	Lack of appetite	
	Food Allergies	
	Lack of money for food	

Dietary Needs		Comments
	Pureed food	
	Low salt	
	Diabetic diet	
	Low fat/cholesterol	
	Dietary supplements	

Meals eaten daily? ☐ 1 or less ☐ 2 ☐ 3 ☐ More than 3

Current Height: _____ Current Weight: _____
Weight change? ☐ Loss ☐ Gain How much over what period of time?

Physician advised of weight loss/weight gain? ☐ Yes ☐ No

Comments:

Home Safety

Check and comment on any that make home environment hazardous, challenging or uninhabitable		Comments
Lighting (adequacy of lighting, exposed wiring)	☐	
Flooring & carpeting (holes in floor, wires in pathway, scatter rugs)	☐	
Bathroom & toilet room (non-operating, leaking, no rails or grab bars, slippery bathtub, outside toilet, no running water, no plumbing, honey bucket)	☐	
Kitchen (dangerous stove, inoperative refrigerator, infestation of rats or bugs)	☐	
Heating and cooling (inoperative)	☐	
Personal safety (fear of violence, safety problem going to mailbox, visiting neighbors, heavy traffic)	☐	
Access to home (difficulty entering/leaving home)	☐	
Fall Prevention Issues	☐	
Unhygienic conditions	☐	
Fire risks	☐	
Additional Observations:		

Services Receiving and/or Needed

Services Currently Receiving:	Provider:	**Services Needed or Would Like:**
☐ Home-Delivered or Congregate Meals		☐ Home –Delivered or Congregate Meals
☐ Respite		☐ Respite
☐ Chore		☐ Chore
☐ PCA		☐ PCA
☐ Adult Day		☐ Adult Day
☐ Transportation		☐ Transportation
☐ Lifeline		☐ Lifeline
☐ Home Health Nurse		☐ Home Health Nurse
☐ DME		☐ DME
☐ Public Assistance		☐ Public Assistance
Comments:		

Care Concerns and tips for good care:

Case Manager Narrative:

_____ _____

Case Manager Signature Date