### Personal, Psychosocial and Family Functioning and Financial Information:

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<th>Comments</th>
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#### A. Household Members

- Names and relationships

#### B. Behavior Indicators/Psychosocial Functioning

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<th>GOOD</th>
<th>FAIR</th>
<th>POOR</th>
<th>COMMENTS</th>
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<td>PT PCP</td>
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<td>Functional Ability</td>
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<td>Memory</td>
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<td>Comprehension</td>
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<td>Judgement/Decision Making</td>
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<td>Communication Ability</td>
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<td>Knowledge of Health Problems</td>
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<td>Motivation to Resolve Needs</td>
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<td>Compliance with Treatment</td>
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<td>Ability to Accept Help</td>
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#### C. Significant psycho/social/emotional factors/needs for counseling

- Comments

### Specific Information Desired

- Comments

### II. Medical Social Work Assessment

- Comments

### Client/Designee:

**I certify that the Matrix Home Care Employee listed on this time slip worked the times indicated and the work was performed in a satisfactory manner. I agree to the times regarding this time slip.**

**Employee Signature:**

**Patient/Client Signature:**
## II. ASSESSMENT SUMMARY:

### III. LONG-TERM CARE PLANNING:

- Access community resource utilization on ongoing basis
- Provide information, referral consultation & collateral contacts as needed
- Counsel/teach re: appropriate community resource utilization
- Instruct pt/family to call Care Team if assistance needed after discharge

### IV. Problem Areas/Reasons:

**HOUSING:**
- Adequate: YES
- NO
- Due to: Crowing
- Sanitation
- Structural deficiency
- Neighborhood
- Dysfunctional utilities
- Other: ____________________

**EQUIPMENT/SUPPLIES/INFORMATION:**
- Adequate: YES
- NO
- Due to: Knowledge deficit
- Income deficit
- Other: ____________________

**SAFETY:**
- Adequate: YES
- NO
- Due to: Lack of supervision
- Abuse/neglect
- Poor judgement
- Environment
- Alcohol/substance abuse
- Prome to falls or medical emergencies
- Other: ____________________

**TRANSPORTATION:**
- Adequate: YES
- NO
- Due to: Unable to drive
- Unable to ride in car
- Driver no available
- Can’t afford
- Inaccessibility
- Other: ____________________

### INCOME:

- Adequate: YES
- NO
- Due to: No income resource
- Disproportionate living or medical expenses
- Poor financial planning/decision making
- Other: ____________________

### PERSONAL CARE/HOUSEKEEPING:

- Adequate: YES
- NO
- Due to: Lives alone
- Elderly/ill PCP
- Extreme dependency of pt.
- Employed PCP
- Refuses PCP
- Cannot afford to hire
- Other: ____________________

### FOOD MEALS:

- Adequate: YES
- NO
- Due to: Pt/PCP unable to prepare meals
- Inadequate income
- Inability to shop for groceries
- Other: ____________________

### OTHER:

- ____________________
- ____________________
- ____________________
- ____________________
- ____________________
- ____________________
- ____________________
- ____________________

Comments:

________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Signature: ____________________ Date: ____________________

10/09/12 Medical Social Work Assessment