VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Date Screen: __ / __ / __
Assessment: __ / __ / __
Reassessment: __ / __ / __

1 IDENTIFICATION/BACKGROUND

Name & Vital Information

Client Name: _____ Client SSN: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip Code)

Phone: _____ City/County Code: _____

Directions to House: **Pets?**

Demographics

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

Marital Status: ____ Married 0 ____ Widowed 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 _____

Education:
____ Less than High School 0
____ Some High School 1
____ High School Graduate 2
____ Some College 3
____ College Graduate 4
____ Unknown 9

Communication of Needs:
____ Verbally, English 0
____ Verbally, Other Language 1
Specify: _____
____ Sign Language / Gestures / Device 2
____ Does Not Communicate 3
Hearing Impaired? ____

Ethnic Origin: _____ Specify: _____

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: _____	_____

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		*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

What types of health insurance do you have?

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			

Where you usually live, are there any problems?

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

Describe Problems:

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		MH & HH 3		Performed by Others 40			Is Not Performed 50
	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	External Device Not self care 4	Indwelling Catheter Not self care 5	Ostomy Not self care 6
	No 00	Yes						
Bowel								
Bladder								

Comments:

Ambulation	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40	Is Not Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
Walking									
Wheeling									
Stairclimbing									
								Confined Moves About	Confined Does Not Move About
Mobility									

IADLS	Needs Help?	
	No 0	Yes 1
Meal Preparation		
Housekeeping		
Laundry		
Money Management		
Transportation		
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 0 Yes 1 *Location*

_____ _____ Living Will, _____

_____ _____ Durable Power of Attorney for Health Care, _____

_____ _____ Other, _____

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: _____ None 00 _____ DX1 _____ DX2 _____ DX3

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)…?	**How do you take your medications?**
No 0 Yes 1	___ Without assistance 0
_____ _____ Adverse reactions / allergies	___ Administered / monitored by lay person 1
_____ _____ Cost of medication	___ Administered / monitored by professional
_____ _____ Getting to the pharmacy	nursing staff 2
_____ _____ Taking them as instructed / prescribed	Describe help: _____
_____ _____ Understanding directions / schedule	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)
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 (4
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	____ None 000	____ None 000
____ Hip Fracture 1	____ Finger(s)/Toe(s) 1	____ Partial 1
____ Other Broken Bone(s) 2	____ Arm(s) 2	____ Total 2
____ Dislocation(s) 3	____ Leg(s) 3	Describe: _____
____ Combination 4	____ Combination 4	
Previous Rehab Program?	**Previous Rehab Program?**	**Previous Rehab Program?**
____ No/Not Completed 1	____ No/Not Completed 1	____ No/Not Completed 1
____ Yes 2	____ Yes 2	____ Yes 2
Date of Fracture/Dislocation?	**Date of Amputation?**	**Onset of Paralysis?**
____ 1 Year or Less 1	____ 1 Year or Less 1	____ 1 Year or Less 1
____ More than 1 Year 2	____ More than 1 Year 2	____ More than 1 Year 2

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 0	Yes 1	
____	____	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.

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.)*

Person: **Please tell me your full name** (so that I can make sure our record is correct).
Place: **Where are we now** *(state, country, town, street/route number, street name/box number)?*
Give the client 1 point for each correct response.
Time: **Would you tell me the date today** *(year, season, date, day, month)***?**

_____ Oriented 0
_____ 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, of the time 4
_____ Comatose 5

Spheres affected: _____

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.

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.

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

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

No 0	**Yes** 1	
_____	_____	Short-Term Memory Loss?
_____	_____	Long-Term Memory Loss?
_____	_____	Judgment Problems?

Optional: **MMSE Score**

_____ (5)
_____ (5)
_____ (3)
_____ (5)

Total: _____

Note: Score of 14 or below implies cognitive impairment

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 . . . ?

No 0	Yes 1		No 0	Yes 1		No 0	Yes 1	
____	____	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:

Social Status

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

No 0 Yes 1 *Describe*

_____ _____ Solitary Activities, _____

_____ _____ 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?

_____ Never 0
_____ At one time, but no longer 1
_____ Currently 2
How much: _____
How often: _____

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

_____ Never 0
_____ At one time, but no longer 1
_____ Currently 2
How much: _____
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 to you, ever been concerned about your use of alcohol/other mood altering substances?	**Do (did) you ever use alcohol/other mood-altering substances with …**	**Do (did) you ever use alcohol/other mood-altering substances to help you …**
_____ No 0 _____ Yes 1 **Describe concerns:** _____	No 0 Yes 1 _____ _____ Prescription drugs? _____ _____ OTC medicine? _____ _____ Other substances? **Describe what and how often:**	No 0 Yes 1 _____ _____ Sleep? _____ _____ Relax? _____ _____ Get more energy? _____ _____ Relieve worries? _____ _____ Relieve physical pain? **Describe what and how often:**

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:

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 #: _____