VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

For informational purposes only.
Must be filled out by Albemarle County Adult Services Worker.

Dates:
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
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? _____

Primary Caregiver/Emergency Contact/Primary Physician

Name: _____ Relationships: _____
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	

Optional: Total monthly _____

Do you currently receive income from…?

No 0	Yes 1		*Optional: Amount*
		Black Lung	
		Pension	
		Social Security	
		VA Benefits	
		Wages/Salary	
		Other	

Does anyone cash your check, pay your bills

No 0	Yes 1		*Names*
		Legal Guardian	
		Power of Attorney	
		Representative Payee	
		Other	

Do you receive any benefits or entitlements?

No 0	Yes 1	
		Food Stamps
		General Relief
		State and Local Hospitalization
		Subsidized Housing
		Tax Relief

What types of health insurance do you have?

		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
_____	_____	Electric 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?	
	No 00	Yes
Bathing		
Dressing		
Toileting		
Transferring		
Eating/Feeding		

MH Only 10 Mechanical Help	HH Only 2 D Human Help		MH & HH 3 D		Performed D by Others 40			Is Not D .Performed 50
	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
					Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	

Continence	Needs Help?	
	No 00	Yes
Bowel		
Bladder		

Incontinent Less than Weekly 1	Ext. Device/ Indwelling/ Ostomy Self Care 2	Incontinent D Weekly or More 3	External D Device Not Self Care 4	Indwelling D Catheter Not Self Care 5	Ostomy D Not Self Care 6

Ambulation	Needs Help?	
	No 00	Yes
Walking		
Wheeling		
Stairclimbing		
Mobility		

MH Only 10 Mechanical Help	HH Only 2 D Human Help		MH & HH 3 D		Performed D by Others 40	Is Not D Performed 50
	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
					Confined Moves About	Confined Does Not Move About

IADLS	Needs Help?	
	No 0	D Yes 1
Meal Preparation		
Housekeeping		
Laundry		
Money Mgmt.		
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*

_____ _____ _____

_____ _____ 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: _____ **None00** _____ **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)…?

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'a Ataxia (14)
    - Multiple Scierosis (15)
    - Muscular Dystrophy (16)
    - Spina Bifida (17)
- Digestive/Liver/Gall Bladder (18)
- Endocrine (Gland)Problems
  - Diabetes (19)
  - Other Endocrine Problem (20)
- Eye Disorders (21)
- Immune System Disorders (22)
- Muscular/Skeletal
  - Arthritis/Rheumatoid Arthritis (23)
  - Osteoporosis (24)
  - Other Muscular/Skeletal Problems (25)
- Neurological Problems
  - Brian 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 (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	____ 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: _____ Weight: _____ Recent Weight Gain/Loss: ____ No 0 ____ Yes 1
(Inches) *(lbs.)* 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

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	
		Eye care	
		Glucose/Blood Sugar	
		Injections/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, county, 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, all 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?

Optional: MMSE Score
(5)
(5)
(3)
(5)
Total:

Note: Score of 14 or below implies cognitive impairment.

No 0 Yes 1

_____ _____ Short-Term Memory Loss?
_____ _____ Long-Term Memory Loss?
_____ _____ Judgment Problems?

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
_____ _____ Death of someone close
_____ _____ Family conflict
_____ _____ Financial problems
_____ _____ Major illness- family/friend
_____ _____ Recent move/relocation
_____ _____ Victim of a crime
_____ _____ Failing health
_____ _____ 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*

_____ _____ _____

_____ _____ 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?

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.

	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	No 0 Yes 1	No 0 Yes 1
Describe concerns:	_____ _____ Prescription drugs?	_____ _____ Sleep?
	_____ _____ OTC medicine?	_____ _____ Relax?
	_____ _____ Other substances?	_____ _____ Get more energy?
	Describe what and how often:	_____ _____ 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:*

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 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 #:** _____