

HARDY'S HOME INVESTORS NON-MEDICAL ASSESSMENT

Consumer Name:		Phone:
Address:		
Physician Name:		Phone:
Responsible Party Name:		Phone:
Emergency Contact Name:		Phone:
ASSESSMENT		
General Topics	Subject Matter	Action(S) Indicated
General Information		
Current Situation HX		
Recent Hospitalizations/ Health Problems		
Height & Weight	Weight Status: ____ Increase ____ Static ____ Decrease Recent WT Changes:	
Current Medications		
Need for Palliative Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dental Care		
Vision		
Hearing		
Mental Health Status	<input type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input type="checkbox"/> Other: MEMORY: <input type="checkbox"/> Intact <input type="checkbox"/> Poor REASONING/JUDGMENT: <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Unimpaired	
LIVING HABITS		
Smoking Habits	<u>Consumer Smokes:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <u>Issue/Problem:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol Consumption	<u>Consumer Drinks:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Issue/Problem:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	

Special Dietary Requirements		
Allergies	<input type="checkbox"/> No <input type="checkbox"/> Yes- specify	
Eating Habits Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
COMMUNICATION		
Language/ Communication	Primary Language: Speaks/Understands English: <input type="checkbox"/> Yes <input type="checkbox"/> No Can make needs known: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Speech		
Understanding	<input type="checkbox"/> Unimpaired <input type="checkbox"/> Understands Simple Phrases Only <input type="checkbox"/> Understands Key Words Only <input type="checkbox"/> Understanding Unknown <input type="checkbox"/> Not Responsive	

CONSUMER NAME: _____

ABILITY TO COMPLETE ACTIVITIES OF DAILY LIVING		
Functional Limitations	<input type="checkbox"/> No <input type="checkbox"/> Yes-explain:	
Mobility	<input type="checkbox"/> Indep <input type="checkbox"/> Unable <input type="checkbox"/> Needs assist	
Ambulation	<input type="checkbox"/> Indep <input type="checkbox"/> Unable <input type="checkbox"/> Needs assist	
Transfers	<input type="checkbox"/> Indep <input type="checkbox"/> Unable <input type="checkbox"/> Needs assist	
Bathing	<input type="checkbox"/> Independent in Bathtub or Shower <input type="checkbox"/> Independent with Mechanical Aids <input type="checkbox"/> Requires Minor Assistance or Supervision: <input type="checkbox"/> Getting In/Out of Tub/Shower <input type="checkbox"/> Turning Taps On/Off <input type="checkbox"/> Washing Back <input type="checkbox"/> Requires Continued Assistance <input type="checkbox"/> Resists Assistance	
Dressing	<input type="checkbox"/> Independent <input type="checkbox"/> Supervision or Needs some occasional assist <input type="checkbox"/> Periodic or Daily Assist Needed: Difficulty with:	
Grooming & Hygiene	<input type="checkbox"/> Independent <input type="checkbox"/> Reminder, Motivation/or Direction <input type="checkbox"/> Assistance with Some Things <input type="checkbox"/> Requires Total Assistance <input type="checkbox"/> Resists Assistance	
Eating	<input type="checkbox"/> Independent <input type="checkbox"/> Independent with Special Provision for Disability <input type="checkbox"/> Intermittent Assist With: <input type="checkbox"/> Cutting Up/Pureeing Food <input type="checkbox"/> Must Be Fed <input type="checkbox"/> Resists Feeding	
Bladder Control	<input type="checkbox"/> Totally Continent <input type="checkbox"/> Needs Routine Toileting or Reminder <input type="checkbox"/> Incontinent occasionally <input type="checkbox"/> Incontinent daily	

Bowel Control	<input type="checkbox"/> Total Control Needs Routine Toileting or Reminder <input type="checkbox"/> No Bowel Control Due to Identifiable Factors <input type="checkbox"/> Loses Bowel Control occasionally <input type="checkbox"/> Loses Bowel Control daily	
Toileting	<input type="checkbox"/> Raised Toilet Seat or Commode <input type="checkbox"/> Difficulty With Buttons, Zippers <input type="checkbox"/> Needs Help with Aids (E.g. Catheter, Condom Drainage, etc.) <input type="checkbox"/> Other:	
Movement	<input type="checkbox"/> Exercises Daily <input type="checkbox"/> Type/Time/Distance: <input type="checkbox"/> Recent Changes to Routine: <input type="checkbox"/> Exercise Alone <input type="checkbox"/> Exercises With Attendant	

ABILITY TO COMPLETE INSTRUMENTAL ACTIVITIES OF DAILY LIVING

MealPrep	<input type="checkbox"/> Independent <input type="checkbox"/> Able if Ingredients Supplied <input type="checkbox"/> Can Make/Buy Meals Diet is Inadequate <input type="checkbox"/> Physically/Mentally Unable to Prepare Food <input type="checkbox"/> Chooses Not to Prepare Food	
Housekeeping	<input type="checkbox"/> Independent <input type="checkbox"/> Generally Independent But Needs Help With Heavier Tasks <input type="checkbox"/> Can Perform Only Light Tasks Adequately <input type="checkbox"/> Performs Light Tasks But Not Adequately <input type="checkbox"/> Needs Regular Help and/or Supervision <input type="checkbox"/> No Opportunity to Do Housework/Chooses Not to Do Housework	
Shopping	<input type="checkbox"/> Independent <input type="checkbox"/> Can Shop if Accompanied <input type="checkbox"/> Unable to Shop <input type="checkbox"/> No Opportunity to Shop/Chooses Not to Shop <input type="checkbox"/> Uses Private Vehicle <input type="checkbox"/> Uses Taxi/Bus	
Transportation	<input type="checkbox"/> Independent <input type="checkbox"/> Must be Accompanied <input type="checkbox"/> Must be Driven <input type="checkbox"/> Physically or Mentally Unable to Travel <input type="checkbox"/> Needs Ambulance for Transporting	
Telephone Use	<input type="checkbox"/> Independent <input type="checkbox"/> Can Dial Well Known Numbers <input type="checkbox"/> Answers Only <input type="checkbox"/> Unable <input type="checkbox"/> No Opportunity to Use Telephone/Chooses Not to	

ATTENDANT PROFILE

Attendant	<input type="checkbox"/> Independent <input type="checkbox"/> Needs Attendant: Frequency: <input type="checkbox"/> Intermittent <input type="checkbox"/> 24 hours <input type="checkbox"/> Daytime <input type="checkbox"/> Night <input type="checkbox"/> Attendant Needs Met by: <input type="checkbox"/> Spouse <input type="checkbox"/> Friend <input type="checkbox"/> Family <input type="checkbox"/> Not met	
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SOCIAL PROFILE

Living Arrangements	Where: With Whom: Adequate: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Any Safety/health hazards	<input type="checkbox"/> No <input type="checkbox"/> Yes-specify:	
Home Environmental Assessment:		

Living Companions	<input type="checkbox"/> Alone <input type="checkbox"/> With Spouse/Partner <input type="checkbox"/> With Adult Child <input type="checkbox"/> With Child(ren) <input type="checkbox"/> With Other Adult Male <input type="checkbox"/> With Other Adult Female <input type="checkbox"/> Principal Helper:	
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Social Activities Involvement:		
Religion & Culture	Ethnicity: Religion: Actively Practicing: <input type="checkbox"/> Yes <input type="checkbox"/> No	
FINANCIAL PROFILE		
Financial Benefits	<input type="checkbox"/> Social Security Pension <input type="checkbox"/> State Income Supplement <input type="checkbox"/> Veterans/Disability Pension <input type="checkbox"/> Company Pension <input type="checkbox"/> Other	
Managing Finances	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Trustee <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Other	
ADDITIONAL INFORMATION		
Other information that could impact the level of care/services required to meet needs.		

Assessor Name/Title (Print)

Assessor Signature Date

Client or Client's Representative's Signature Date