IOWA HHS

Iowa Department of Health and Human Services

Service Worker Comprehensive Assessment

This form helps the HHS service worker have a clear picture of your medical and daily care needs. It is important for you to complete and return this form so we can determine whether or not you qualify for services.

This form may be completed by you or by someone who cares for you. Read the instructions carefully and answer each question. If you need more space, use the back of the form. If you need help completing this form, contact the worker listed below. **Be sure to sign this form on page 9 before returning it**. Once you have completed the form, please return it to:

Worker name:	Title: Social Worker II	
Agency: Iowa Department of Health and Human Services		
Address:		FAX:
City:	State: IA	ZIP code:
Phone:	Email:	
Signature:	Date:	

Tell us about yourself:

Name:	Date of birth:	Medicaid ID number:
Current address:		County:
City:	State:	ZIP code:
Home phone:	Work phone:	Cell phone:
Email address:	Height:	Weight:
Sex: ☐ M ☐ F	Marital status:	Veteran: ☐ Yes ☐ No

Do you have a job or do volunteer work? ☐ Yes ☐ No

If yes, list where you go to work, how often, and what you do there:

_____

_____

Do you drive? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

If not, please use the chart below to tell us who lives in your household. (If you need more lines, please list in the narrative on page 7.)

Name:	Relationship to you:	Age:	Does this person help care for you?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Has anyone moved in or out of the house in the last year? ☐ Yes ☐ No

If yes, who?_____

Emergency contact:

Name:		Relationship:
Address:		
City:	State:	ZIP code:
Home phone:	Work phone:	Cell phone:
Email address:		

Does anyone not in your household care for you (unpaid)? ☐ Yes ☐ No

Name:		**Relationship:**
Address:		
City:	State:	ZIP code:
Home phone:	Work phone:	Cell phone:
Email address:		

Is there anyone that you would **not** want to be involved with your care if you were sick or needed help? ☐ Yes ☐ No

Name:	Relationship:

Tell us about your medical care:

Doctor's name:	Phone number:
Office name/address:	
Dentist's name:	
Eye doctor's name:	

Services: Do you receive any of the following services?		Days Per Week	Provider Name	Provider Phone
Nursing:	☐ Yes ☐ No			
Physical therapy:	☐ Yes ☐ No			
Occupational therapy:	☐ Yes ☐ No			
Speech therapy:	☐ Yes ☐ No			
Supervision for safety:	☐ Yes ☐ No			
Diabetes education:	☐ Yes ☐ No			
Respiratory treatment:	☐ Yes ☐ No			
Nasogastric tube care:	☐ Yes ☐ No			
Other (specify):	☐ Yes ☐ No			

Do you have a plan for home therapy? ☐ Yes ☐ No

If so, what therapist oversees this plan?_____

Assistive devices: In this section, check whether or not you use the device listed. On the line for each item, provide details including how often it is used and who helps if needed.

Oxygen:	☐ Yes ☐ No
Tracheostomy:	☐ Yes ☐ No
Ventilator:	☐ Yes ☐ No
Pull-ups or Depends:	☐ Yes ☐ No
Glasses:	☐ Yes ☐ No
Hearing aids:	☐ Yes ☐ No

Medical conditions and equipment: Check whether or not you have the condition or use the equipment listed. On the line for each item, provide details regarding how often the condition occurs or the equipment needs to be used and who helps if needed.

Allergies:	☐ Yes ☐ No
Blood sugar checks:	☐ Yes ☐ No
Bowel program:	☐ Yes ☐ No
Catheter:	☐ Yes ☐ No Who changes and how often? Check type: ☐ Indwelling ☐ Urethral ☐ Suprapubic
Chest percussion:	☐ Yes ☐ No
Colostomy bag:	☐ Yes ☐ No
Control of bladder:	☐ Yes ☐ No
Control of bowels:	☐ Yes ☐ No
Dialysis:	☐ Yes ☐ No
Dietary needs:	☐ Yes ☐ No
Feeding pump:	☐ Yes ☐ No
G-tube:	☐ Yes ☐ No
Implanted port:	☐ Yes ☐ No
Inhalation therapy:	☐ Yes ☐ No
Injections:	☐ Yes ☐ No
IV therapy:	☐ Yes ☐ No
Open wound:	☐ Yes ☐ No
Rashes:	☐ Yes ☐ No
Seizures:	☐ Yes ☐ No

If you answered yes to any of the items on page 4, please give a detailed explanation about those items.

_____

_____

_____

_____

_____

Mobility: Please indicate your need for the following devices or help. Check 'yes' or 'no' and use the line for each item to explain how often the device or assistance is needed and who helps.

Help transferring to or from chair, bed, stool:	☐ Yes ☐ No	
Assistance in or out of a vehicle:	☐ Yes ☐ No	
Positioning:	☐ Yes ☐ No	
Someone to stand near when walking or transferring:	☐ Yes ☐ No	
Slide board:	☐ Yes ☐ No	
Mechanical lift:	☐ Yes ☐ No	
Walker:	☐ Yes ☐ No	
Cane:	☐ Yes ☐ No	
Wheelchair:	☐ Yes ☐ No	
Brace:	☐ Yes ☐ No	
Helmet:	☐ Yes ☐ No	
Crutches:	☐ Yes ☐ No	
Communication devices:	☐ Yes ☐ No	
Weighted blankets or vest:	☐ Yes ☐ No	
Harness or gait belt:	☐ Yes ☐ No	

Wound care: Please describe any wound care you are receiving.

Type of Wound	Types of Treatment	How often is dressing changed?	Who provides treatment?
Bed sore:			
Surgical wound:			
Other open area:			

Activities of daily living: For each activity listed, place a check mark to state whether you can do the activity alone, can do it with help such as a verbal reminder, help from a device or piece of equipment, or help from someone else, or you cannot do it. On the next line, please write what kind of help you need, who helps you, and how often help is required (daily, weekly, etc.).

	No help needed	Verbal reminder	Help from a device	Help from a person	Dependent
Bathing or showering:	☐	☐	☐	☐	☐
Washing or combing hair:	☐	☐	☐	☐	☐
Shaving:	☐	☐	☐	☐	☐
Brushing teeth or denture care:	☐	☐	☐	☐	☐
Putting on or taking off clothes:	☐	☐	☐	☐	☐
Buttoning or zipping clothing:	☐	☐	☐	☐	☐
Putting shoes or socks on:	☐	☐	☐	☐	☐
Making meals:	☐	☐	☐	☐	☐
Eating:	☐	☐	☐	☐	☐

	No help needed	Verbal reminder	Help from a device	Help from a person	Dependent
Toileting:	☐	☐	☐	☐	☐
Transportation:	☐	☐	☐	☐	☐
Housekeeping:	☐	☐	☐	☐	☐
Laundry:	☐	☐	☐	☐	☐
Shopping:	☐	☐	☐	☐	☐
Communication:	☐	☐	☐	☐	☐
Money management:	☐	☐	☐	☐	☐
Medication management:	☐	☐	☐	☐	☐

Other therapy/services: Please use the chart below to tell us about any other therapy or services that you receive (such as nursing, home health, etc.).

Type of Service	Provider Name	Provider Phone	How often is service received?
Physical therapy:			
Speech therapy:			
Occupational therapy:			
Other therapy:			

Current Medications: Please use the chart below to tell us about any medications you take.

Medication Name:	Helps with _____:	Dosage and taken how often:	Prescribing doctor:

Are any medications kept in a special place, like a locked container or the refrigerator? ☐ Yes ☐ No

What pharmacy do you use?_____

How do you remember to take medications? (check all that apply)

☐ By following directions ☐ Calendar ☐ RN set-up ☐ Caregiver administers
☐ Bubble wrap or blister pack ☐ Pill minder ☐ Medpass machine ☐ Egg carton/envelopes
☐ Other

Comments:

_____

Narrative:

Please use the space below and on the following page to tell us more about yourself. Include some information about a "typical" day in your life. Who helps you? What they do and when? Do you feel safe in your home? Include any risk factors you have that were not identified by the questions on this form and tell how these are addressed.

If you are completing this for your child, please include any behavioral or safety concerns. Also explain the types of help that your child requires on a regular basis and how your child's needs may differ from other children of the same age.

In addition to the information already provided, please supply the following:

- ☐ Copy of the current Individual Education Plan (IEP) if applicable.
- ☐ Therapy notes.
- ☐ Any other information that you feel would assist the IHHRC worker in learning about you and your care needs.

Certification:

By signing below, I state that that the information provided on this form is correct and truthful.

Person who completed this form (please print):	Relationship to member:
Signature:	Date:

The following sections are to be completed by the *service worker only*.

Interdisciplinary team members consulted (including member):

Name	Title (if applicable)	Relationship to member

Additional records reviewed:

Comments: