MSSP Initial Psychosocial Assessment

Instructions: Inquire about each area as appropriate, and enter response or indicate if not applicable in the comments. It is necessary to record a response to each area of the assessment.

Participant Name: _____ **MSSP #**_____
Assessment Date: _____
Staff Code: _____ **Staff Signature:** _____

Living Arrangements
What is the participant's usual living situation?
☐ Apartment ☐ Board and Care ☐ House ☐ Mobile Home ☐ Other: _____
Describe:

☐ Owned ☐ Rented ☐ Subsidized
Who lives with participant?

General
Occupation history:

Significant current and past activities and/or interests (including religious and social activities, pets, etc.)

Financial
What are the sources of income for the participant?

How is the participant managing financially? ☐ Problematic Expenses ☐ Benefits ☐ Budget
☐ Medicare ☐ IHSS
☐Other: Explain

Does the participant have?
☐ Conservator ☐ Substitute Payee ☐ Someone with Power of Attorney

☐ Someone with Durable Power of Attorney for Health

Care Comments:

Family and Social Network
How often does the participant leave the house and where does the participant go?

Location	How often?	Comments:
	☐ Daily ☐ Weekly ☐ Monthly ☐ Other:	
	☐ Daily ☐ Weekly ☐ Monthly ☐ Other:	
	☐ Daily ☐ Weekly ☐ Monthly ☐ Other:	
	☐ Daily ☐ Weekly ☐ Monthly ☐ Other:	
	☐ Daily ☐ Weekly ☐ Monthly ☐ Other:	
	☐ Daily ☐ Weekly ☐ Monthly ☐ Other:	

Describe the participant's support system (direct help, emotional support, family, friendships, etc.)

Name	Relationship	How frequent is the contact?	Informal Support	Describe support provided, problems, quality (in person, virtual, etc.):
		☐ Daily ☐ Weekly ☐ Monthly ☐ Other:		
		☐ Daily ☐ Weekly ☐ Monthly ☐ Other:		

Name	Relationship	How frequent is the contact?	Informal Support	Describe support provided, problems, quality (in person, virtual, etc.):
		☐ Daily ☐ Weekly ☐ Monthly ☐ Other:		
		☐ Daily ☐ Weekly ☐ Monthly ☐ Other:		
		☐ Daily ☐ Weekly ☐ Monthly ☐ Other:		
		☐ Daily ☐ Weekly ☐ Monthly ☐ Other:		

Is there an apartment manager or neighbor who can be called if necessary?
☐ Yes ☐ No If yes, who? _____ Phone (optional) _____
Other Comments:

Environmental Safety

Must participant climb stairs to enter or leave house? Particular problems, describe: ☐ Yes ☐ No

Environmental Safety Special Equipment Checklist (complete here or FNAG):	Does Participant Have?	Does Participant Use? (Optional)	Does Participant Need?
Tub	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Shower	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand-held shower	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Bath bench/chair	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Grab bars, toilet	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Grab bars, shower	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Grab bars, tub	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Raised toilet seat	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Bedside commode	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Incontinence supplies	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Ambulation aids, cane	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Ambulation aids, walker	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Ambulation aids, wheelchair	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Ambulation aids, scooter	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Ambulation aids, other	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Emergency response system	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Smoke alarm	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Carbon monoxide alarm	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Check any of the following which are problems:
☐ Loose Rugs ☐ Electrical Cords ☐ Unsafe Stairs ☐ History of falls

☐ Cluttered House ☐ Unclean House

☐ Inadequate kitchen facilities ☐ Inadequate bathroom facilities

☐ Inadequate heating ☐ Inadequate cooling ☐ Phone Accessibility

☐ Other:

Comments/Describe:

Formal Service Received Last Month Including Any Care Management Programs (Pre-MSSP)
Comments/Describe:

IHSS: _____ # _____ Hours _____

Transportation: _____

Meals: _____

Day Care: _____

Other:

Participant Needs List:

X _____ _____
Staff Signature / Date Print Name/Title