

# Veteran Functional Assessment Instrument

The Program of Comprehensive Assistance for Family Caregivers (PCAFC) provides services and additional benefits to approved and designated Family Caregivers of eligible Veterans or service members who are in need of personal care services for a minimum of six continuous months based on any one of the following: an inability to perform an activity of daily living; or a need for supervision, protection, or instruction.

The assessment of the need for personal care services is just one piece of the overall application or reassessment process.

The Veteran Functional Assessment Instrument captures the Veteran or service member's functional needs, as it relates to the requirements for the PCAFC. The assessment instrument should only be used with Veterans or service members who have applied to or are participating in the PCAFC and a consult has been placed for this assessment by Caregiver Support Program Staff. The author completing this assessment must be in compliance with all required Caregiver Support Program and VA trainings.

## Part A: Activities of Daily Living (ADLs)

### Instructions:

- a) For each question below, select the response that best describes the person's functional ability **each time the activity occurs**. If the activity was not attempted, select the reason (Person refused, Not applicable, or Not attempted).
- b) When considering how to answer the question, please remember that personal care service must be needed on an ongoing basis, not intermittently, **for a minimum of 6 continuous months**. Navigate to the "Definitions" sheet for descriptions of the response options.
- c) Please use the **Notes/comments** section to provide any additional pertinent information or observations that support the response selected or clarifying information provided by the Veteran and/or authorized participants in the assessment that you believe will be helpful in understanding the Veteran's overall level of assistance needed for that activity.
- d) If helper assistance is required because person's performance is unsafe or of poor quality, select the response according to amount of assistance provided. Activities may be completed with or without assistive devices.

**Please note:** Responses are based on a Veteran's **actual functional ability**, **NOT** preference, willingness, or motivation to perform.

### Eating

**(1) Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the person.

- Independent
- Setup or cleanup assistance
- Supervision or touching assistance
- Partial/moderate assistance
- Substantial/maximal assistance
- Dependent
- Person refused
- Not applicable – Person does not usually do this activity
- Not attempted due to **short-term medical condition or safety concerns**

Notes/comments:

## Grooming

**(2)(a) Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.]

- Independent
- Setup or cleanup assistance
- Supervision or touching assistance
- Partial/moderate assistance
- Substantial/maximal assistance
- Dependent
- Person refused
- Not applicable – Person does not usually do this activity
- Not attempted due to **short-term medical condition or safety concerns**

**(2)(b) Wash upper body:** The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.

- Independent
- Setup or cleanup assistance
- Supervision or touching assistance
- Partial/moderate assistance
- Substantial/maximal assistance
- Dependent
- Person refused
- Not applicable – Person does not usually do this activity
- Not attempted due to **short-term medical condition or safety concerns**

Notes/comments:

## Bathing

**(3) Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.

- Independent
- Setup or cleanup assistance
- Supervision or touching assistance
- Partial/moderate assistance
- Substantial/maximal assistance
- Dependent
- Person refused
- Not applicable – Person does not usually do this activity
- Not attempted due to **short-term medical condition or safety concerns**

Notes/comments:

## Dressing and Undressing

**(4)(a) Upper body dressing:** The ability to dress and undress above the waist, including fasteners, if applicable.

- Independent
- Setup or cleanup assistance
- Supervision or touching assistance

	<input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<b>(4)(b) Lower body dressing:</b> The ability to dress and undress below the waist, including fasteners; does not include footwear.	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<b>(4)(c) Putting on/taking off footwear:</b> The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility, including fasteners, if applicable.	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<b>Notes/comments:</b>	
<b>Toileting</b>	
<b>(5) Toileting hygiene:</b> The ability to maintain perineal/menstrual hygiene and adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>

Notes/comments:

## Prosthetics (Use of Assistive Devices)

**Please note:** This does not include assistive devices used to support ambulation, e.g., a walker. This question specifically addresses any prosthetic or orthopedic devices that the person must don on and/or off that replaces or supports a body part or function of a body part.

**(6) Prosthetics (Use of Assistive Devices):** Ability to adjust special prosthetic or orthopedic appliances. The adjustment of appliances that any person (with or without a disability) would need assistance with should not be considered (for example, supports, belts, lacing at back, etc.).

- Independent
- Setup or cleanup assistance
- Supervision or touching assistance
- Partial/moderate assistance
- Substantial/maximal assistance
- Dependent
- Person refused
- Not applicable – Person does not usually do this activity
- Not attempted due to **short-term medical condition or safety concerns**

Notes/comments:

## Mobility

**(7) Positioning/Transfers: Positioning/Transfers must be answered for all assessments.**

**(7)(a) Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back.

- Independent
- Setup or cleanup assistance
- Supervision or touching assistance
- Partial/moderate assistance
- Substantial/maximal assistance
- Dependent
- Person refused
- Not applicable – Person does not usually do this activity
- Not attempted due to **short-term medical condition or safety concerns**

**(7)(b) Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.

- Independent
- Setup or cleanup assistance
- Supervision or touching assistance
- Partial/moderate assistance
- Substantial/maximal assistance
- Dependent
- Person refused

	<input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<b>(7)(c) Lying to sitting on side of bed:</b> The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor and with no back support.	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<b>(7)(d) Sit to stand:</b> The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<b>(7)(e) Chair/bed-to-chair transfer:</b> The ability to transfer to and from a bed to a chair (or wheelchair).	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<b>(7)(f) Toilet transfer:</b> The ability to get on and off a toilet or commode.	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity

Not attempted due to **short-term medical condition or safety concerns**

**(8) Mobility (Walking, Manual Wheelchair, Motorized Wheelchair/Scooter):**

**Please note:** When answering Walking, Manual Wheelchair, and Motorized Wheelchair/Scooter Questions 9-11, answer the one question that represents the person’s PRIMARY mode of ambulation and consider use of assistive devices. (For example, if person walks most of the time but only uses a wheelchair sometimes for long distances, answer the Walking question.)

**Select one of the following:**

- Person walks (Yes. If yes, continue to next question 9a.)
- Person uses manual wheelchair (Yes. If yes, continue to question 10a.)
- Person uses motorized wheelchair/scooter (Yes. If yes, continue to question 11a.)
- Person does not walk nor use a manual/motorized wheelchair/scooter (Yes. If yes, continue to Part B: Supervision, Protection, or Instruction.)

Please provide additional information:

**(9) Walking**

**(9)(a) Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor or similar space.

If response is Person refused, Not applicable or Not attempted, skip to question 9(e).

- Independent
- Setup or cleanup assistance
- Supervision or touching assistance
- Partial/moderate assistance
- Substantial/maximal assistance
- Dependent
- Person refused
- Not applicable – Person does not usually do this activity
- Not attempted due to **short-term medical condition or safety concerns**

**(9)(b) Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.

- Independent
- Setup or cleanup assistance
- Supervision or touching assistance
- Partial/moderate assistance
- Substantial/maximal assistance
- Dependent
- Person refused
- Not applicable – Person does not usually do this activity
- Not attempted due to **short-term medical condition or safety concerns**

**(9)(c) Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

- Independent
- Setup or cleanup assistance
- Supervision or touching assistance

	<input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<p><b>(9)(d) Walk 10 feet on uneven surfaces:</b> The ability to walk 10 feet on uneven or sloping surfaces, <b>(indoor or outdoor)</b> such as turf or gravel.</p>	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<p><b>(9)(e) 1 step (curb):</b> The ability to go up and down a curb and/or up and down one step.</p>	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<p><b>(9)(f) 4 steps:</b> The ability to go up and down four steps with or without a rail.</p> <p>If response is Person refused, Not applicable or Not attempted, skip to question 9(h).</p>	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<p><b>(9)(g) 12 steps:</b> The ability to go up and down 12 steps with or without a rail.</p>	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance

	<input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<b>(9)(h) Picking up object:</b> The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<b>(9)(i) Walk indoors:</b> The ability to walk from room to room, around furniture and other obstacles.	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<b>(9)(j) Carries something in both hands:</b> The ability to carry something in both hands while walking indoors (e.g., several dishes, light laundry basket, tray with food).	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<b>(9)(k) Walk for 15 minutes:</b> The ability to walk without stopping or resting (e.g., through a department store, supermarket.)	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused



	<input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<b>(9)(I) Walk across a street:</b> The ability to cross a street before light turns red.	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<b>(10) Manual Wheelchair</b>	
<b>(10)(a) Wheel 50 feet with two turns:</b> Once seated in wheelchair, the ability to wheel at least 50 feet and make two turns. If response is Person refused, Not applicable or Not attempted, skip to question 10(d).	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<b>(10)(b) Wheel 150 feet:</b> Once seated in wheelchair, the ability to wheel at least 150 feet in a corridor or similar space.	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<b>(10)(c) Wheel for 15 minutes:</b> Once seated in wheelchair, the ability to wheel without stopping or resting (e.g., through a department store, supermarket).	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this

	<p>activity</p> <p><input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b></p>
<p><b>(10)(d) Wheel across a street:</b> Once seated in a wheelchair, the ability to cross a street before light turns red.</p>	<p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Setup or cleanup assistance</p> <p><input type="checkbox"/> Supervision or touching assistance</p> <p><input type="checkbox"/> Partial/moderate assistance</p> <p><input type="checkbox"/> Substantial/maximal assistance</p> <p><input type="checkbox"/> Dependent</p> <p><input type="checkbox"/> Person refused</p> <p><input type="checkbox"/> Not applicable – Person does not usually do this activity</p> <p><input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b></p>
<p><b>(11) Motorized Wheelchair/Scooter</b></p>	
<p><b>(11)(a) Wheel 50 feet with two turns:</b> Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.</p> <p>If response is Person refused, Not applicable or Not attempted, skip to question 11(d).</p>	<p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Setup or cleanup assistance</p> <p><input type="checkbox"/> Supervision or touching assistance</p> <p><input type="checkbox"/> Partial/moderate assistance</p> <p><input type="checkbox"/> Substantial/maximal assistance</p> <p><input type="checkbox"/> Dependent</p> <p><input type="checkbox"/> Person refused</p> <p><input type="checkbox"/> Not applicable – Person does not usually do this activity</p> <p><input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b></p>
<p><b>(11)(b) Wheel 150 feet:</b> Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.</p>	<p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Setup or cleanup assistance</p> <p><input type="checkbox"/> Supervision or touching assistance</p> <p><input type="checkbox"/> Partial/moderate assistance</p> <p><input type="checkbox"/> Substantial/maximal assistance</p> <p><input type="checkbox"/> Dependent</p> <p><input type="checkbox"/> Person refused</p> <p><input type="checkbox"/> Not applicable – Person does not usually do this activity</p> <p><input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b></p>
<p><b>(11)(c) Wheel for 15 minutes:</b> Once seated in a wheelchair/scooter, the ability to wheel without stopping or resting (e.g., through a department store, supermarket.)</p>	<p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Setup or cleanup assistance</p> <p><input type="checkbox"/> Supervision or touching assistance</p> <p><input type="checkbox"/> Partial/moderate assistance</p> <p><input type="checkbox"/> Substantial/maximal assistance</p> <p><input type="checkbox"/> Dependent</p> <p><input type="checkbox"/> Person refused</p> <p><input type="checkbox"/> Not applicable – Person does not usually do this</p>

	activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>
<b>(11)(d) Wheel across a street:</b> Once seated in a wheelchair/scooter, the ability to wheel across a street before light turns red.	<input type="checkbox"/> Independent <input type="checkbox"/> Setup or cleanup assistance <input type="checkbox"/> Supervision or touching assistance <input type="checkbox"/> Partial/moderate assistance <input type="checkbox"/> Substantial/maximal assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Person refused <input type="checkbox"/> Not applicable – Person does not usually do this activity <input type="checkbox"/> Not attempted due to <b>short-term medical condition or safety concerns</b>

**Notes/comments:**

## Veteran Functional Assessment Instrument

### Part B: Supervision, Protection, or Instruction

**Instructions:** For each question below, select the response(s) that best describes the person’s need for supervision, protection or instruction that is necessary in order to maintain personal safety **on a DAILY basis**. When considering how to answer the question, please remember that personal care services must be needed on an ongoing basis, not intermittently, for a **minimum of 6 continuous months**. Navigate to the “Definitions” sheet for descriptions of the response options.

Please use the **Notes/comments** section to provide any additional pertinent information or observations that support the response selected or clarifying information provided by the Veteran and/or authorized participants in the assessment that you believe will be helpful in understanding the Veteran’s overall need for supervision or protection.

**Please note:** Responses are based on a Veteran's **actual functional ability**, **NOT** preference, willingness, or motivation to perform.

## Medication Management

<b>(1)(a)</b> Does the person take any medication(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Chose not to answer
<b>(1)(b)</b> Does the person need assistance with medication management?	<input type="checkbox"/> Needs no help or supervision <input type="checkbox"/> Needs medication setup <input type="checkbox"/> Needs visual or verbal reminders <input type="checkbox"/> Needs medication administration

**Notes/comments:**

## Self-Preservation

**Please note:** The answers to questions 2-7 should be congruent in describing the person's ability to manage his/her safety or protection.

<b>2)</b> Does the person have the judgment and physical ability to cope, make appropriate decisions and take action in a changing environment or a potentially harmful situation?	<input type="checkbox"/> Independent <input type="checkbox"/> Minimal (verbal/physical prompts for preservation) <input type="checkbox"/> Mentally unable <input type="checkbox"/> Physically unable <input type="checkbox"/> Both mentally and physically unable
<b>3)</b> Is this person at risk of self-neglect?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4)</b> Veteran has the following risk factors (Check all that apply):	<input type="checkbox"/> Not applicable <input type="checkbox"/> Alcohol and/or other drug use leading to health or safety concerns <input type="checkbox"/> Behaviors that pose a threat of harm to self or others <input type="checkbox"/> Dehydration or malnutrition <input type="checkbox"/> Hygiene that may compromise health <input type="checkbox"/> Impairment of orientation, memory, reasoning and/or judgment <input type="checkbox"/> Inability to manage medications or to seek medical treatment that may threaten health or safety <input type="checkbox"/> Unsafe/unhealthy living conditions <input type="checkbox"/> Other
<b>5)</b> Is this person at risk of neglect, abuse or exploitation by another person?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>6)</b> What type of support does the person need <u>in the home</u> to remain safe, such as assistance with	<input type="checkbox"/> Someone else needs to be with the person always, to observe or provide supervision. <input type="checkbox"/> Someone else needs to be around always, but they only need to check on the person now and then.

<p>activities that require remembering, decision-making, or judgment?</p>	<p><input type="checkbox"/> Sometimes the person can be left alone for an hour or two</p> <p><input type="checkbox"/> Sometimes the person can be left alone for most of the day</p> <p><input type="checkbox"/> The person can be left alone all day and all night, but someone needs to check in on the person every day.</p> <p><input type="checkbox"/> The person can be left alone without anyone checking in.</p>
<p>7) What type of support does the person need <u>away from home</u> to remain safe, such as assistance with activities that require remembering, decision-making, or judgment?</p>	<p><input type="checkbox"/> The person requires intense support when leaving home because of behavioral difficulties (becomes very confused or agitated during outings, engages in inappropriate behavior, becomes aggressive etc.)</p> <p><input type="checkbox"/> Someone always needs to be with the person to help with remembering, decision making or judgment when away from home.</p> <p><input type="checkbox"/> The person can go places alone as long as they are familiar places</p> <p><input type="checkbox"/> The person does not need help going anywhere</p>
<h2>Safety</h2>	
<p><b>Please note:</b> When answering the following question, if the answer to the first question (8)(a) is No or Not applicable, please skip to question 9.</p> <p><b>(8)(a) Delusions/Hallucinations:</b> Person engages in markedly inappropriate behavior that affects a person's daily functioning and social interactions. Behavior characterized by a radical change in personality and a distorted or diminished sense of reality.</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Not applicable</p>
<p><b>(8)(b)</b> If the answer to question 8a) is Yes, please select the type(s) of psychotic behaviors displayed (select all that apply):</p>	<p><input type="checkbox"/> Catatonic behavior</p> <p><input type="checkbox"/> Delusions</p> <p><input type="checkbox"/> Disorganized speech</p> <p><input type="checkbox"/> Hallucinations</p> <p><input type="checkbox"/> Thought disorder</p> <p><input type="checkbox"/> Other</p>
<p><b>(8)(c)</b> If the answer to question 8a) is Yes, please select the <b>type</b> of intervention needed.</p> <p>Intervention: Support and/or services provided by staff and/or caregiver.</p>	<p><input type="checkbox"/> Requires no intervention</p> <p><input type="checkbox"/> Needs intervention in the form of cues – responds to cues</p> <p><input type="checkbox"/> Needs redirection – responds to redirection</p> <p><input type="checkbox"/> Needs behavior management or instruction – resists intervention</p> <p><input type="checkbox"/> Needs behavior management or instruction – physically resists intervention</p>
<p><b>(8)(d)</b> If the answer to question 8a) is Yes, please select the <b>frequency</b> of intervention needed.</p>	<p><input type="checkbox"/> Less than weekly</p> <p><input type="checkbox"/> One time per week</p> <p><input type="checkbox"/> Two times per week</p>

<p>How often on a weekly basis is intervention needed?</p>	<input type="checkbox"/> Three times per week <input type="checkbox"/> 4 or more times per week but not daily <input type="checkbox"/> Daily
<p><b>Please note:</b> When answering the following question, if the answer to the first question (9)(a) is No or Not applicable, please skip to question 10.  <b>(9)(a) Agitation:</b> Person has a tendency, or would without an intervention, to suddenly or quickly become upset or violent.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
<p><b>(9)(b)</b> If the answer to question 9a) is Yes, please select the type(s) of agitation behaviors displayed (select all that apply):</p>	<input type="checkbox"/> Easily agitated <input type="checkbox"/> Easily angered <input type="checkbox"/> Easily frustrated <input type="checkbox"/> Other
<p><b>(9)(c)</b> If the answer to question 9a) is Yes, please select the <b>type</b> of intervention needed.</p> <p>Intervention: Support and/or services provided by staff and/or caregiver.</p>	<input type="checkbox"/> Requires no intervention <input type="checkbox"/> Needs intervention in the form of cues – responds to cues <input type="checkbox"/> Needs redirection – responds to redirection <input type="checkbox"/> Needs behavior management or instruction – resists intervention <input type="checkbox"/> Needs behavior management or instruction – physically resists intervention
<p><b>(9)(d)</b> If the answer to question 9a) is Yes, please select the <b>frequency</b> of intervention needed.</p> <p>How often on a weekly basis is intervention needed?</p>	<input type="checkbox"/> Less than weekly <input type="checkbox"/> One time per week <input type="checkbox"/> Two times per week <input type="checkbox"/> Three times per week <input type="checkbox"/> 4 or more times per week but not daily <input type="checkbox"/> Daily

<p><b>Please note:</b> When answering the following question, if the answer to the first question (10)(a) is No or Not applicable, please skip to question 11.</p> <p><b>(10)(a) Impulsivity:</b> Person has a propensity, or would without an intervention, for sudden or spontaneous decisions or actions.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
<p><b>(10)(b)</b> If the answer to question 10a) is Yes, please select the type(s) of impulsive behaviors displayed (select all that apply):</p>	<input type="checkbox"/> Disregard for personal safety <input type="checkbox"/> Easily influenced by others <input type="checkbox"/> Financial <input type="checkbox"/> High risk behaviors <input type="checkbox"/> Thoughtless about boundaries <input type="checkbox"/> Other
<p><b>(10)(c)</b> If the answer to question 10a) is Yes, please select the <b>type</b> of intervention needed.</p> <p>Intervention: Support and/or services provided by staff and/or caregiver.</p>	<input type="checkbox"/> Requires no intervention <input type="checkbox"/> Needs intervention in the form of cues – responds to cues <input type="checkbox"/> Needs redirection – responds to redirection <input type="checkbox"/> Needs behavior management or instruction – resists intervention <input type="checkbox"/> Needs behavior management or instruction – physically resists intervention
<p><b>(10)(d)</b> If the answer to question 10a) is Yes, please select the <b>frequency</b> of intervention needed.</p> <p>How often on a weekly basis is intervention needed?</p>	<input type="checkbox"/> Less than weekly <input type="checkbox"/> One time per week <input type="checkbox"/> Two times per week <input type="checkbox"/> Three times per week <input type="checkbox"/> 4 or more times per week but not daily <input type="checkbox"/> Daily
<p><b>Self-Direction</b></p>	
<p>Based upon the person’s functional needs as answered in Part B, Supervision, Protection, or Instruction, as answered above, please answer the following two questions.</p> <p><b>Please note</b> this is not a question asking about legal capacity to make healthcare decisions.</p>	
<p><b>11)</b> Can this person identify their own needs?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><b>12)</b> Can this person provide and/or arrange for their health and safety?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><b>Notes/comments:</b></p>	
<p><i>End of Assessment.</i></p>	