Resident Assessment
Service Coordinator Program

Resident Name: _____ Date: _____

PART A: FUNCTIONAL SKILLS

ACTIVITIES OF DAILY LIVING (ADL's and self-personal care)		
Eating – must be able to feed self	____ Needs assistance w/cooking ____ Needs assistance obtaining food	____ Independent ____ Deficient
Dressing	____ Needs assistance ____ Able to dress elf	____ Independent ____ Deficient
Bathing	____ Needs assistance getting in/out of tub or shower ____ Able to wash self	____ Independent ____ Deficient
Grooming	____ Needs assistance in washing hair ____ Able to take care of personal appearance	____ Independent ____ Deficient
Home Management Activities	____ Needs assistance doing laundry ____ Needs assistance going to doctor ____ Needs assistance going from one location to another	____ Independent ____ Deficient

Possible Resident Services:

Homemaker	Medical Equipment	Delivered Meals	Lifeline
Transportation	Housekeeping	Adult Day Care	Other
Home Health Aide	Personal Care	Medicare/Medicaid	
Social Visiting	Visiting Nurse	Medical Assessment	

PART B: MENTAL FUNCTIONING

Does the service coordinator observe any of the following:

Disoriented: Yes No Memory Impaired: Yes No Wanders: Yes No
Forgetful: Yes No Confused: Yes No Flight of ideas: Yes No
Delayed Reaction: Yes No

Possible Resident Services:

Medical Assessment	Counseling	Power of Attorney
Medical Treatment	Psychiatric Evaluation	Dementia/Alzheimer's
Adult Protective Services	Guardianship	Substance Abuse

Clothing:	___Inappropriate	____Appropriate	____Not fully clothed	____Multilayers
Grooming:	___Not Clean	____Unshaven	____Body-urine odor	____Satisfactory
Alcohol/Drugs:	___ Slurred Speech	___ Staggers	____Alcohol smell	____ Empty Bottles
Signs of Poor Judgement	___ Strangers in Home	___Gives away money	____Lets no one in home	____Appropriate

PART C: EMOTIONAL STATUS

Does resident state or imply any of these behaviors?

Loneliness:	Yes	No	Easily Upset	Yes	No
Worry/Anxiety	Yes	No	Medication Abuse	Yes	No
Suicidal Talk	Yes	No	Suicidal Behavior	Yes	No
Sleep Problems	Yes	No	Sleeping Pills	Yes	No

Has there been any history of mental health in your family? Yes No

Are you currently, or have you ever received, professional help/counseling? Yes No

Are you receiving any mental health treatment services now? If so, what type?
Outpatient: Yes No Counseling: Yes No Medication: Yes No

Does the resident feel he/she needs assistance? Yes No

PART D: PERSONAL FUNCTIONING

Does the service coordinator observe the resident displaying any of these behaviors?

Active		Wants company		Never leaves home		Responsive	
Has been active		Wants friendship		Has experienced a loss		Monotone speech	
Wants to be Active		Wants to Volunteer		Friendly		Difficulty in speech	
Wants to work		Has limited support		Pleasant		Feels hopeless	
Complains of Threats		Withdrawn		Hallucinates		Afraid	
Tearful		Suspicious		Angry		Anxious	
Other		Other		Other		Other	

Possible Resident Services:

Social Visiting	Congregate Meals	Pastoral Care
Social Telephoning	Volunteer Placement	Resident Association
General Socialization	Employment	Other

PART E: COMMUNITY SUPPORT

Does the resident have family and/or friends that do the following?

Call regularly	Yes	No	Assist Sometimes	Yes	No	Resident refuses help	Yes No
Visit regularly	Yes	No	Assist, but stressed	Yes	No	Does not need help	Yes No
Assist w/care	Yes	No	Have no family	Yes	No	Resident is satisfied	Yes No

Possible Resident Services:

Social Visiting	Congregate Meals	Pastoral Visit Other_____
Social Telephoning	Home Delivered Meal	Hobbies/Talents_____
Counseling	Respite	Activities/Groups_____

PART F: IDENTIFYING INFORMATION

Name: _____ Social Security #: _____

Complex: _____ Apt #: _____

Phone #: _____ Date of Birth: _____ Age: _____

Male Female Marital Status: Single Married Divorced Widowed

Living Arrangements: Alone With Spouse With Other: _____

Family Living in the Area: Mother Father Sister Brother

Daughter Son Aunt Uncle Cousin Niece Nephew

PART G: ADDITIONAL INFORMATION

Income Information:

Social Security $ _____ Pension $ _____

SSI $ _____ Cash in Value of Life Insurance _____

Insurance Information:

Medicare # _____ Supplemental _____

Medicaid # _____ Full Benefits: Yes No

QMB SLMB Food Stamps $ _____

Spend down: Yes No Veteran Status: Yes No Widow

PART H: ADVANCE DIRECTIVES/LEGAL DOCUMENTS

Living Will: Yes No Would like one: Yes No

Medical Power of Attorney: Yes No Would like one: Yes No

Life Insurance: Yes No Would like some: Yes No

Will: Yes No Would like one: Yes No

Payee Arrangement: Yes No Do you feel you need one: Yes No

Other: _____

Service Coordinator Signature: _____