

Dependent Adult Assessment Tool

Name: First	Middle Initial	Last	Date of Birth (Month/Day/Year)
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Legal decision maker (Please check all that apply. If yes, name below.)

- Guardian Yes No Don't know
- Attorney-in-fact (general, financial) Yes No Don't know
- Attorney-in-fact (durable, medical) Yes No Don't know
- Other (Please specify.) _____

Payee Yes No Don't know

Contact Info (Name)	Role	Address	Work Phone	Alternative Phone

Medical and Physical Issues

Diagnosis (Current diagnoses, DSM IV code, IQ score, and source of information)

DSM IV diagnosis: _____

Other (including medical and medications): _____

Health Conditions

1. Overall, how would:

The client rate the client's health:

- Excellent
- Very good
- Good
- Fair
- Poor
- No response

The worker rate the client's health:

- Excellent
- Very good
- Good
- Fair
- Poor
- No response

2. Any health problems, including allergies? Are there any current medical treatments? If yes, list:

How does this condition affect the client and how long has the client had the condition?

3. Hearing

- No hearing impairment
- Hearing difficulty at level of conversation
- Hears only very loud sounds
- No useful hearing
- Not determined

Comments: _____

4. Vision

- Has no vision impairment
- Has difficulty seeing at level of print (far-sighted)
- Has difficulty seeing obstacles in environment (near-sighted)
- Has no useful vision
- Not determined

Comments: _____

5. Orientation (Ask if the client knows what day it is, the date, time of day, or who is the President. Answers should be based on cognitive level and age-appropriateness.)

- Oriented
- Minor forgetfulness
- Partial or intermittent periods of disorientation
- Totally disoriented; does not know time, place, identity
- Not determined

Comments: _____

Risk Assessment Domains

Assessment of ability to perform necessary functions to meet essential human needs.

Domain	Independent No Risk	Needs Supervision/ Assistance Low Risk	Dependent on Others for this Activity Moderate-High Risk
1. Environmental safety and housing conditions Does the home present: <ul style="list-style-type: none"> <input type="checkbox"/> Unsanitary conditions which may include pest infestations <input type="checkbox"/> Unsafe structural concerns <input type="checkbox"/> Excessive clutter that may pose a fire hazard or exit hazard <input type="checkbox"/> Nonworking utilities necessary to maintain safety <input type="checkbox"/> Tripping hazards <input type="checkbox"/> Homeless <input type="checkbox"/> Frequent moves 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Financial management Does the client have a current or recent history of: <ul style="list-style-type: none"> <input type="checkbox"/> Mismanaging a checkbook or funds <input type="checkbox"/> Not knowing the client's financial institution <input type="checkbox"/> Being exploited financially (family members, solicitors) <input type="checkbox"/> Having inadequate resources to support critical care needs 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Degree of isolation Does the client: <ul style="list-style-type: none"> <input type="checkbox"/> Lack someone to assist if client becomes ill <input type="checkbox"/> Infrequently comes into contact with others <input type="checkbox"/> Lack assistance with shopping, transportation, and other critical care needs <input type="checkbox"/> Feel that nobody cares about them 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Mental health management Does the client: <ul style="list-style-type: none"> <input type="checkbox"/> Have a current or recent past mental health problems that negatively affects the ability to meet essential needs <input type="checkbox"/> Have a history of thoughts of suicide (in the past three months) <input type="checkbox"/> Have a depressed mood <input type="checkbox"/> Involuntarily hospitalized <input type="checkbox"/> Voluntarily hospitalized 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Domain	Independent No Risk	Needs Supervision/ Assistance Low Risk	Dependent on Others for this Activity Moderate-High Risk
5. Substance abuse management Does the client: <input type="checkbox"/> Have a current or recent past of abusing drugs or alcohol which has negatively affected the ability to provide for critical needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Medical management Does the client: <input type="checkbox"/> Have a history of being hospitalized in the past six months <input type="checkbox"/> Have a life-threatening condition or serious health condition <input type="checkbox"/> Not have a primary physician <input type="checkbox"/> Not recall the names of the primary care physician and specialists <input type="checkbox"/> Have a history of missing medical appointments in the last three months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Medication management Does or has the client: <input type="checkbox"/> Not recall the name of the pharmacy <input type="checkbox"/> Not properly store medications <input type="checkbox"/> Miss or misused medication in the past 30 days which has affected the client's health <input type="checkbox"/> Been unable to administer medications <input type="checkbox"/> Experience significant side effects from the medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Nutrition management, eating, and obtaining food Does the client: <input type="checkbox"/> Lack awareness for the nutritional needs, including special needs <input type="checkbox"/> Have inadequate supply of food or inappropriate food <input type="checkbox"/> Have a poor appetite <input type="checkbox"/> Not follow a medically necessary diet <input type="checkbox"/> Eat food that is not safe <input type="checkbox"/> Have difficulty swallowing food or liquid <input type="checkbox"/> Lack the ability to prepare meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Domain	Independent No Risk	Needs Supervision/ Assistance Low Risk	Dependent on Others for this Activity Moderate-High Risk
9. Hygiene management, grooming, bathing, dressing, toileting, and laundry Does the client: <input type="checkbox"/> Wear inappropriate clothing for the season or appear unkempt <input type="checkbox"/> Lack awareness of personal hygiene and grooming <input type="checkbox"/> Lack the ability to bathe, dress, manage toileting needs, and complete laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Risk of abuse Does the client: <input type="checkbox"/> Have a history of being the subject of prior dependent adult abuse <input type="checkbox"/> Have a history of domestic violence <input type="checkbox"/> Have a recent history of being threatened physically, emotionally, or with a more restrictive placement <input type="checkbox"/> Family denies the presence of family violence <input type="checkbox"/> Family is resistant to services and support to address family violence issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Personal behavior management Does the client: <input type="checkbox"/> Fail to use adaptive devices (wheelchair, cane, hearing aids) <input type="checkbox"/> Refuse medications <input type="checkbox"/> Use illegal drugs in the past six months <input type="checkbox"/> Threaten to or act upon violent urges <input type="checkbox"/> Drive against the advice of others <input type="checkbox"/> Have a history of getting lost <input type="checkbox"/> Display an inability to arrange appointments <input type="checkbox"/> Leave facilities against medical advice <input type="checkbox"/> Refuse medical attention or recommendations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Walking, ambulation, and stair climbing Does the client: <input type="checkbox"/> Have a history of tripping <input type="checkbox"/> Have a history of being unable to get out of bed, off the floor, or out of a chair <input type="checkbox"/> Lack the ability to walk up and down stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total Boxes Checked			

