Iowa Department of Human Services

ASSESSMENT SUMMARY

Date:

Name Of Consumer:	Social Security Number:	
Address:	Phone (home):	Phone (work):
	Residence county (#):	Legal settlement county (#):
Date Of Birth:	Gender: ☐ Male ☐ Female	

Ethnic Origin:
☐ White not of Hispanic origin ☐ American Indian ☐ Other (specify)
☐ African-American ☐ Alaskan Native
☐ Black not of Hispanic origin ☐ Asian/Pacific Islander
☐ Hispanic ☐ Declined to respond

Primary Diagnosis:
☐ MR: IQ number: _____ ☐ ☐ Moderate ☐ Severe ☐ Profound
☐ CMI Diagnosis (optional):
☐ DD ☐ BI

Secondary Diagnosis: Other:

Funding Source:
☐ Medicaid Number: _____ ☐ Medicare Number: _____
☐ Medically Needy ☐ Iowa Plan ☐ Other (Specify type and number):
☐ HCBS Waiver ☐ Other _____

Guardian:	Phone (home):	Phone (work):
Address:		
Payee:		Phone:
Address:		
Case Manager:		Phone:
Address:		

Did case manager change during the assessment period? ☐ No ☐ Yes

Reason for change:
☐ Case Manager Request ☐ Consumer Moved ☐ Staff Turnover
☐ Change In County Contract ☐ Consumer/Guardian Request ☐ Other
☐ Conflict Of Interest ☐ Medical Leave

Date Case Management Initiated:

Date Case Management Terminated:	Reason for Termination:	☐ Deceased	☐ No Longer Needed
		☐ ICF	☐ Voluntary Withdrawal
		☐ New Case Management Provider	☐ Other

Number of hospitalizations during the assessment period related to:

A. Medical _____

B. Psychiatric _____

C. 23-hour observations _____

Number of substantiated reports of abuse during the assessment period: _____

Number of criminal convictions during the assessment period: _____

Average monthly gross earned income of previous three months: _____

Monthly unearned income (SSI, SSDI, VA, interest income, etc.): _____

Reason for completing assessment: ☐ Initial OAP ☐ Annual OAP ☐ Special OAP ☐ Termination

Living location: _____ If other, specify: _____

Competitive Employment: ☐ Yes ☐ No

List services provided in the following chart using the codes below:

-- SERVICES PROVIDED --			
1) Service:		If other:	
2) Service:		If other:	
3) Service:		If other:	
4) Service:		If other:	
5) Service:		If other:	
1) Rehabilitative Work Setting:			
2) Rehabilitative Work Setting:			

Living Locations	Rehabilitative Work Settings	Services
Own home	Supported Employment	Nursing
Relative's Home	Sheltered Work/Work Activity	Supported Community Living
RCF	No Rehabilitative Employment	Vocational Rehabilitation
RCF - MR	Child	Legal Services
RCF - PMI		Mental Health Services
ICF		Transportation
Homeless		Home Care Aid Services
Other (please specify)		HCBS - MR
		HCBS - BI
		Community And Natural Supports
		Adult Residential Services
		Adult Day Care
		In-Home Health Related Care
		Other (please specify)

Assessment Score Summary:

	Safety Assessment	Score
#1	Safety needs	
#2	Abuse or exploitation	
#3	Involuntary commitment	
#4	Acts of aggression	

	Health Assessment	Score
#5	Substance abuse	
#6	Personal hygiene	
#7	Nutrition	
#8	Medication management	

	Self-Sufficiency Assessment	Score
#9	Basic needs	
#10	Community mobility	
#11	Community integration	
#12	Money management	
#13	Job performance	

	Stability Assessment	Score
#14	Follow through	
#15	Coping skills	
#16	Interpersonal skills	

Areas of strength as indicated from the assessment:

1. _____
2. _____
3. _____
4. _____

Needs as indicated from the assessment:

1. _____
2. _____
3. _____
4. _____

Other needs:

1. _____
2. _____
3. _____
4. _____

Desired results:

1. _____
2. _____
3. _____
4. _____

Consumer wants:

Other factors affecting current situation:

Responses to interventions (for past years):

Dictated:	Typed: