Appendix 26 ▪ 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 ID: _____
Assessment Date: _____
Staff Name/Title: _____ 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? _____

_____

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

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?

_____

Does the participant have any challenges managing their finances? ☐ Yes ☐ No
☐ Problematic Expenses ☐ Benefits ☐ Budget
☐ Other: _____

Does the participant have an authorized representative?
☐ Conservator ☐ Substitute Payee ☐ Power of Attorney (Identify Type): _____
Name: _____ Relationship: _____

Contact Information (optional): _____
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.). Describe support provided, problems, quality (in-person, virtual, etc.).

Name	Relationship	How frequent is the contact?	Informal Support	Describe Support Provided:
		☐Daily ☐Weekly ☐Monthly ☐Other	☐	
		☐Daily ☐Weekly ☐Monthly ☐Other	☐	
		☐Daily ☐Weekly ☐Monthly ☐Other	☐	
		☐Daily ☐Weekly ☐Monthly ☐Other	☐	
		☐Daily ☐Weekly ☐Monthly ☐Other	☐	
		☐Daily ☐Weekly ☐Monthly ☐Other	☐	

Is the participant at risk for social isolation? ☐ Yes ☐ No

Comments:

Psychological Functioning

Evaluate each aspect of the participant's psychological functioning and indicate the level of impairment as either None, Some or Severe in the table below. Explanatory comments are required if "Some" or "Severe" are selected. If there is a history of the impairment, or it is controlled with medications, indicate "Some" and explain in comments. If the care manager is unable to complete the reason must be documented in the comments.

Psychological Function	Level of Impairment	Describe Level of Impairment
Memory	☐ None ☐ Some ☐ Severe	
Orientation	☐ None ☐ Some ☐ Severe	
Judgment	☐ None ☐ Some ☐ Severe	
Anxiety	☐ None ☐ Some ☐ Severe	
Combative, Abusive, or Hostile Behavior	☐ None ☐ Some ☐ Severe	
Depression	☐ None ☐ Some ☐ Severe	
Delusions, Hallucinations	☐ None ☐ Some ☐ Severe	
Paranoid Thinking, Suspiciousness	☐ None ☐ Some ☐ Severe	
Wandering	☐ None ☐ Some ☐ Severe	
Suicidal	☐ None ☐ Some ☐ Severe	
Other	☐ None ☐ Some ☐ Severe	

Describe the participant's adaptive/coping Skills:

Any indications observed of abuse, neglect (including self-neglect), or exploitation?

Comments:

Environmental Safety

Any accessibility issues in or around the home (i.e. difficult entry stairs)? ☐ Yes ☐ No
Check any of the following which are problems:

☐ Loose Rugs ☐ Electrical Cords ☐ Unsafe Stairs ☐ History of Falls

☐ Cluttered House ☐ Unclean House ☐ Pest Issues

☐ Concerning Odors ☐Inadequate Kitchen Facilities ☐ Inadequate Bathroom Facilities

☐ Inadequate Heating ☐ Inadequate Cooling ☐ Inadequate Lighting

☐ Phone/Internet Accessibility Issues ☐ Weapons

☐ Other: _____

Comments/Describe:

Discuss safety and special equipment with the participant, indicating what type of equipment they have and if certain equipment is needed.

Safety and Special Equipment Checklist:	**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
Bath mats for shower/tub	○Yes ○No	○Yes ○No	○Yes ○No
Non-slip floor mats	○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
Bed cane/rail	○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

Safety and Special Equipment Checklist:	Does Participant Have?	Does Participant Use? (Optional)	Does Participant Need?
Ambulation aids, scooter	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
Ambulation aids, other	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
Ramp	◯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
Other (Explain in comments)	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No

Comments:

Formal Services

Include any care management programs received.

Benefit Type	Benefit Information
IHSS Current Hours:	
Transportation:	
Meals:	
Adult Day Care/ Community-Based Adult Services (CBAS):	
CalFresh:	
Medicare:	
Social Security:	
Section 8:	
Enhanced Care Management &/or Community Support:	
Other:	

Who provided assessment information:

Name:_____ Relationship: _____

How reliable is provided information?_____

Comments:

Participant Needs List: