CLIENT NAME: **Client SSN:**

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

1. IDENTIFICATION/ BACKGROUND

Dates: Screen: __ / __ / __
Assessment: __ / __ / __
Reassessment: __ / __ / __

Name & Vital Information

Client Name: _____ Client SSN: _____
(Last) (First) Middle Initial)
Address: _____
(Street) (City) (State) (Zip Code)
Phone: _____ City/County Code: _____

Pets?

Demographics

Birthdate: ___/___/_____ **Age:** _____ **Sex:** ____ Male 0 ____ Female 1
(Month) (Day) (Year)

Marital Status: __ Married0 ___ Wid-owed 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? _____

CLIENT NAME:	Client SSN:

Primary Caregiver/Emergency Contact/Primary Physician

Name: _____ **Relationship:** _____

Address: _____ **Phone:** (H) _____ (W) _____

Name: _____ **Relationship:** _____

Address: _____ **Phone:** (H) _____ (W) _____

Name of Primary Physician: _____ **Phone:** _____

Address: _____

Initial Contact

Who called: _____

(Name) (Relation to Client) (Phone)

Presenting Problem/Diagnosis:

CLIENT NAME:	Client SSN:

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	_____
_____	_____	Chore/Companion/Homemaker	_____
_____	_____	Congregate Meals/Senior Center	_____
_____	_____	Financial Management/Counseling	_____
_____	_____	Friendly Visitor/Telephone Reassurance	_____
_____	_____	Habilitation/Supported Employee	_____
_____	_____	Home Delivered Meals	_____
_____	_____	Home Health/Rehabilitation	_____
_____	_____	Home Repairs/Weatherization	_____
_____	_____	Housing	_____
_____	_____	Legal	_____
_____	_____	Mental Health (Inpatient/Outpatient)	_____
_____	_____	Mental Retardation	_____
_____	_____	Personal Care	_____
_____	_____	Respite	_____
_____	_____	Substance Abuse	_____
_____	_____	Transportation	_____
_____	_____	Vocational Rehab/Job Counseling	_____
_____	_____	Other: _____	_____

CLIENT NAME:	Client SSN:

Financial Resources

Where are you on the 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: _____

Do you currently receive income from…?

No 0	**Yes 1**		*Optional: Amount*
_____	_____	Black Lung,	_____
_____	_____	Pension,	_____
_____	_____	Social Security,	_____
_____	_____	SSI / SSDI,	_____
_____	_____	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,	_____
_____	_____	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

No 0	**Yes 1**		
_____	_____	Medicare, #	_____
_____	_____	Medicaid, #	_____
		Pending: ☐ No 0 ☐ Yes 1	
		QMB/SLMB ☐ No 0 ☐ Yes 1	
_____	_____	All Other Public/Private:	_____

CLIENT NAME:	Client SSN:

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			
___ Adult Foster 60			
___ Nursing Facility 70			
___ Mental Health/ Retardation Facility 80			
___ Other 90			

CLIENT NAME:	**Client SSN:**

Where you usually live, are there any problems?

No	**Yes**	*Check All Problems That Apply*	**Describe Problems:**
0	1		
____	____	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: _____	

CLIENT NAME:	Client SSN:

2. FUNCTIONAL STATUS (Check only one block for each level of functioning)

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

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

Comments:

CLIENT NAME: **Client SSN:**

Ambulation	Needs Help?	
	No 00	**Yes**
Walking		
Wheeling		
Stair-climbing		
Mobility		

MH Only 10 Mechanical Help	**HH Only** 2 Human Help **D**		**MH & HH** 3 **D**		**Per-formed by Others** 40 **D**	**Is Not Performed** 50 D
	Super-vision 1	Physical Assist-ance 2	Super-vision 1	Phys-ical Assist-ance 2		
					Confined Moves About	**Confined** Does Not Move About

IADLS	Needs Help?	
	No 0	**Yes** 1 **D**
Meal Preparation		
House-keeping		
Laundry		
Money Management		
Transporta-tion		
Shopping		
Using Phone		
Home Maintenance		

Comments:

Outcome: Is this a short assessment?

No, Continue with **Section 3** 0	Yes, Service Referrals 1	Yes, No Service Referrals 2
____	____	____

Screener: _____ **Agency:** _____

CLIENT NAME:	Client SSN:

3. PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) *(List all)*	Phone	Date of Last Visit	Reason for Last Visit

Admission: 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			
		Nursing Facility			
		Adult Care Residence			

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

No **Yes** *Location*

0 **1**

____ ____ _____

____ ____ Durable Power of Attorney for Health Care, _____

____ ____ Other, _____

CLIENT NAME:	Client SSN:

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

Enter Codes for 3 Major, Active Diagnoses (DX):	None 00	DX 1	DX 2	DX 3
	___	___	___	___

Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1.		
2.		
3.		
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 medications?

___ Without assistance 0

___ Administered / monitored by lay person 1

___ Administered / monitored by professional nursing staff 2

Describe help: _____

Name of helper: _____

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)

CLIENT NAME:		Client SSN:
		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 Disorder (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:	Client SSN:

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

CLIENT NAME:	Client SSN:

Nutrition

Height: _____ (inches) **Weight:** _____ (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

___ ___ 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: _____

CLIENT NAME:	Client SSN:

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	_____

Do you have 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 special nursing care, such as …?

No 0	Yes 1		*Site, Type, Frequency*
____	____	Bowel/Bladder Training	_____
____	____	Dialysis	_____
____	____	Dressing/Wound Care	_____
____	____	Eyecare	_____
____	____	Glucose/Blood Sugar	_____
____	____	Infections/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.

CLIENT NAME:	**Client SSN:**

Comments:

Optional: Physician's Signature: _____ Date: _____

Others: _____ Date: _____
(Signature/Title)

CLIENT NAME:	Client SSN:

4. PSYCHO-SOCIAL ASSESSMENT

Cognitive Function

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

Optional: **MMSE Score**

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.* (5)

Time: Would you tell me the date today *(year, season, date, day, month)**?*** (5)

___ Oriented $_0$ Spheres affected: _____

___ 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 $_5$

Recall/Memory/Judgment

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. (3)

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

**Short-Term: ***Ask the client to recall the 3 words he was to remember. (5)

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

Total: _____

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

No $_0$ **Yes** $_1$

Note: Score of 14 or below implies cognitive impairment

____ _____ Short-Term Memory Loss?

____ _____ Long-Term Memory Loss?

____ _____ Judgment Problems?

CLIENT NAME:	Client SSN:

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: _____ Source of Information: _____

Life Stressors

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

___	___	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:	Client SSN:

Emotional Status

In the past month, how often did you . . . ?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable to Assess 9
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you don'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 NAME:	Client SSN:

Social Status

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

No 0 Yes 1 *Describe*

____ ____ _____

____ ____ With Friends / Family, _____

____ ____ 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

____ ____

CLIENT NAME:	Client SSN:

Hospitalization/Alcohol – Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems?

_____ No 0 _____ Yes 1

Name of Place	Admit Date	Length of Stay/Reason

Do (did) you ever drink alcoholic beverages?

_____
_____ At one time, but no longer
_____ Currently 2
How much: _____
How often: _____

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

At one time, but no longer 1

How often: _____

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

Have you, or someone close

____ No 0 ____ Yes 1

Describe concerns: _____

Do (did) you ever use

No 0 Yes 1

____ ____ Prescription drugs?
____ ____ OTC medicine?
____ ____ Other substances?

Describe what and how often:

Do (did) you ever use

No 0 Yes 1

____ ___ Sleep?
____ ___ Relax?
____ ___ Get more energy?
____ ___ Relieve worries?
____ ___ Relieve physical pain?

Describe what and how often:

CLIENT NAME:	**Client SSN:**

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

_____ Never $_0$

_____ At one time, but no longer $_1$

_____ Currently $_2$

How much: _____

How often: _____

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

CLIENT NAME:	Client SSN:

5. 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 client become a burden for the caregiver?

___ Not at all $_0$
___ Somewhat $_1$
___ Very much $_2$

Describe any problems with continued caregiving:

CLIENT NAME:	Client SSN:

Preferences

Client's preference for receiving needed care: _____

Family/Representative's preference for client's care: _____

Physician's comments (if applicable)**:** _____

CLIENT NAME:	Client SSN:

Client Case Summary

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

Optional: Case assigned to: _____ Code #: _____