

INHOME SERVICE UNIT  
PROGRAM EVALUATION

CASE MANAGEMENT  
CLIENT PROFILE

PROGRAM NAME :  
PROGRAM OFFICER :

ID #  
DATE :

Complete a Client Profile for each case you review. Once the client profile is completed you will be able to answer the evaluation questions for each client. Make sure you answer all questions on the client profile do not leave any questions blanks. If the case has no documentation or documentation is not adequate please explain in space for question.

CLIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

DATE OF INTAKE \_\_\_\_\_ DATE OF ASSESSMENT \_\_\_\_\_

DATE OF REASSESSMENT \_\_\_\_\_ CASE MANAGER \_\_\_\_\_  
(NAME)

SEX: MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

LIVES: ALONE \_\_\_\_\_ OTHER \_\_\_\_\_ ETHNICITY \_\_\_\_\_

IF NOT ALONE WITH WHOM \_\_\_\_\_

REFERRAL SOURCE \_\_\_\_\_

PRESENTING PROBLEM

SPECIAL CIRCUMSTANCES

CLIENT CURRENTLY HAS MEDICAID YES \_\_\_\_\_ NO \_\_\_\_\_  
IF YES MEDICAID # \_\_\_\_\_

INFORMAL SUPPORTS YES \_\_\_\_\_ NO \_\_\_\_\_  
IF YES EXPLAIN WHO AND WHAT THEY DO FOR CLIENT

**SERVICE REQUESTED**

IS CLIENT CURRENTLY GETTING SERVICES FROM ANOTHER AGENCY?

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LIST ALL CLIENT'S IADL'S AND ADL'S THAT CLIENT CANNOT PERFORM. MAKE SURE YOU EXPLAIN WHO WILL ASSIST CLIENT WITH THESE UNMET NEEDS. BE SURE TO INCLUDE IF UNMET NEEDS ARE BEING MET BY INFORMAL SUPPORT OR FORMAL SUPPORT INCLUDING DFTA.

LIST ALL MEDICATION CLIENT USES DAILY AND DOSAGES

MEDICATION COMMENTS

DOSE THE CLIENT HAVE ANY CHRONIC ILLNESSESS OR IMPAIRMENTS?

LIST CLIENT'S COGNITIVE STATUS

DOES THE CLIENT USE ANY ASSISTIVE DEVICES

DOES THE CLIENT REQUIRE A MENTAL HEALTH EVALUATION

DID THE NUTRITION SCREENING SHOW ANY RISK AND REQUIRE ANY FOLLOW-UP

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LIST ANY HOUSING, OR HOUSING SAFETY ISSUES

LIST ALL SOURCES OF INCOME AND TOTAL INCOME FOR CLIENT

EMERGENCY CONTACTS (NAME/ADDRESS/ RELATIONSHIP)  
CLIENT'S CARE PLAN, LIST FORMAL AND INFORMAL SERVICES AND  
AMOUNT NEEDED TO ADDRESS CLIENT'S NEEDS

**SUMMARY OF CLIENT'S IN-HOME EVALUATION**

WAS CLIENT ASSESSMENT SIGNED BY CASE MANGER?  
YES \_\_\_\_\_ NO \_\_\_\_\_

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DID SOCIAL WORK SUPERVISOR OR PROGRAM DIRECTOR SIGN CLIENT ASSESSMENT? YES \_\_\_\_\_ NO \_\_\_\_\_

**OTHER ASSESSMENT FORMS**

WAS THE MOST RECENT SIGNED RELEASE OF INFORMATION FORM IN THE CLIENT'S CASE RECORD? YES \_\_\_\_\_ NO \_\_\_\_\_  
COMMENTS:

DID THE CASE MANAGER COMPLETE THE CLIENT'S FINANCIAL ASSESSMENT FORM ACCURATELY? YES \_\_\_\_\_ NO \_\_\_\_\_  
LIST CLIENT'S BENEFITS AND ENTITLEMENTS.

COMMENTS:

WAS CLIENT'S SERVICE AGREEMENT COMPLETED ACCURATELY? YES \_\_\_\_\_ NO \_\_\_\_\_  
LIST AUTHORIZED SERVICES OR REFERRALS FOR CLIENT.

COMMENTS:

AS THEIR DOCUMENTATION THAT THE CLIENT WAS GIVEN A COPY OF THE "CLIENT'S RIGHTS" FORM? YES \_\_\_\_\_ NO \_\_\_\_\_  
COMMENTS:

IS THE CLIENT'S REFERRAL FORM COMPLETED ACCURATELY YES \_\_\_\_\_ NO \_\_\_\_\_  
COMMENTS:

WAS THE CLIENT'S REFERRAL FORM SENT TO EACH SERVICE PROVIDER WITHIN 5 WORKING DAYS AFTER THE TELEPHONE REFERRAL IF THERE WAS NO WAITING LIST FOR SERVICE **YES**\_\_\_\_\_ **NO**\_\_\_\_\_

COMMENTS:

DID THE CASE MANAGER COMPLETE AND SEND A NEW REFERRAL FORM TO THE SERVICE PROVIDER AFTER AN INITIAL ASSESSMENT, EVENT BASED REASSESSMENT OR REASSESSMENT **YES**\_\_\_\_\_ **NO**\_\_\_\_\_

COMMENTS:

WAS THERE AN EVENT IN THE CLIENT'S LIFE THAT REQUIRED AN "EVENT BASED REASSESSMENT **YES**\_\_\_\_\_ **NO**\_\_\_\_\_

COMMENTS:

DID THE CASE MANAGER FOLLOW-UP WITH THE CLIENT WITHIN 24 HOURS OF THE START OF DFTA FUNDED HOMECARE SERVICES AND WAS IT DOCUMENTED IN THE CLIENT'S RECORD **YES**\_\_\_\_\_ **NO**\_\_\_\_\_

COMMENTS:

