# Manitoba Home Care Program
# CARE ASSESSMENT FORM

Applicant's Name ________________ Phone No. ________________ Date ________________

Address ________________ Postal Code ________________ PHIN No. ________________

TYPE OF ASSESSMENT ☐ Admission ☐ Reassessment Coordinator ________________

Location where assessment completed (own house, hospital, etc.) Office Location ________________

**FAMILY INFORMATION/FUNCTIONAL ASSESSMENT**

1. Who lives in same household with applicant? (If none write "none" in space.)

| Name | Age | Relationship | REMARKS: (Indicate if supportive of applicant and how.) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

2. List relevant family members. (If none, write "none" in space.)
   Please check ( √ ) next of Kin or local person responsible.

| Please check ( √ ) | REMARKS: (Indicate distance, frequency of contact, Supportiveness of applicant and how.) |
|---|---|
| Name<br>Address | |
| Name<br>Address | |
| Name<br>Address | |
| Name<br>Address | |

3. Any additional information/assessment re family functioning pertinent to assessment for/delivery of home care:

MG-8513 (Rev. 10/05)

## HOUSEHOLD INFORMATION/FUNCTIONAL ASSESSMENT

4. APPLICANT LIVES IN ____ House ____ Rooms ____ Apartment ____ Senior Citizen Housing ____ Family Care/Foster Home
____ Other (specify) ______________________ REMARKS: ______________________

5. INDICATE FACILITIES AVAILABLE AND ADEQUACY

| | Available (type) | Adequacy (yes, no, if no explain) |
|---|---|---|
| HEATING | | |
| COOKING | | |
| REFRIGERATION | | |
| LAUNDRY | | |
| DRYING | | |
| WATER | | |
| TOILET | | |
| BATHING | | |
| STAIRS | | |
| TELEPHONE | | |

6. Indicate if any of the above facilities (including their location) affect the ability of the applicant to function in home or to get outside:

7. Indicate if any of the above facilities (including their location) will affect the need for and delivery of services in the home:

8. HOUSEHOLD TASKS/MANAGEMENT

| | Formerly Done By Applicant Yes/No | Still Done Yes/No | REMARKS: Where still done indicate any limitations, also where not done but if formerly done indicate why not done and specify who (if anyone) now does it. |
|---|---|---|---|
| LIGHT CLEANING | | | |
| HEAVY CLEANING | | | |
| PERSONAL LAUNDRY | | | |
| HOUSEHOLDLAUNDRY | | | |
| SHOPPING | | | |
| FULL MEAL PREPARATION | | | |
| LIGHT MEAL PREPARATION | | | |
| USE PHONE | | | |
| MANAGEMENT OF OWN AFFAIRS | | | |

9. Any additional information/assessment re household functioning pertinent to the assessment for/delivery of home care:

## HEALTH INFORMATION/HEALTH FUNCTIONAL ASSESSMENT

10. MAJOR CLINICAL FINDINGS: (Do not repeat if on basic information sheet.)

Diagnosis Known:

To Family ____ Yes ____ No

To Applicant ____ Yes ____ No

11. CLINICAL HISTORY:

12. ALLERGIES: if any, describe

| 13. Medication | Dosage | Frequency | Route | Prescribed By | Date |
|---|---|---|---|---|---|
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Ability to Administer: ____ Independent ____ Requires Assistance Specify ____________________

Compliance:

14. Current prescribed treatments, if any: Indicate applicant's ability to manage own treatment.

____ Independent ____ Requires Assistance Specify ____________________

15. Have clinical findings/treatment been confirmed with attending physician?

____ Yes ____ No

If Yes, how. If No, what is the plan for confirmation?

16. NUTRITION: Is applicant eating adequately: ____ Yes ____ No

Is applicant on special diet? ____ Yes ____ No

COMMENTS:

17. Any additional information/assessment re physical health functioning pertinent to the assessment for/delivery of home care:

## PERSONAL CARE INFORMATION/FUNCTIONAL ASSESSMENT

**REMARKS:** **Should reveal any patterns/inconsistencies.**
**Should include any current or planned treatment/intervention.**
**Should cover implications for self care, for socialization.**

| | |
|---|---|
| 18. SIGHT:<br>_____ Wears glasses _____ Yes _____ No<br>_____ Adequate for all activities<br>_____ Inadequate for some activities (specify)<br>_____ Inadequate for personal safety (specify) | REMARKS: |
| 19. HEARING<br>_____ Wears hearing aid _____ Yes _____ No<br>_____ Adequate for all activities<br>_____ Inadequate for some activities (specify)<br>_____ Inadequate for personal safety (specify) | REMARKS: |
| 20. COMMUNICATION:<br>_____ Gestures Only _____ Written Only<br>_____ Adequate for all activities<br>_____ Inadequate for some activities (specify)<br>_____ Unable to communicate | REMARKS: |
| 21. AMBULATION:<br>_____ Independent with or without mech. Aid<br>_____ Outdoors with assistance<br>_____ Indoors ambulation with assistance<br>_____ Stairs with assistance<br>_____ Stairs independent<br>_____ Cannot manage stairs<br>_____ Wheelchair independent<br>_____ Wheelchair with assistance | REMARKS: |
| 22. TOILETING:<br>CONTINENCE / MANAGEMENT<br>_____ Completely continent / _____ Independent<br>_____ Incontinent urine, occasionally / _____ Dependent (elaborate)<br>_____ Incontinent urine, night only / _____ Catheter<br>_____ Incontinent urine, always / _____ Ostomy<br>_____ Incontinent feces, occasionally / _____ Condom Drainage<br>_____ Incontinent feces, always / _____ Bathroom Routine<br>_____ Other Aids | REMARKS: |

| 23. TRANSFERRING: | REMARKS: |
| --- | --- |
| ______ Independent<br>______ Bed to chair with assistance<br>______ Bedfast, can turn self in bed<br>______ Bedfast, must be turned in bed | |
| 24. EATING:<br>Dentures: ______ Upper ______ Lower<br>______ Independent<br>______ Requires assistance or encouragement<br>______ Has to be fed | REMARKS: |
| 25. DRESSING:<br>______ Independent<br>______ Requires assistance or encouragement<br>______ Has to be dressed/undressed | REMARKS: |
| 26. BATHING:<br>______ Independent<br>______ Can sponge bath self<br>______ Can bath only with assistance or encouragement<br>______ Has to be bathed | REMARKS: |
| 27. CARE OF HAIR:<br>______ Independent<br>______ Requires assistance or encouragement<br>______ Cannot care for own hair | REMARKS: |

28. FOOT CARE:

______ Independent

______ Requires Assistance

______ Cannot care for own feet

29. CARE FOR PROTHESIS:

Where applicable, indicate type of prosthesis and ability of applicant to care for such.

Any additional information/assessment re personal care functioning pertinent to the assessment for/delivery of home care:

## PSYCHO/SOCIAL INFORMATION/FUNCTIONAL ASSESSMENT

30. Has applicant's living pattern/role in family or household altered in past year? Describe showing whether there has been change or loss and indicate whether (how) applicant is coping. Look for indicators of loneliness, bereavement or loss of status.

31. Describe how applicant spends his/her time in a typical day at home and indicate if applicant describes his/her activities as being meaningful to others, to self or simply as a means of passing time.

32. Are there any activities which the applicant formerly was engaged in at home which he/she now misses? Why? Could the applicant be involved again in the same or similar activity with assistance/intervention? What?

| 33. Neighbours, friends in contact with applicant: | | REMARKS: (Indicate frequency of contact and supportiveness to applicant and in what way.) |
|---|---|---|
| Name | Phone # | |
| Address | | |
| Name | Phone # | |
| Address | | |
| Name | Phone # | |
| Address | | |
| Name | Phone # | |
| Address | | |

34. Describe applicant's involvement in community (include church, legion, fraternal, etc.)

35. Are there any community activities in which the applicant formerly was involved which he/she now misses? Could the applicant be involved again with assistance/intervention? What?

36. Does travel outside the home affect applicant's ability to participate in activities, to receive medical care, to manage the household, etc.? If so, describe why, how and intervention indicated.

37. Specify cultural/religious preferences of applicant relevant to delivery of home care services (language, special food, etc.)

**REMARKS:** **Should reveal any patterns/inconsistencies.**
**Should include any current or planned treatment/intervention.**
**Should cover implications for self care, for socialization.**

| 38. MENTAL STATUS: | REMARKS: |
|---|---|
| ______ Completely oriented<br>______ Forgetful/confused occ.<br>______ Disoriented | |
| **39. MOOD:** | **REMARKS:** |
| ______ Seems content<br>______ Seems concerned about specific problem<br>______ Seems somewhat tense and anxious<br>______ Seems depressed<br>______ Unusual, unpredictable behavior (specify)<br>______ Not motivated for some activities (specify) | |
| **40. MOTIVATION:** | **REMARKS:** |
| ______ Motivated for all activities<br>______ Not motivated for some activities (specify)<br>______ Not motivated for most activities | |
| **41. JUDGEMENT IN PRESENT SITUATION:** | **REMARKS:** |
| ______ Realistic<br>______ Adequate for personal safety<br>______ Limited ability to make judgements<br>______ Unrealistic | |

42. Any additional information/assessment re psycho/social functioning pertinent to assessment for/delivery of home care:

## SUMMARY ASSESSMENT

Under the following headings indicate the area(s) (if any) where the applicant cannot meet need through self-functioning or through the services of available family or others, and which, if the need is not met, places the applicant at risk of no being able to remain in the community-or-places the applicant at risk of deterioration which could directly contribute toward inability to remain in the community.

Where the applicant's ability to remain in the community is dependent upon the service of others in the household or in the community, show where the relief of such providers is realistically indicated for continued living in the community.

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HOUSEHOLD MAINTENANCE NEEDS

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HEALTH NEEDS

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PERSONAL CARE NEEDS

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PSYCHO/SOCIAL NEEDS

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SUPPLIES/EQUIPMENT NEEDS