Appendix 30 ▪ Functional Needs Assessment Grid

Participant/Resident: _____ MSSP ID: _____ Date: _____

Care Manager Name/Title: _____

ADL/IADL FUNCTIONING	Safe Functioning Level: Mark the box indicating the level at which the participant/resident can safely perform the function.	Current Help: Mark the box(s) indicating the type (if any) of help the participant/resident currently receives.	For Deinstitutionalization only: Note initial assessment of help/resources needed for resident to make a successful transition to community. Include IADLs resident may not be performing while living in the facility.

*ADLs / IADLs	Independent	Verbal Cueing	Stand-by Assist	Hands-on Assist	Dependent	Para Medical	Formal Help	Informal Help	Needs More Help	Comments
Eating*										
Dressing*						N/A				
Transferring*										
Bathing*						N/A				
Toileting*										
Grooming*										
Medications										
Stair Climbing						N/A				
Mobility Indoor						N/A				
Mobility Outdoor						N/A				
Housework						N/A				
Laundry						N/A				
Shopping/Errands						N/A				
Meal Prep/Cleanup						N/A				
Transportation										
Telephone						N/A				
Money Management						N/A				

DEINSTITUTIONALIZATION ONLY- CHECK EVALUATION NEEDED: _____ ☐ PHYSICAL THERAPY ☐ NUTRITION ☐ SPEECH ☐ OCCUPATIONAL THERAPY