3 West Road | Virks Building | Cranston, RI 02920

Attachment 3 – Enhanced Care Assessment

Date of Referral:		Date of Assessment:
Assessor:	Agency:	Contact #:

Client Information

Name:	DOB:	SSN:
AL Residence:	Address:	
Contact:	Phone:	

Diagnosis: ____

How many prescription medications does the client take? _________________________

Is the client followed by behavioral health provider? [ ] Yes [ ] No

If yes, name of provider: ____

ADL Functional Abilities

Functional Code	Explain Limitations /Extra Needs
	Ambulation:
	Transfers:
	Bathing/Grooming:
	Dressing:
	Eating:
	Toileting:
	Medication Management:

Code Key- To be used when completing assessment. Actual level of involvement in self-care over 24 hours for the past 7 days.

0 = INDEPENDENT: NO TALK, NO TOUCH
No help or oversight provided to the individual during the activity (with or without the use of an assistive device)
1 = SUPERVISION: TALK, NO TOUCH
Oversight, cueing, and encouragement provided to the individual during the activity (with or without the use of an assistive device)
2 = LIMITED ASSISTANCE: TALK AND TOUCH
Individual highly involved in activity, received physical **guided assistance, no lifting** of any part of the individual
3 = EXTENSIVE ASSISTANCE: TALK, TOUCH AND LIFT
Individual performed part of activity **but** caregiver provides physical assistance to **lift, move or shift individual**
4 = TOTAL DEPENDENCE: ALL ACTION BY CAREGIVER
Individual does not participate in any part of the activity
5 = ACTIVITY DID NOT OCCUR: NO ACTION
The activity was not performed by the individual or caregiver

Cognitive Status

Is the client impaired? [ ] Yes [ ] No

Cognitive Skills for Daily Decision Making (check one)		
	Independent	Decisions consistent/reasonable
	Modified Independence	Some difficulty in new situations only
	Moderately Impaired	Decision poor/cure/supervision required
	Severely Impaired	Never/rarely makes decisions

Summary/Recommendations: Provide a summary of functional abilities and need for enhanced care.

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Signature: ______________________________ Date:____________________