[VI]RGINIA UNIFORM ASSESSMENT INSTRUMENT

Dates: Screen: 03/08/96
Assessment: 03/08/96
Reassessment: __/__/__

12 - Regular Assisted Living

1 IDENTIFICATION/BACKGROUND

Name & Vital Information

Client Name: Key (Last) Natasha (First) T (Middle Initial) Client SSN: [redacted]

Address: Martin's Place 2035 Spadina (Street) Chesapeake (City) VA (State) 23324 (Zip Code)

Phone: (804) [redacted] City/County Code: 5 5 0

Directions to House: Pets? No

Demographics

Birthdate: 03 (Month) / 16 (Day) / 72 (Year) Age: 24 Sex: __ Male 0 ✓ Female 1

Marital Status: __ Married 0 __ Widowed 1 __ Separated 2 __ Divorced 3 ✓ Single 4 __ Unknown 9

Race:
- __ White 0
- ✓ Black/African American 1
- __ American Indian 2
- __ Oriental/Asian 3
- __ Alaskan Native 4
- __ Unknown 9 ________

Ethnic Origin: ________

Education:
- __ Less than High School 0
- ✓ Some High School 1
- __ High School Graduate 2
- __ Some College 3
- __ College Graduate 4
- __ Unknown 9

Specify: ________

Communication of Needs:
- ✓ Verbally, English 0
- __ Verbally, Other Language 1 Specify: ________
- __ Sign Language/Gestures/Device 2
- __ Does Not Communicate 3

Hearing Impaired? ____

Primary Caregiver/Emergency Contact/Primary Physician

Name: Martin's Place Relationship: ACR
Address: 2035 Spadina Ave Ches 23324 Phone: (H) [redacted] (W)

Name: Mrs Hunter Relationship: Grandmother
Address: 4029 Ahoy Dr Ches 23321 Phone: (H) [redacted] (W)

Name of Primary Physician: Dr. Soriano Phone: [redacted]
Address: 610 Liberty St. Ches, VA 23324

Initial Contact

Who called: Beth Whitney (Name) Case Manager (Relation to Client) [redacted] (Phone)

Presenting Problem/Diagnosis:
Placement in an ACR

CLIENT NAME: Natasha Key **Client SSN:** [redacted]

Current Formal Services

Do you currently use any of the following types of services?

No 0	Yes 1	*Check All Services That Apply*	Provider/Frequency:
✓		Adult Day Care	
✓		Adult Protective	
	✓	Case Management	CSB about once a week
✓		Chore/Companion/Homemaker	
✓		Congregate Meals/Senior Center	
✓		Financial Management/Counseling	
✓		Friendly Visitor/Telephone Reassurance	
✓		Habilitation/Supported Employment	
✓		Home Delivered Meals	
✓		Home Health/Rehabilitation	
✓		Home Repairs/Weatherization	
✓		Housing	
✓		Legal	
	✓	Mental Health (~~Inpatient~~/Outpatient)	CSB Every 2 weeks
✓		Mental Retardation	
✓		Personal Care	
✓		Respite	
✓		Substance Abuse	
✓		Transportation	
✓		Vocational Rehab/Job Counseling	
	✓	Other: Psycho-Social Rehab	Coastal Club House Everyday

Financial Resources

Where are you on this scale for annual (monthly) family income before taxes?

	$20,000 or More ($1,667 or More) 0
	$15,000 - $19,999 ($1,250 - $1,666) 1
	$11,000 - $14,999 ($ 917 - $1,249) 2
	$ 9,500 - $10,999 ($ 792 - $ 916) 3
	$ 7,000 - $ 9,499 ($ 583 - $ 791) 4
✓	$ 5,500 - $ 6,999 ($ 458 - $ 582) 5
	$ 5,499 or Less ($ 457 or Less) 6
	Unknown 9

Number in Family unit: ______

Optional: Total monthly family income: 470.00

Do you currently receive income from . . . ?

No 0	Yes 1		*Optional: Amount*
		Black Lung,	
		Pension,	
		Social Security,	
	✓	SSI/~~SSDI~~,	470.00
		VA Benefits,	
		Wages/Salary,	
		Other,	

Does anyone cash your check, pay your bills or manage your business?

No 0	Yes 1		*Names*
✓		Legal Guardian,	
✓		Power of Attorney,	
	✓	Representative Payee,	Ramona Bracey
✓		Other,	

Do you receive any benefits or entitlements?

No 0	Yes 1	
✓		Auxiliary Grant
✓		Food Stamps
✓		Fuel Assistance
✓		General Relief
✓		State and Local Hospitalization
✓		Subsidized Housing
✓		Tax Relief

What types of health insurance do you have?

No 0	Yes 1	
✓		Medicare, #
	✓	Medicaid, # [redacted]
		Pending: ☐ No 0 ☐ Yes 1
		QMB/SLMB: ☐ No 0 ☐ Yes 1
		All Other Public/Private:

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NAME: Natasha Key Client SSN: [redacted]

Physical Environment

Where do you usually live? Does anyone live with you?

	Alone 1	Spouse 2	Other 3	Names of Persons in Household
___ House: Own 0				
___ House: Rent 1				
___ House: Other 2				
___ Apartment 3				
___ Rented Room 4				

	Name of Provider (Place)	Admission Date	Provider Number (If Applicable)
✓ Adult Care Residence 50	Martins Place	2/1/96	
___ Adult Foster 60			
___ Nursing Facility 70			
___ Mental Health/ Retardation Facility 80			
___ Other 90			

Where you usually live, are there any problems?

No 0	Yes 1	*Check All Problems That Apply*
✓	___	Barriers to Access
✓	___	Electrical Hazards
✓	___	Fire Hazards/No Smoke Alarm
✓	___	Insufficient Heat/Air Conditioning
✓	___	Insufficient Hot Water/Water
✓	___	Lack of/Poor Toilet Facilities (Inside/Outside)
✓	___	Lack of/Defective Stove, Refrigerator, Freezer
✓	___	Lack of/Defective Washer/Dryer
✓	___	Lack of/Poor Bathing Facilities
✓	___	Structural Problems
✓	___	Telephone Not Accessible
✓	___	Unsafe Neighborhood
✓	___	Unsafe/Poor Lighting
✓	___	Unsanitary Conditions
✓	___	Other: ______

Describe Problems:

Client Name: Natasha Key **Client SSN:** [redacted]

❷ Functional Status (Check only one block for each level of functioning)

ADLS	Needs Help? No 00	Needs Help? Yes	MH Only 10 Mechanical Help	HH Only 2 Human Help: Supervision 1	HH Only 2 Human Help: Physical Assistance 2	MH & HH 3: Supervision 1	MH & HH 3: Physical Assistance 2	Performed by Others 40			Is Not Performed 50
Bathing	✓										
Dressing	✓										
Toileting	✓										
Transferring	✓										
								Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	
Eating/Feeding	✓										

Continence	Needs Help? No 00	Needs Help? Yes	Incontinent Less than weekly 1	External Device/ Indwelling/ Ostomy Self care 2	Incontinent Weekly or more 3	External Device Not self care 4	Indwelling Catheter Not self care 5	Ostomy Not self care 6
Bowel	✓							
Bladder		✓	✓					

Comments: Sometimes has a Leakage Problem At night

Ambulation	Needs Help? No 00	Needs Help? Yes	MH Only 10 Mechanical Help	HH Only 2 Human Help: Supervision 1	HH Only 2 Human Help: Physical Assistance 2	MH & HH 3: Supervision 1	MH & HH 3: Physical Assistance 2	Performed by Others 40	Is Not Performed 50
Walking	✓								
Wheeling	✓								
Stairclimbing	✓								
								Confined Moves About	Confined Does Not Move About
Mobility	✓								

IADLS	Needs Help? No 0	Needs Help? Yes 1
Meal Preparation		✓
Housekeeping		✓
Laundry		✓
Money Management		✓
Transportation		✓
Shopping		✓
Using Phone	✓	
Home Maintenance		✓

Comments: Ms. Key is Currently in an ACR. She Can not take Responsibility for her IADLS because of her Mental illness

Outcome: Is this a short assessment?

✓ No, Continue with Section ◆ 0 ___ Yes, Service Referrals 1 ___ Yes, No Service Referrals

Screener: ______________________ Agency: ______________________

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NAME: Natasha Key

Client SSN: [redacted]

PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) *(List all)*	Phone	Date of Last Visit	Reason for Last Visit
Dr. Soriano	[redacted]	3/5/96	Physical + TB skin test
Dr. Lassiter	[redacted]	2/96	Therapy

Admissions: In the past 12 months, have you been admitted to a . . . for medical or rehabilitation reasons?

No 0	Yes 1		Name of Place	Admit Date	Length of Stay/Reason
	✓	Hospital	Maryview Psych	10/95	overnight for Hearing Voices
✓		Nursing Facility			
	✓	Adult Care Residence	Martin's Place	2/96	

Do you have any advanced directives such as . . . (Who has it . . . Where is it . . .)?

No 0	Yes 1		Location
✓	___	Living Will,	
✓	___	Durable Power of Attorney for Health Care,	
✓	___	Other,	

Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as . . . (Refer to the list of diagnoses)?

Current Diagnoses	Date of Onset
Paranoid Schizophrenic	1984

Enter Codes for 3 Major, Active Diagnoses: ___ None 00 34 DX1 35 DX2 ___ DX3

	Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1.	Prolyxin	1 2X Aday	Mental Disorder
2.	Artane	3 At Bedtime	Sideaffects of above
3.	Prolyxin	injation every 2weeks	Mental Disorder
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Total No. of Medications: ___ (If 0, skip to Sensory Function) **Total No. of Tranquilizer/Psychotropic Drugs:** ___

Do you have any problems with medicine(s) . . . ?

No 0	Yes 1	
✓	___	Adverse reactions/allergies
✓	___	Cost of medication
✓	___	Getting to the pharmacy
✓	___	Taking them as instructed/prescribed
✓	___	Understanding directions/schedule

How do you take your medicine(s)?

- ___ Without assistance 0
- ___ Administered/monitored by lay person 1
- ✓ Administered/monitored by professional nursing staff 2

Describe help: Administered by ACR

Name of helper: ACR Staff

Diagnoses:

- Alcoholism/Substance Abuse (01)
- Blood-Related Problems (02)
- Cancer (03)
- Cardiovascular Problems
  - Circulation (04)
  - Heart Trouble (05)
  - High Blood Pressure (06)
  - Other Cardiovascular Problems (07)
- Dementia
  - Alzheimer's (08)
  - Non-Alzheimer's (09)
- Developmental Disabilities
  - Mental Retardation (10)
  - Related Conditions
    - Autism (11)
    - Cerebral Palsy (12)
    - Epilepsy (13)
    - Friedreich's Ataxia (14)
    - Multiple Sclerosis (15)
    - Muscular Dystrophy (16)
    - Spina Bifida (17)
- Digestive/Liver/Gall Bladder (18)
- Endocrine (Gland) Problems
  - Diabetes (19)
  - Other Endocrine Problems (20)
- Eye Disorders (21)
- Immune System Disorders (22)
- Muscular/Skeletal
  - Arthritis/Rheumatoid Arthritis (23)
  - Osteoporosis (24)
  - Other Muscular/Skeletal Problems (25)
- Neurological Problems
  - Brain Trauma/Injury (26)
  - Spinal Cord Injury (27)
  - Stroke (28)
  - Other Neurological Problems (29)
- Psychiatric Problems
  - Anxiety Disorders (30)
  - Bipolar (31)
  - Major Depression (32)
  - Personality Disorder (33)
  - Schizophrenia (34)
  - Other Psychiatric Problems (35)
- Respiratory Problems
  - Black Lung (36)
  - COPD (37)
  - Pneumonia (38)
  - Other Respiratory Problems (39)
- Urinary/Reproductive Problems
  - Renal Failure (40)
  - Other Urinary/Reproductive Problems (41)
- All Other Problems (42)

CLIENT NAME: Natasha Kay **Client SSN:** [redacted]

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment 0	Impairment Record Date of Onset/Type of Impairment		Complete Loss 3	Date of Last Exam
		Compensation 1	No Compensation 2		
Vision	✓				
Hearing	✓				
Speech	✓				

Physical Status

Joint Motion: How is your ability to move your arms, fingers and legs?

- ✓ Within normal limits or instability corrected 0
- ___ Limited motion 1
- ___ Instability uncorrected or immobile 2

Have you ever broken or dislocated any bones? Ever had an amputation or lost any limbs? Lost voluntary movement of any part of your body?

Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
✓ None 000	✓ None 000	✓ None 000
___ Hip Fracture 1	___ Finger(s)/Toe(s) 1	___ Partial 1
___ Other Broken Bone(s) 2	___ Arm(s) 2	___ Total 2
___ Dislocation(s) 3	___ Leg(s) 3	Describe: ___
___ Combination 4	___ Combination 4	
Previous Rehab Program?	**Previous Rehab Program?**	**Previous Rehab Program?**
___ No/Not Completed 1	___ No/Not Completed 1	___ No/Not Completed 1
___ Yes 2	___ Yes 2	___ Yes 2
Date of Fracture/Dislocation?	**Date of Amputation?**	**Onset of Paralysis?**
___ 1 Year or Less 1	___ 1 Year or Less 1	___ 1 Year or Less 1
___ More than 1 Year 2	___ More than 1 Year 2	___ More than 1 Year 2

Nutrition

Height: 5' 5 5/16" (inches) **Weight:** 202 (lbs.) **Recent Weight Gain/Loss:** ✓ No 0 ___ Yes 1

Describe: ___

Are you on any special diet(s) for medical reasons?

- ✓ None 0
- ___ Low Fat/Cholesterol 1
- ___ No/Low Salt 2
- ___ No/Low Sugar 3
- ___ Combination/Other 4

Do you take dietary supplements?

- ✓ None 0
- ___ Occasionally 1
- ___ Daily, Not Primary Source 2
- ___ Daily, Primary Source 3
- ___ Daily, Sole Source 4

Do you have any problems that make it hard to eat?

No 0	Yes 1	
✓	___	Food Allergies
✓	___	Inadequate Food/Fluid Intake
✓	___	Nausea/Vomiting/Diarrhea
✓	___	Problems Eating Certain Foods
✓	___	Problems Following Special Diets
✓	___	Problems Swallowing
✓	___	Taste Problems
✓	___	Tooth or Mouth Problems
___	✓	Other: Constipation

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NAME: Natasha Key Client SSN: [redacted]

Current Medical Services

Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as ...?

No 0	Yes 1		Frequency
✓		Occupational	
✓		Physical	
✓		Reality/Remotivation	
✓		Respiratory	
✓		Speech	
	✓	Other	PsychoSocial Therapy

Do you have any pressure ulcers?

		Location/Size
✓	None 0	
	Stage I 1	
	Stage II 2	
	Stage III 3	
	Stage IV 4	

Special medical procedures: Do you receive any of the following nursing services?

No 0	Yes 1		Site, Type, Frequency
✓		Bowel/Bladder Training	
✓		Dialysis	
✓		Dressing/Wound Care	
✓		Eyecare	
✓		Glucose/Blood Sugar	
✓		Injections/IV Therapy	
✓		Oxygen	
✓		Radiation/Chemotherapy	
✓		Restraints (Physical/Chemical)	
✓		ROM Exercise	
✓		Trach Care/Suctioning	
✓		Ventilator	
✓		Other:	

Medical/Nursing Needs

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs? ___ No 0 ✓ Yes 1

If yes, describe ongoing medical/nursing needs:

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

Comments:
Client needs to see a Mental Health Nurse every 2 weeks for a Prolyxin injection

Optional: Physician's Signature: ______________ Date: ______________

Others: ______________ Date: ______________
(Signature/Title)

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CLIENT NAME: Natasha Key

4 PSYCHO-SOCIAL ASSESSMENT

Client SSN: [redacted]

Cognitive Function

Orientation

(Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)

Person: Please tell me your full name (so that I can make sure our record is correct).

Place: Where are we now *(state, county, town, street/route number, street name/box number)*? *Give the client 1 point for each correct response.*

Time: Would you tell me the date today *(year, season, date, day, month)*?

- ✓ Oriented 0
- ___ Disoriented - Some spheres, some of the time 1
- ___ Disoriented - Some spheres, all the time 2
- ___ Disoriented - All spheres, some of the time 3
- ___ Disoriented - All spheres, all of the time 4
- ___ Comatose 5

Spheres affected: ________________

Recall/Memory/Judgement

Recall: I am going to say three words, and I want you to repeat them after I am done (House, Bus, Dog). Ask the client to repeat them. *Give the client 1 point for each correct response on the first trial.* Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

Attention/ Concentration: *Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (D)LROW).*

Short-Term: Ask the client to recall the 3 words he was to remember.

Long-Term: When were you born (What is your date of birth)?

Judgement: If you needed help at night, what would you do?

No 0	Yes 1	
✓	___	Short-Term Memory Loss?
✓	___	Long-Term Memory Loss?
✓	___	Judgement Problem?

Optional: MMSE Score

___ (5)

___ (5)

___ (3)

___ (5)

Total: ______

Note: Score of 14 or below implies cognitive impairment

Behavior Pattern

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc.) or become agitated and abusive?

- ___ Appropriate 0
- ___ Wandering/Passive - Less than weekly 1
- ___ Wandering/Passive - Weekly or more 2
- ✓ Abusive/Aggressive/Disruptive - Less than weekly 3
- ___ Abusive/Aggressive/Disruptive - Weekly or more 4
- ___ Comatose 5

Type of inappropriate behavior: Has hit Staff members in the Past

Source of Information: APS Report + CSB

Life Stressors

Are there any stressful events that currently affect your life, such as . . . ?

No 0	Yes 1		No 0	Yes 1		No 0	Yes 1	
✓	___	Change in work/employment	✓	___	Financial problems	✓	___	Victim of a crime
✓	___	Death of someone close	✓	___	Major illness - family/friend	✓	___	Failing health
✓	___	Family conflict	___	✓	Recent move/relocation	✓	___	Other: ________

Client Name: Natasha Key   Client SSN: [redacted]

Emotional Status

In the past month, how often did you:	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Feel anxious or worry constantly about things?				✓	
Feel irritable, have crying spells or get upset over little things?				✓	
Feel alone and that you didn't have anyone to talk to?				✓	
Feel like you didn't want to be around other people?	✓				
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?				✓	
Feel sad or hopeless?	✓				
Feel that life is not worth living . . . or think of taking your life?	✓				
See or hear things that other people did not see or hear?				✓	
Believe that you have special powers that others do not have?	✓				
Have problems falling or staying asleep?	✓				
Have problems with your appetite . . . that is, eat too much or too little?	✓				

Comments: Client is Considered a Paranoid Schizophrenic

Social Status

Are there some things that you do that you especially enjoy?

No 0	Yes 1		Describe
	✓	Solitary Activities,	Listen to Music, Watch TV
	✓	With Friends/Family,	Dance, Skate, Swim
✓		With Groups/Clubs,	
✓		Religious Activities,	

How often do you talk with your children, family or friends, either during a visit or over the phone?

Children	Other Family	Friends/Neighbors
___ No Children 0	___ No Other Family 0	___ No Friends/Neighbors 0
✓ Daily 1	___ Daily 1	___ Daily 1
___ Weekly 2	✓ Weekly 2	___ Weekly 2
___ Monthly 3	___ Monthly 3	✓ Monthly 3
___ Less than Monthly 4	___ Less than Monthly 4	___ Less than Monthly 4
___ Never 5	___ Never 5	___ Never 5

Are you satisfied with how often you see or hear from your children, other family and/or friends?

___ No 0 ✓ Yes 1

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CLIENT NAME: Natasha Key

Client SSN:

Hospitalization/Alcohol - Drug Use

[illegible]

__ No 0 ✓ Yes 1

Name of Place	Admit Date	Length of Stay/Reason
Maryview Psych Hospital	10/95	overnight Hearing Voices
Norfolk Community Hospital	9/95	11 days hearing Voices

Do (did) you ever drink alcoholic beverages?

- __ Never 0
- ✓ At one time, but no longer 1
- __ Currently 2
- How much: ____
- How often: ____

Do (did) you ever use non-prescription, mood altering substances?

- __ Never 0
- ✓ At one time, but no longer 1
- __ Currently 2
- How much: ____
- How often: ____

If the client has never used alcohol or other non-perscription, mood altering substances, skip to the tobacco question.

Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?

__ No 0 ✓ Yes 1

Describe concerns: out too late

Do (did) you ever use alcohol/other mood-altering substances with...

No 0	Yes 1	
✓		Prescription drugs?
	✓	OTC medicine?
✓		Other substances?

Describe what and how often: ____

Do (did) you ever use alcohol/other mood-altering substances to help you...

No 0	Yes 1	
✓		Sleep?
✓		Relax?
✓		Get more energy?
✓		Relieve worries?
✓		Relieve physical pain?

Describe what and how often: ____

Do (did) you ever smoke or use tobacco products?

- __ Never 0
- __ At one time, but no longer 1
- ✓ Currently 2
- How much: 1/2 a pack
- How often: everyday

Is there anything we have not talked about that you would like to discuss?

No

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Client Name: Natasha Key

Client SSN: [redacted]

Assessment Summary

Indicators of Adult Abuse and Neglect: *While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1 - 55.3 to report this to the local Department of Social Services, Adult Protective Services.*

Caregiver Assessment

Does the client have an informal caregiver?

✓ No 0 (Skip to Section on Preferences) ___ Yes 1

Where does the caregiver live?

___ With client 0
___ Separate residence, close proximity 1
___ Separate residence, over 1 hour away 2

Is the caregiver's help . . .

___ Adequate to meet the client's needs? 0
___ Not adequate to meet the client's needs? 1

Has providing care to the client become a burden for the caregiver?

___ Not at all 0
___ Somewhat 1
___ Very much 2

Describe any problems with continued caregiving:

Preferences

Client's preferences for receiving needed care: Wants to ~~leave~~ live in an ACR

Family/Representative's preferences for client's care:

Physician's comments (if applicable):

CLIENT NAME: Natasha Key **Client SSN:** [redacted]

Client Case Summary

Ms Key has been diagnosed as a Paranoid Schizophrenic. She has acted out in the past by hitting staff members. Her behavior is controlled by medications. The client has been known to decompensate which has required hospitalization in the past. She is currently being treated for her mental illness by Chesapeake Community Services Board. She attends a day placement at Coastal Club House for Psycho-Social Therapy. Ms Key is in need of supervision for her IADL's and medication management. She also needs a payee for her SSI check.

Unmet Needs

No 0	Yes 1	(Check All That Apply)
	✓	Finances
✓		Home/Physical Environment
✓		ADLS
	✓	IADLS

No 0	Yes 1	(Check All That Apply)
✓		Assistive Devices/Medical Equipment
✓		Medical Care/Health
✓		Nutrition
	✓	Cognitive/Emotional
✓		Caregiver Support

Assessment Completed By:

Assessor's Name	Signature	Agency/Provider Name	Provider #	Section(s) Completed
Jeanne C. Blessing	Jeanne C. Blessing	Chesapeake Social Services	[redacted]	All

Optional: Case assigned to: ______________________ Code #: ______________