



**7. To be completed by S S W**

OTHERS IN HOME/HOUSEHOLD: Indicate days/hours that these persons will provide care to patient.  
If none will assist explain in narrative.

	NAME	Age	Relationship	Days/Hours at Home	Days/Hours will Assist
1.					
2.					
3.					
4.					

**8. To be completed by S S W**

SIGNIFICANT OTHERS OUTSIDE OF HOME: Indicate days/hours when persons below will provide care to patient.

	Name	Address	Age	Relationship	Days/Hours Assisting
1.					
2.					
3.					
4.					
5.					

**9. To be completed by S S W**

COMMUNITY SUPPORT: Indicate organization/persons serving patient at present or has provided a service in the past six (6) months.

	Organization	Type of Service	Presently Receiving	Contact Person	Tel No.
1.					
2.					
3.					
4.					

**10. To be completed by S S W and R.N.**

PATIENT TRAITS:

	Yes	No	?N/A	If you check No. ?N/A, describe
Appears self directed and/or independent				
Seems to make appropriate decisions				
Can recall med routine/recent events				
Participates in planning/treatment program				
Seems to handle crises well				
Accepts diagnosis				
Motivated to remain at home				

**11. To be completed by S S W and R.N. as appropriate**  
 FAMILY TRAITS:

	Yes	No	?	
a. Is motivated to keep patient home				If no, because _____
b. Is capable of providing care (physically & emotionally)				If no, because _____
c. Will keep patient home if not involved with care				Because _____
d. Will give care if support service given				How much _____
e. Requires instruction to provide care				In what – who will give _____

**12. To be completed by R.N.**

Home/Place where care will be provided:	Yes	No	?	If problem, describe
Neighborhood secure/safe				
Housing adequate in terms of: Space				
Convenient toilet facilities				
Heating adequate and safe				
Cooking facilities & refrigerator				
Laundry facilities				
Tub/shower/hot water				
Elevator				
Telephone accessible & usable				
Is patient mobile in house				
Any discernible hazards (please circle)				Leaky gas, poor wiring, unsafe floors, steps, other (specify)
Construction adequate				
Excess use of alcohol/drugs by patient/ caretaker; smokes carelessly.				
Is patient's safety threatened if alone?				
Pets				

ADDITIONAL ASSESSMENT FACTORS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**13. To be completed by R.N.**  
 RECOVERY POTENTIAL ANTICIPATED

		COMMENTS
Full recovery	<input type="checkbox"/>	_____
Recovery with patient management residual	<input type="checkbox"/>	_____
Limited recovery managed by others	<input type="checkbox"/>	_____
Deterioration	<input type="checkbox"/>	_____

**14. To be completed by R.N. – S S W to complete “D” as appropriate  
FOR THE PATIENT TO REMAIN AT HOME – SERVICES REQUIRED**

WHO WILL PROVIDE

SERVICES REQUIRED	YES	NO	TYPE/FREQ/DUR	AGENCY/FAMILY	AGENCY FREQUENCY
A. Bathing					
Dressing					
Toileting					
Admin. Med.					
Grooming					
Spoon feeding					
Exercise/activity/walking					
Shopping (food/supplies)					
Meal preparation					
Diet Counseling					
Light housekeeping					
Personal laundry/household linens					
Personal/financial errands					
Other					
B. Nursing					
Physical Therapy					
Home Health Aide					
Speech Pathology					
Occupational Therapy					
Personal Care					
Homemaking					
Housekeeping					
Clinic/Physician					
Other 1.					
2.					
C. Ramps outside/inside					
Grab bars/hallways/bathroom					
Commode/special bed/wheelchair					
Cane/walker/crutches					
Self-help device, specify					
Dressings/cath. equipment, etc.					
Bed protector/diapers					
Other					
D. Additional Services (Lab, O <sup>2</sup> , medication)					
Telephone reassurance					
Diversion/friendly visitor					
Medical social service/counseling					
Legal/protective services					
Financial management/conservatorship					
Transportation arrangements					
Transportation attendant					
Home delivered meals					
Structural modification					
Other					

**15. To be completed by S S W and R.N**

DMS Predictor Score \_\_\_\_\_ Override necessary  Yes  No

Can patient's health/safety needs be met through home care now?  Yes  No

If no, give specific reason why not \_\_\_\_\_

Institutional care required now?  Yes  No If yes, give specific reason why.

Level of institutional care determined by your professional judgment:  SNF  HRF  DCF

Can the patient be considered at a later time for home care?  Yes  No  N/A

**16. To be completed by S S W**

**SUMMARY OF SERVICE REQUIREMENTS**

Indicate services required, schedule and charges (allowable charge in area)

Services	Provided by	Hrs./Days/Wk.	Date Effective	Est. Dur.	Unit Cost	Payment by			
						MC	MA	Self	Other
Physician									
Nursing									
Home Health Aide									
Physical Therapy									
Speech Pathology									
Resp. Therapy									
Med. Soc. Work									
Nutritional									
Personal Care									
Homemaking									
Housekeeping									
Other (Specify)									
Medical Supplies/Medication									
1.									
2.									
3.									
Medical Equipment									
1.									
2.									
3.									
Home Delivered Meals									
Transportation									
Additional Services									
1.									
2.									
	<b>SUBTOTAL</b>								
Structural Modification									
Other (Specify)									
1.									
2.									

SUBTOTAL \_\_\_\_\_

TOTAL COST \_\_\_\_\_

17. To be completed by S S W and R.N.

**Person who will relieve in case of emergency**

Name	Address	Telephone	Relationship
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Narrative: Use this space to describe aspects of the patients care not adequately covered above.

Assessment completed by:	_____	_____
	R.N.	Agency
	_____	_____
	Date Completed	Telephone No.
	_____	_____
	Local DSS Staff	District
	_____	_____
	Date Completed	Telephone No.
	_____	_____
	Supervisor DSS	District
	_____	_____
	Date	Telephone No.

Authorization to provide services: \_\_\_\_\_  
Local DSS Commissioner or Designee Date