HDM INITIAL ASSESSMENT Completed by: _____

CLIENT NAME:	ASSESSMENT DATE: LIVES ALONE: (circle one) YES NO
REASON /NEED FOR HOME DELIVERY:	
ANTICIPATED LENGTH OF SERVICE: (Long-term vs. short term)	
Referred by: Relationship: Address: Phone:	
Case manager/social worker: (Name, phone, agency)	IN-HOME ASSISTANCE? NONE INFORMAL IHSS PRIVATE PAY HOMEMAKER
INFORMAL CAREGIVER (Family/friend) Relationship: _____ Name: Phone:	
TRANSPORATION: (Circle one) DOES CLIENT STILL DRIVE? YES NO IS THERE A CAREGIVER THAT IS AVAILABLE DURING THE DAY THAT DRIVES? YES NO Notes:	
ADDITIONAL INFORMATION: (Physical condition/Health)	
ASSISTIVE DEVICES: (circle all that apply) Cane/crutches Walker Wheelchair assist Wheelchair confined walks without assistance	
WEIGHT HISTORY: ANY SIGNIFICANT LOSS PAST 6 MONTHS? YES NO HOW MANY LBS?_____ USUAL WEIGHT:_____ CURRENT WEIGHT _____ HEIGHT _____	
Supplemental food: (circle all that apply) Brown Bag Commodities CSFP Love Center Other:	
Equipment check: (Circle all available) Refrigerator / stove / microwave In good working order ? YES NO Can client heat food independently? YES NO NOTES:	
Emergency Contact: (Name) (Phone) (Relationship)	
PLAN: Begin HDM - Start Date: _____ Other: _____ REFER TO: Senior Info & Assist Brown Bag Linkages FCSP Senior Transportation Senior Law Project Adult Protective Agency (APS) Health Insurance Counseling (HICAP) NOTES:	