Tennessee Department of Human Services

Social Assessment and Service Plan - SSBG

Client Name _____ County _____ Date ___/___/___

Street Address _____ ( ) - Telephone Number _____ Reassessment Due Date ___/___/___

City _____ State _____ Zip Code _____ ( ) - Alternate Telephone No. (Cell) _____ Email Address _____

Directions/Instructions _____ Completed By _____

Reason For Referral:

- ☐ Abuse:
- ☐ Neglect:
- ☐ Exploitation:
- ☐ Health/Medical Needs:
- ☐ Other: _____

Ethnic Background

- ☑ Black
- ☐ Hispanic or Latino
- ☐ White/Non-Hispanic
- ☐ Other: _____

Primary Clients	Date of Birth	Gender	Relationship	Health	Count
	/ /				
	/ /				
Others in the Home *(Not Primary Clients)*	**Date of Birth**	**Gender**	**Relationship**	**Health**	**Count**
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				

Marital Status: ☐ Single ☑ Divorced ☐ Married ☐ Widowed ☐ Cohabitating

Service Goal *(Circle Number)*:

II. Achieving or Maintaining Self-Sufficiency
III. Preventing or Remedying Neglect, Abuse, or Exploitation
IV. Preventing or Reducing Institutional Placements through Community Care

Home Environment *(Check All That Apply)*:

- ☐ House (Own/Rent)
- ☑ Apartment (Own/Rent)
- ☐ Trailer (Own/Rent)
- ☐ Housing Projects
- ☐ Other:

- ☑ Range
- ☑ Refrigerator
- ☐ Washer
- ☐ Dryer
- ☑ Electricity

- ☑ Water
- ☐ Heat:
- ☑ A/C:
- ☑ Clean
- ☐ Cluttered

- ☐ Extreme Fifth
- ☐ Smoke Alarm: ☐ Operable ☐ Inoperable
- ☐ Pest Infestation: ☐ High ☐ Low
- ☐ Telephone

Pets: ☑ No ☐ Yes Type: _____ Number: _____ ☐ Inside ☐ Outside Aggressive ☐ No ☐ Yes

Safety Plan: _____

Are there any weapons in the home? ☑ No ☐ Yes Type: _____ Location: _____

Safety Plan: _____

Client Name _____ County _____ Date 1 1

Health And Socio-Emotional Observations *(Check All That Apply)*:

- ☑ Diabetic
- ☐ Heart problems
- ☑ High blood pressure
- ☐ Mental illness
- ☐ Memory loss
- ☐ Paralysis
- ☐ Bedfast
- ☐ Seizures
- ☐ Oxygen
- ☐ Nervous
- ☐ Fearful
- ☐ Hepatitis
- ☐ Fall Risk
- ☐ Uncooperative
- ☐ Complaining
- ☐ Skin breakdown
- ☐ Traumatic Brain Injury (TBI)
- ☑ Sleep problems
- ☑ Vision loss Left eye
- ☐ Hearing loss
- ☑ Incontinence: ☐ Bladder ☐ Bowel
- ☐ Amputee:
- ☑ Arthritis
- ☑ Depressed/tearful
- ☐ Parkinson's
- ☑ Dental problems
- ☐ Blindness
- ☐ HIV
- ☐ Tuberculosis
- ☑ Pleasant
- ☐ Cancer
- ☑ Back problems
- ☐ stroke
- ☐ Confused
- ☑ Difficulty breathing
- ☐ Speech problems
- ☐ Communicable disease
- ☐ Obesity

Allergies: _____

Other: swollen feet

Is Client Currently Receiving Shots For Any Medical Condition?

☑ No ☐ Yes If "yes", was proper disposal of needles discussed with client? ☐ No ☐ Yes

Falls/Hospitalizations:

Has client fallen in past three (3) months? ☐ No ☑ Yes No. of occurrences: 1

Has client been hospitalized in last year? ☐ No ☑ Yes No. of occurrences: 2

Reason: Sugar levels

Cognitive/ Decision Making/Mental Health:

Was the client's response to the questions below accurate?

What year is it? ☑ No ☐ Yes What month is it? ☑ No ☐ Yes Where are we now? ☐ No ☑ Yes

Client's Overall Mental Clarity/Cognitive Function appears: ☐ Good ☑ Fair ☐ Poor

Does the client experience depression? ☐ Yes: (☑ Mild ☐ Moderate ☐ Severe) ☐ No

In the past six (6) months, has the client gained or lost more than ten (10) pounds without trying? ☐ No ☑ Yes

In the past year, has the client received mental health treatment or counseling? ☑ No ☐ Yes

Additional notes regarding client's mental/emotional presentation:

Financial Information:

Sources of income (monthly): Employment: $ _____ SSI: $ 1200 SS/Retirement: $ _____

Rent: $ 510 Food Stamps: $ _____ Other: _____

Expenses (monthly): Rent: $ _____ Utilities: $ 400 Telephone: $ 22

Other:

food - N/A medication - N/A (ASK Daughter)

Does client receive any financial assistance? ☑ No ☐ Yes Source(s): _____

Total Monthly Income: $ _____ Total Monthly Expenditures: $ _____

Comments: _____

Client Name _____ County _____ Date ___/___/___

Problems/Concerns:

- [x] Inadequate/unclean clothing Bedding
- [x] Inadequate income
- [ ] Inadequate housing
- [ ] Unable to maintain
- [x] Inadequate food supply (ex. Skipping meals, need meals:
- [x] Poor hygiene
- [ ] Unemployment
- [x] Trouble paying bills
- [ ] Threat of eviction
- [ ] Unable to get to doctor
- [ ] Overcrowded home
- [x] Assistance accessing essential transportation home

- [ ] Medication issues (*i.e.*, can't afford, forgetful):
- [ ] Exploitation:
- [ ] Unsafe environment:
- [ ] Marital/Relationship Problems:
- [ ] Medical Issues:
- [ ] Psychological Issues:
- [ ] Behavioral Health Issues:
- [ ] Alcohol problems:
- [ ] Activities of Daily Living (ADL): (*Bathing, Dressing, Toileting, Transferring, Eating, Walking in Home*)
- [ ] Instrumental Activities of Daily Living (IADL): (*Meal Prep, Shopping, Med Mgmt. Money Mgmt. Phone, House Hold Chores, Transportation*)
- [ ] Communication Needs and Sensory Devices:

Special Notations/Further Explanation About the Client's Problems or Situation:

Is Client a Veteran? [x] No [ ] Yes **Widow(er) of Veteran?** [ ] No [ ] Yes

If so, what branch of the military services? [ ] Army [ ] Navy [ ] Air Force [ ] Marines

Natural Support:

Other Services/Agencies in the Home:

Screen for alternate services? [ ] CHOICES [ ] OPTIONS [ ] OTHER:

Resources currently utilized:

Resources needed:

DHS staff should check the "Forms" section of the intranet to ensure the use of current versions. Forms may not be altered without prior approval.

Client Name _____ County _____ Date ___/___/___

Doctor(s): _____

Power of Attorney (*POA*):

Financial: ☐ No ☐ Yes Name: Daughter Relationship: _____
Telephone No. ( ) -

Medical: ☐ No ☐ Yes Name: _____ Relationship: _____
Telephone No. ( ) -

Advanced Directives (*Agency must have a copy on file or be posted in home in order to honor wishes*):

☐ No ☐ Yes Health Care Agent: _____ Telephone: ( ) -
Instructions from document:

Emergency Contact Person (*Required*):

Name: _____ Relationship to Client: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: ( ) - Alternate Phone: ( ) -
Notes: _____

Disaster/ Emergency Evacuation Plan:

Ambulation: ☐ Ambulatory ☐ Non-Ambulatory ☐ Requires assistance with ambulation
Exit home independently? ☐ No ☐ Yes
If no, how will client exit? _____
In the event of fire: Exit 1: _____ Exit 2: _____
Weather-related Emergency: ☐ Will evacuate to safe place/shelter ☐ Has safe place in home
Location of safe place in home: _____
Detailed Plan: _____

CLIENT'S FEELINGS ABOUT SERVICES PROVIDED: ☐ Good ☐ Fair ☐ Poor

What benefits does client report from service? _____
The client(s) has/have: ☐ ***Progressed*** ☐ ***Stabilized*** ☐ ***Regressed*** (since the last assessment)
Please explain:

Objectives: What do you see as the main focus?

☐ Improve/maintain personal hygiene
☐ Have adequate clean clothes
☐ ~~Budget money to pay bills~~
☐ Learn about available resources
☐ Prevent eviction
☐ Encourage activities to reduce depression and/or improve emotional stability
☐ Improve/maintain clean environment
☐ improve/maintain adequate food supply
☐ ~~Improve/maintain ability to maintain medical care~~
☐ Learn to be more self-reliant
☐ Remain safely in home

Partnership for Families, Children, and Adults, Inc.
Elder Services
Application for Service

	Homemaker Services	**Cost Center**	504
Date:		**Name:**	

Location of interview

☒ Client's Home ☐ Partnership Office ☐ Telephone or videophone ☐ Shelter ☐ Hospital ☐ School
☐ Nursing Home ☐ Other (*describe*)

Staff Information:	**Name:** Kendra Brabham
	Title: Program Manager

Information provided by *(may be one or more individuals)*

☒ Self
☐ Family/friend
☐ Caseworker
☐ Other

If other than self, name and relationship to potential client : NA

Phone number of informant: NA

Primary Concerns	The resident was referred by APS for homemaker services.

Client Demographics and contact information

DOB:		**Medicare #**	
SS #:			
Street:			client is homeless.)
City:	Chattanooga	**State:**	TN
County:	Hamilton	**Zip Code***	
Phone/Videophone/TTY/Email:			
Gender*	☑ **Male** ☐ **Female** ☐ **Unk.** ☐ **Other**	**Age***	**Legal* Status** ☒ **Adult** ☐ **Dependent Adult**
Ethnicity*	☐ **Caucasian/white** ☑ **African/American/Black** ☐ **Latino** ☐ **Asian/Oriental** ☐ **Biracial/multi-ethnic** ☐ **Middle Eastern** ☐ **Native American/Eskimo** ☐ **Pacific Islander/Polynesian** ☐ **Indian** ☐ **Unknown** ☐ **Other**		
Primary Language:	☒ **English** ☐ **American Sign Language** ☐ **Spanish** ☐ **Pidgin Signed English (PSE)** ☐ **Other (describe)**		
Income level*	☐ $4,999 and below ☐ $5,000 to $9,999 ☑ $10,000 to $19,999 ☐ $20,000 to $29,999 ☐ $30,000 and above ☐ Not disclosed/not available		
Disability*	If none, indicate as N/A:		
Citizenship*	Indicate if Client is a non- U.S citizen: Yes		
Veteran*	☐ YES ☑ NO : Army		

Primary Source(s) of income *(Include amount per year, month, or week, if available; please identify if client is employed)*

Social Security → 1200 each month

Referral Source

☒ Adult Protective Services ☐ Family/Friend ☐ Health Department ☐ Homeless Shelter ☐ SETAAAD
☐ Home Health ☐ Legal/Law/police ☐ Media/Marketing ☐ Self ☐ Other (describe)