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|  | **Tennessee Department of Human Services****SSBG Social Assessment and Service Plan** |

| **CLIENT INFORMATION** |
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| Name:       | County: Choose an item. | Date:       |
| Street Address:       | City:       | Zip code:       |
| Phone:       | Email Address:       |
| DOB:       | Demographic Info:  | Marital status:  | Sex:  |
| General health conditions:       |
| Client a veteran?  | Widow(er) of veteran?  | Branch:  |
| Does client need LEP plan?  | If so, describe plan:       |
| Reason For Referral:   | Narrative:       |
| Service Goal:   |
| **Emergency Contact:** |
| Name:       | County: Choose an item. | Date:       |
| Street Address:       | City:       | Zip Code:       |
| Phone:       | Alternate Phone:       | Relationship to Client:       |
| Notes:       |

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| **ASSESSMENT** |
| **Reassessment Due Date:**       |
| **Home Environment** |
| **Dwelling Type:** | **Utilities:** | **Available appliances:** | **Environmental Conditions:**  |
|  |  | [ ]  Water | [ ]  Range  | Pest Infestation:  |
| Other:       | [ ]  Electricity  | [ ]  Refrigerator | Type of Pests:       |
|  | [ ]  Gas/Propane  | [ ]  Washer |
|  | [ ]  Heat  | [ ]  Dryer |
|  | [ ]  A/C  | [ ]  Telephone |
|  |  | [ ]  Operable Smoke Alarm |
| Pets  | Type:       | Quantity:  | Aggressive:  |
| Safety Plan Regarding Aggressive Animals:       |
| Weapons in home?  | Type:   | Location:       |
| Safety Plan Regarding Weapons in Home:       |
| **Physical Health** |
| Health Professional(s):       |
| **Medical Power of Attorney (POA)** |
| Name:       | Relationship:       | Phone:       |
| **Advanced Directives** |
| Copy on file or posted in home:  | Action plan to acquire or post:       |
| Health Care Agent:       | Phone:       |
| Instructions from document:       |
| **Special Diet** |
| [ ]  N/A | [ ]  Diabetic | [ ]  Heart healthy | [ ]  Gluten-free/Celiacs |
| [ ]  Renal | [ ]  Vegetarian/vegan | [ ]  Kosher/Halal | [ ]  Other:       |
| **Health Conditions** |
| [ ]  | Diabetes | [ ]  | Oxygen-Dependent | [ ]  | Blindness | [ ]  | Schizophrenia |
| [ ]  | Heart Problems | [ ]  | Difficulty Breathing | [ ]  | Hearing Loss | [ ]  | Anxiety |
| [ ]  | High Blood Pressure | [ ]  | Hepatitis | [ ]  | Speech problems | [ ]  | Depression |
| [ ]  | Stroke | [ ]  | HIV | [ ]  | Amputee:       | [ ]  | Bi-Polar |
| [ ]  | Paralysis | [ ]  | Tuberculosis | [ ]  | Incontinence: | [ ]  | ADHD |
| [ ]  | Dementia | [ ]  | Cancer |  | [ ]  Bladder [ ]  Bowel | [ ]  | Hoarding |
| [ ]  | Memory Loss | [ ]  | Parkinson’s | [ ]  | Obesity | [ ]  | Fall Risk |
| [ ]  | Confusion | [ ]  | Skin Breakdown | [ ]  | Sleep Disorder | [ ]  | Bedfast |
| [ ]  | Seizures | [ ]  | Arthritis | [ ]  | Back problems | [ ]  | Allergies:       |
| [ ]  | Traumatic Brain Injury | [ ]  | Vision Loss | [ ]  | Dental problems | [ ]  | Other:       |
| **Injections** |
| Does client receive injections for any medical condition?  |
| Location injections administered:  | If at home, injections administered by:  |
| If injections administered by client or caregiver, was proper disposal of needles reviewed with parties?  |
| **Falls/Hospitalizations** |
| Has client fallen in past three (3) months?  | Number of occurrences:  |
| Has client been hospitalized in last year?  | Number of occurrences:  |
| Reason(s):       |
| **Medical/Physical Areas of Concern** |
| [ ]  Inadequate/unclean clothing | [ ]  Poor hygiene | [ ]  Shopping |
| [ ]  Food (eating) | [ ]  Food (preparation) | [ ]  Transportation |
| [ ]  Space for in-home mobility | [ ]  Medication | [ ]  Access to medical care |
| [ ]  Communication aids | [ ]  Housework | [ ]  Incontinence supplies |
| [ ]  Overcrowded home | [ ]  Domestic violence | [ ]  Alcohol/substance abuse |
| Action plan to address areas of concern:       |
| **Mental Health** |
| Mental Health Professional(s):       |
| **Cognitive/Decision Making** |
| Indicate the client’s responses to the following questions: |
| What year is it?       | What month is it?       | Who is the president of the US?       |
| Responses satisfactory?  | Client’s mental clarity/cognitive function appears:  |
| **Mental Health Conditions** |
| Client feels depressed?  | Clients feels anxious?  |
| In past six (6) months, has client gained or lost more than ten (10) pounds unaccountably?  |
| In past year, has client received mental health treatment or counseling?  |
| Does client have mental health prescriptions?  | Taking as prescribed?  |
| Additional notes regarding client’s mental/emotional presentation:       |
| **Finances** |
| **Income** | **Total monthly income excluding financial assistance: $** |
| Sources of income: | [ ]  Employment | [ ]  SSI | [ ]  SSD | [ ]  SS/Retirement | [ ]  Pension | [ ]  Rental | [ ]  Other |
| Does client receive financial assistance?  | Type:       |
| Has client been assisted with applying for:  | [ ]  Disability | [ ]  SNAP | [ ]  LIHEAP |
| **Expenses** | **Total monthly expenses: $** |
| Rent/Mortgage $      | Food $      | Electric $      | Gas/Propane $      | Water $      | Telephone $      |
| Bus Pass $      | Vehicle Payment $      | Cable/Internet $      | Insurance including Medicare $      |
| Medications $      | Diabetes testing supplies: $      | Other:       |
| Comments:       |
| **Financial Areas of Concern** |
| [ ]  Inadequate/unclean clothing | [ ]  Inadequate medical care | [ ]  Transportation |
| [ ]  Inadequate income | [ ]  Unemployment | [ ]  Communication/sensory aids |
| [ ]  Inadequate housing | [ ]  Needs assistance paying bills | [ ]  Threat of eviction |
| [ ]  Exploitation:       |
| Action plan to address areas of concern:       |
| **Support Systems** |
| Natural Supports (Friends, neighbors, family, etc.):       |
| **Others in the Home** | **Date of Birth** | **Sex** | **Relationship** | **General Health Conditions** |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
| **Other Services/Agencies in Home** |
| [ ]  CHOICES | [ ]  OPTIONS | [ ]  Home Health | [ ]  Hospice | [ ]  Private Pay HM  | [ ]  Other:       |
| Does client need screening for alternate services?  | Plan of Action:       |
| **Financial Power of Attorney (POA)** |
| Name:       | Relationship:       | Phone:       |
| **Disaster/Emergency Evacuation Plan:** |
| Ambulation:  | Exit home independently?  |
| Exit plan:       | Date plan reviewed with client       |
| Fire exit 1:       | Fire exit 2:       | Date exits reviewed with client       |
| In case of weather-related emergency:  | Date plan reviewed with client       |
| Location of safe place in home:       |
| Detailed evacuation plan:       |
| **General Assessment** |
| Since the last assessment, client has:  |
| Please explain:       |

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| **SERVICE PLAN**  |
| **Objectives** |
| [ ]  Personal hygiene | [ ]  Clean environment |
| [ ]  Clean and seasonally appropriate clothing | [ ]  Food/medication supply |
| [ ]  Budgeting | [ ]  Access to medical care |
| [ ]  Learn about available resources | [ ]  Self-reliance |
| [ ]  Prevent eviction | [ ]  Remain safely in home |
| [ ]  Activities to improve emotional stability | [ ]  Other       |
| **Assistive Devices Needed** |
| [ ]  Live Alert™ or equivalent | [ ]  Sock aid/shoe horn | [ ]  Grab bar(s) | [ ]  Bedside commode |
| [ ]  Oxygen | [ ]  Wheelchair | [ ]  Shower chair | [ ]  Bed cane |
| [ ]  Pill box | [ ]  Walker | [ ]  Hospital bed | [ ]  Other:       |
| [ ]  Grabber tool | [ ]  Cane | [ ]  Trapeze bar | Acquisition goal date:       |
| **Task Assignment** |
| Tasks are authorized services based on client need and are selected through discussion with client. They can be assigned to either caregiver or client and may require more time than is available. Tasks should therefore be prioritized based on need. |
| **Task** | **Teach** | **Perform** | **Notes** |
| Bathroom | [ ]  | [ ]  |       |
| Living area | [ ]  | [ ]  |       |
| Kitchen | [ ]  | [ ]  |       |
| Bedroom | [ ]  | [ ]  |       |
| Refrigerator | [ ]  | [ ]  |       |
| Change bedding | [ ]  | [ ]  |       |
| Laundry | [ ]  | [ ]  |       |
| Mop/Sweep | [ ]  | [ ]  |       |
| Vacuum | [ ]  | [ ]  |       |
| Dust | [ ]  | [ ]  |       |
| Remove trash | [ ]  | [ ]  |       |
| Team clean | N/A | [ ]  |       |
| Shop/pharmacy/run errands | [ ]  | [ ]  |       |
| Read/Interpret mail | [ ]  | [ ]  |       |
| Help with resources | [ ]  | [ ]  |       |
| Budgeting/bill pay | [ ]  | [ ]  |       |
| Assistance in obtaining medical care | [ ]  | [ ]  |       |
| Reminders: [ ]  Meds [ ]  Diet [ ]  Exercise | [ ]  | [ ]  |       |
| Dental care | [ ]  | [ ]  |       |
| Meal preparation | [ ]  | [ ]  |       |
| Feeding | [ ]  | [ ]  |       |
| Bath:  |  | [ ]  | [ ]  |       |
| Toileting: | [ ]  Bathroom | [ ]  Commode | [ ]  | [ ]  |       |
|  | [ ]  Bedpan | [ ]  Diapers |  |  |  |
| Dressing | [ ]  | [ ]  |       |
| Grooming | [ ]  | [ ]  |       |
| Transfer | [ ]  | [ ]  |       |
| Walk/exercise | [ ]  | [ ]  |       |
| Emotional support (Supplemental task) | N/A | [ ]  |       |
| Supervision | N/A | [ ]  |       |
| Animal care (Service animal only) | [ ]  | [ ]  |       |
| Other | [ ]  | [ ]  |       |
| **Transportation** |
| **Destination #1:**       | Style:  |
| Schedule:  | Notes:        |
| **Destination #2:**       | Style:  |
| Schedule:  | Notes:        |
| **Destination #3:**       | Style:  |
| Schedule:  | Notes:        |
| **Hours of Service** |
| Hours per week needed:       | Weekly hours from other sources:       | Weekly hours planned by agency:       | Remaining weekly deficit:       |
| Please identify other sources:       |

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| **CLIENT SATISFACTION** |
| The client must be asked the following questions at each assessment. |
| How satisfied are you with the services provided?  |
| How do you benefit from having personal support services?       |
| Does having homemaker services make you feel more independent?  |
| Do you feel that you need personal support services to continue?  |

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| **Completed By:**       | **Date:**  |