PROJECT SAFETY NET
Social Service Evaluation

Subject Name:________________________________ Subject ID#_______________

Evaluator:___________________________________ Evaluation Date___/___/___
m d y

I. FINANCIAL & INSURANCE COVERAGE

INTERVIEWER: "WE NEED TO ASK YOU SOME FINANCIAL QUESTIONS IN ORDER TO DETERMINE WHAT TYPE OF SERVICES WE CAN OFFER YOU."

A. Financial support:

1. For a couple
   a. Total monthly income
      ___ Above $1,129
      ___ Below $1,129
   b. Total savings
      ___ Above $3,500
      ___ Below $3,500

2. For an individual
   a. Total monthly income
      ___ Above $623
      ___ Below $623
   b. Total savings
      ___ Above $2,000
      ___ Below $2,000

3. Are you currently receiving SSI?
   a. ___ No
   b. ___ Yes

B. Monthly rent or mortgage payment: $_______________

C. Health coverage:

1. Medicare?
   a. ___ No
   b. ___ Yes

2. Medi-Cal?
   a. ___ No
   b. ___ Yes

3. Private health insurance (such as Blue Cross or AARP)
   a.___ No
   b.___ Yes ---> name of carrier:_____________________________________

4. HMO (such as Kaiser, FHP or Secure Horizons)
   a.___ No
   b.___ Yes ---> name of HMO:____

II. ASSESSMENT OF FUNCTIONAL IMPAIRMENT

A. INTERVIEWER: 1.ITEMS ARE DESIGNATED AS BASIC ACTIVITIES OF DAILY LIVING (BADL) OR INTERMEDIATE ACTIVITIES OF DAILY LIVING (IADL) TO ASSIST WITH SUMMARY. 2.ITEMS REFER TO CURRENT FUNCTIONAL STATUS. 3. SPECIFY NEED FOR ITEMS CLIENT CANNOT MANAGE INDEPENDENTLY. USE BACK OF PAGE IF YOU NEED MORE ROOM FOR COMMENTS.

BADLs (B) IADLs (I)	Independent without problem	Independent with problem	Requires assist. Has help/ device	Requires assist. Needs referral	Comments
I:Shopping					
I:Meal preparation					
I:Everyday housekeeping					
I:Money/ Financial management					
I:Medication					
I:Telephone					
I:Outdoor mobility					
B:Indoor mobility					
B:Transfer from/ to bed or chair					
B:Eating (include swallowing)					
B:Bathing/ Grooming					
B:Dressing					

B. Transportation (check all that apply): (IADL)

1.____ Still drives
2.____ Has friend/family member drive
3.____ Uses bus
4.____ Uses taxi
5.____ Uses escort transportation
6.____ Needs/wants referral, additional assistance

III. ALCOHOL USE

A. Do you drink any beverages that contain alcohol including beer,liquor or wine?
   1)___No. **IF NO**, skip to IV. Depression on next page.
   2)___Yes

B. Do you have 3 or more drinks or beer, liquor or wine almost every day?
   1)___No
   2)___Yes

C. Does having a few drinks help decrease your shakiness or tremors?
   1)___No
   2)___Yes

D. Do you have rules for yourself that you won't drink before a certain time of day?
   1)___No
   2)___Yes

E. Do you hide your alcohol bottles from family members?
   1)___No
   2)___Yes

F. Did you find your drinking increased after someone close to you died?
   1)___No
   2)___Yes

G. Are you drinking more now than in the past?
   1)___No
   2)___Yes

H. Do you drink to take your mind off your problems?
   1)___No
   2)___Yes

I. Have you ever increased your drinking after experiencing a loss in your life?
   1)___No
   2)___Yes

J. Has a doctor or nurse ever said they were worried or concerned about your drinking?
   1)___No
   2)___Yes

K. Have you ever made rules to manage your drinking?
   1)___No
   2)___Yes

L. When you feel lonely does having a drink help?
   1)___No
   2)___Yes

IV. DEPRESSION

Ask Questions A. and B. if either of the following statements is true:

1) Client screened in on depression, and the Yesavage score is 11 or more.
2) Client seems depressed during the intervention.

Symptoms of depression include:

depressed mood____________________

feelings of worthlessness or guilt____________________

sleep disturbance____________________

trouble concentrating or indecisiveness____________________

weight change____________________

psychomotor agitation or retardation____________________

fatigue____________________

anhedonia____________________

suicidality____________________

A. Do you think of suicide or hurting yourself?

1.____ No
2.____ Yes

Comments:____________________

B. Have you ever felt like attempting suicide or hurting yourself in the past?

1.____ No
2.____ Yes

Comments:____________________

C. Have you ever received treatment for your depression?

1.____ No
2.____ Yes ---> Specify where and what kind of treatment.
    a. ____ Medication(s)
    b. ____ Hospitalization
    c. ____ Counseling
    d. ____ Other

Where treatment occurred:____________________

D. Are you currently receiving treatment for your depression?

1.____ No
2.____ Yes ---> Specify where and what kind of treatment.
    a. ____ Medication(s)
    b. ____ Hospitalization, including day care programs
    c. ____ Counseling
    d. ____ Other

Where treatment occurred:____________________

V. ANXIETY

A. Do you often have problems feeling tense or anxious?

1.___ No ---> skip to VI. Social Support below.
2.___ Yes

Comments:____

B. How often do you feel anxious?

1.___ Daily
2.___ Several times a month
3.___ Occasionally
4.___ Almost never

Comments:____

C. Have you ever felt this way in the past?

1.___ No
2.___ Yes

Comments:____

D. Are you currently under treatment for your anxiety?

1.___ No
2.___ Yes

Comments:____

VI. SOCIAL SUPPORT

A. Do you have **children or other family members** that you discuss personal problems with?

1.___ No ---> Go to F.
2.___ Yes

B. Do any of these relatives live in the Los Angeles area?

1.___ No
2.___ Yes

C. How often do you see them?

1.___ Daily
2.___ Weekly
3.___ Monthly
4.___ Less than monthly
5.___ Seldom or never

D. How often do you speak to them on the telephone?

1.___ Daily
2.___ Weekly
3.___ Monthly
4.___ Less than monthly
5.___ Seldom or never

E. Are you satisfied with this amount of contact with your family?

1.___ No
2.___ Yes

F. Do you have **friends** that you discuss personal problems with?

1.___ No ---> Go to J.
2.___ Yes

G. Do any of these friends live in the Los Angeles area?

1.___ No
2.___ Yes

H. How often do you see them?

1.___ Daily
2.___ Weekly
3.___ Monthly
4.___ Less than monthly
5.___ Seldom or never

I. How often do you speak to them on the telephone?

1.___ Daily
2.___ Weekly
3.___ Monthly
4.___ Less than monthly
5.___ Seldom or never

J. Are you satisfied with this amount of contact with your friends?

1.___ No
2.___ Yes

K. Do you have someone you can count on for help in a medical emergency?
1.___ No
2.___ Yes

L. Is there a place or person you turn to for help, e.g. your rabbi, church, or senior center?
1.___ No
2.___ Yes ---> How often do you go there for help? _______________

M. Do you feel isolated or lonely?
1.___ No
2.___ Yes. ---> how often do you feel isolated or lonely?
a.___ Daily
b.___ Several time a month
c.___ Occasionally
d.___ Almost never

N. Do you feel your daily activities are satisfying?
1.___ No
2.___ Yes

Comments:____

____

Date:__/__/__ ID#___________

VII. **SOCIAL SERVICE EVALUATION SUMMARY**

	Accepts	Refuses	Comments
Evaluation			
All referrals,assistance			
Some referrals,assistance			

Current Status

check all that apply

A. Assessment of Functional Impairment (BADL & IADL):

Choose only one answer for each column	BADL	IADL
1. Adequate and independent		
2. Adequate and has assistance		
3. Inadequate but refuses assistance		
4. Inadequate but has sufficient assistance		
5. Inadequate and needs more assistance		

B. Financial status:
1.____ Adequate
2.____ Economically needy
3.____ Currently receiving SSI
4.____ Eligible, but not receiving SSI

C. Do you think alcohol use may be a problem?
1.____ No
2.____ Yes

D. Emotional & mental status:
1.____ Coping adequately
2.____ Depressed
3.____ Anxious
4.____ Confusion, memory problems or other disorganized thinking
5.____ Suspicious
6.____ Dysthymia/Adjustment disorder
7.____ Other (specify:____)

E. Emotional support system:
1.____ Adequate
2.____ Limited
3.____ Isolated
4.____ Other (specify:____)

Interventions/Referrals Furnished

check all that apply

A. ___ No assistance indicated

B. ___ Refuses to complete evaluation or refuses all assistance

C. Financial assistance
1.___ Financial assistance not indicated
2.___ Refuses financial assistance
3.___ SSI
4.___ Medi-cal
5.___ IHSS
6.___ Education regarding eligibility for financial assistance
7.___ Other (specify:____)

D. Referred to local senior center
1.___ Senior center referral not indicated
2.___ Refuses referral to local senior center
3.___ Yes. ---> specify senior center____________________________

E. Transportation assistance
1.___ Transportation assistance not indicated
2.___ Refuses transportation assistance
3.___ Taxi coupons
4.___ Escort transportation
5.___ Other (specify:____)

F. In-home services
1.___ In-home services not indicated
2.___ Refuses in-home services
3.___ Home delivered meals
4.___ Homemaker services
5.___ Personal care
6.___ Home safety devices
7.___ Other (specify:____)

G. Case management
1.___ Case management not indicated
2.___ Refuses case management referral
3.___ Referral made (specify:____)

H. Mental health referral
1.___ Mental health referral not indicated
2.___ Refuses mental health referral
3.___ Referred to community agency for mental health assistance
4.___ Referred to NP/MD for further mental health evaluation
5.___ Other (specify:____)

I. Other referrals
1.___ No
2.___ Yes ---> specify:____

J.___ Additional comments (optional/use back as needed):

____