Appendix 24 ▪ Deinstitutional Services Assessment

Resident's Name: _____ Date: _____

Address: _____ Date of Birth: _____

City, State, Zip: _____ Age: _____ Phone: _____

Marital Status: _____ Race: _____ Education Level: _____

Primary Language: _____ Translator Needed: ☐ Y ☐ N

Translation to be provided by: _____

Interview participants other than resident: _____

Reason for Admission: _____

Admission Date: _____ **Anticipated Discharge Date:** _____

Admission Location: _____

Insurance Information:

SSN: _____ Medicare/RRB #: _____ Medi-Cal #: _____

Other Insurance: _____

☐ Legal Guardian ☐ Conservator ☐ Durable Power of Attorney

Translator Needed: ☐ Y ☐ N

Name: _____ Phone: _____

Address: _____

Emergency Contact:

Name: _____ Phone: _____

Address: _____

Relationship to Resident: _____

Physician:

Name: _____ Phone: _____

Address: _____

Referral Source:

Section 1: Health-Related Services

This form is intended to be used in conjunction with the Initial Health Assessment (IHA). Complete the IHA for record of diagnoses, health history, and review of systems.

If the participant needs medical or health-related services listed below, specify what care is needed by checking the relevant boxes, then list how often, who will assume current help, and source of payment, if any, in the comments:

- ☐ Unstable, deteriorating, or terminal condition
- ☐ IV Therapy or Transfusions
- ☐ Ostomy
- ☐ Oxygen
- ☐ Respirator Treatments
- ☐ In-home Dialysis
- ☐ Total Parenteral Nutrition
- ☐ Tube Feedings
- ☐ Tracheostomy
- ☐ Wound or Ulcer
- ☐ Urinary Catheter
- ☐ Ventilator
- ☐ PT, OT, Speech
- ☐ Home Health
- ☐ Hospice
- ☐ Behavioral
- ☐ Other: _____

Comments:

Section 2: Planning Issues for Health

Priorities and Support Needs	**Comments:** What needs to be done, when, by whom
☐ Adaptive Equipment ☐ Community Doctor ☐ Dentist ☐ Evaluations (OT, Hearing, Vision, etc.) ☐ Exercise ☐ Medical Supplies ☐ Preventative Health Care ☐ Pharmacy ☐ Pain Management ☐ Specialist ☐ Therapy ☐ Other:	
Resources	**Comments:**
☐ Own Equipment ☐ Other:	

Section 3: Planning Issues for Housing

Priorities	Comments: What needs to be done, when, by whom
☐ Access to Home ☐ Access To Rooms ☐ Appliances ☐ Bathroom Modifications ☐ Change Of Address ☐ Equipment ☐ Furniture ☐ Independent Housing ☐ Keys For Care Providers ☐ Kitchen Modifications ☐ Pet Accommodations ☐ Shared Housing ☐ Subsidized Housing ☐ Telephone/Internet ☐ Utilities ☐ Pest Abatement ☐ Fall Prevention ☐ Other:	
Resources	**Comments:**
☐ Donated Funds ☐ Donated Furniture ☐ Independent Living Center ☐ Own Furniture ☐ Service Clubs (E.G., Kiwanis, Rotary) ☐ Subsidy Programs e.g., LIHEAP, Section 8 ☐ Community Supports (Managed Care Plan) ☐ Other:	

Section 4: Planning Issues for Financial Matters

Priorities	Comments: What needs to be done, when, by whom
☐ Credit History May Be Problematic ☐ Current Bills/Debts That Require Action ☐ Determine Amount and Sources of Income ☐ Develop A Budget ☐ Eligibility For CalFresh ☐ Establish Bank Account ☐ Establish Direct Deposit ☐ Money Management Services ☐ Other:	
Resources	**Comments:**
☐ Family Support ☐ Other Pension ☐ Personal Savings ☐ Social Security ☐ SSI ☐ VA ☐ Other:	

Section 5: Planning Issues for Independence/Self-Determination

Priorities	**Comments**: What needs to be done, when, by whom
Assistance With: ☐ Back-Up Plan for Emergencies ☐ Decision-Making ☐ Emotional Support ☐ Communication Equipment ☐ Health Care Advocate ☐ Support Group ☐ Legal Advice ☐ Living Will ☐ Memory ☐ Power Of Attorney ☐ Record Keeping ☐ Other:	
Previous Experience; contact with community agencies (e.g., IHSS, APS); nature of this experience:	
Resources	**Comments:**
☐ Family ☐ Friends ☐ Independent Living Center ☐ Religious/Spiritual Group ☐ Social Clubs ☐ Other:	

Section 6: Planning Issues for Social and Recreational Needs

Priorities	**Comments:** What needs to be done, when, by whom
☐ Ethnic/Cultural Traditions ☐ Future Events to Plan for (Birthdays, Holidays, Etc.) ☐ Hobbies (Either to Maintain or Develop) ☐ Meet Neighbors ☐ Private Time ☐ Peer Support ☐ Religious/Spiritual Affiliation ☐ Phone Calls ☐ Visits From Friends/Family ☐ Other:	
Resources	**Comments:**
☐ Family/Friends ☐ Place Of Worship ☐ Volunteer Opportunities ☐ Other (Specify):	

Section 7: Planning Issues for Transportation

Priorities	**Comments**: What needs to be done, when, by whom
☐ Mobility Training ☐ Will Require Escort ☐ Routine Transportation (e.g., Bus, Taxi, Dial-A-Ride) (Schedules, Tokens/Scrip) ☐ Transportation From NF To New Residence (Self & Belongings) ☐ Other:	
Resources	**Comments:**
☐ Family ☐ Friends ☐ Own Vehicle ☐ Public Program (e.g., Paratransit Discount) ☐ Volunteer ☐ Other:	

☐ The participant or caregiver was provided education and has knowledge of appropriate care needs to successfully transition to living safely in the community.

Name/Title/Signature: _____ Date: _____