

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Dates:

Screen: _____ / ____ / ____
Assessment: _____ / ____ / ____
Reassessment: _____ / ____ / ____



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

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

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)	Describe Problems:
___	___	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: _____	

Client Name: _____

Client SSN: _____

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

ADLS	Needs Help?	
	No ₀₀	Yes
Bathing		
Dressing		
Toileting		
Transferring		
Eating/Feeding		

Continance	Needs Help?	
	No ₀₀	Yes
Bowel		
Bladder		

Ambulation	Needs Help?	
	No ₀₀	Yes
Walking		
Wheeling		
Stairclimbing		
Mobility		

IADLS	Needs Help?	
	No ₀	Yes ₁
Meal Preparation		
Housekeeping		
Laundry		
Money Mgmt.		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

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

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

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

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:

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	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 Problem (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 (41)
		All Other Problems (42)

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)...?	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 nursing staff 2
_____ Getting to the pharmacy	Describe help: _____
_____ Taking them as instructed/prescribed	Name of helper: _____
_____ Understanding directions/schedule	

Client Name: _____

Client SSN: _____

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment ₀	Impairment		Complete Loss ₃	Date of Last Exam
		Record Date of Onset/Type of Impairment			
		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
<input type="checkbox"/> None 000 <input type="checkbox"/> Hip Fracture 1 <input type="checkbox"/> Other Broken Bone(s) 2 <input type="checkbox"/> Dislocation(s) 3 <input type="checkbox"/> Combination 4 Previous Rehab Program? <input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 Date of Fracture/Dislocation? <input type="checkbox"/> 1 Year or Less 1 <input type="checkbox"/> More than 1 Year 2	<input type="checkbox"/> None 000 <input type="checkbox"/> Finger(s)/Toe(s) 1 <input type="checkbox"/> Arm(s) 2 <input type="checkbox"/> Leg(s) 3 <input type="checkbox"/> Combination 4 Previous Rehab Program? <input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 Date of Amputation? <input type="checkbox"/> 1 Year or Less 1 <input type="checkbox"/> More than 1 Year 2	<input type="checkbox"/> None 000 <input type="checkbox"/> Partial 1 <input type="checkbox"/> Total 2 Describe: _____ Previous Rehab Program? <input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 Onset of Paralysis? <input type="checkbox"/> 1 Year or Less 1 <input type="checkbox"/> 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?	Do you have any problems that make it hard to eat?
<input type="checkbox"/> None 0 <input type="checkbox"/> Low Fat/Cholesterol 1 <input type="checkbox"/> No/Low Salt 2 <input type="checkbox"/> No/Low Sugar 3 <input type="checkbox"/> Combination/Other 4	No ₀ Yes ₁ <input type="checkbox"/> _____ Food Allergies <input type="checkbox"/> _____ Inadequate Food/Fluid Intake <input type="checkbox"/> _____ Nausea/Vomiting/Diarrhea <input type="checkbox"/> _____ Problems Eating Certain Foods <input type="checkbox"/> _____ Problems Following Special Diets <input type="checkbox"/> _____ Problems Swallowing <input type="checkbox"/> _____ Taste Problems <input type="checkbox"/> _____ Tooth or Mouth Problems <input type="checkbox"/> _____ Other: _____
Do you take dietary supplements? <input type="checkbox"/> None 0 <input type="checkbox"/> Occasionally 1 <input type="checkbox"/> Daily, Not Primary Source 2 <input type="checkbox"/> Daily, Primary Source 3 <input type="checkbox"/> Daily, Sole Source 4	

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 _____

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: _____

Do you have pressure ulcers?

None ₀	Location/Size
_____	_____
_____	Stage I 1 _____
_____	Stage II 2 _____
_____	Stage III 3 _____
_____	Stage IV 4 _____

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: _____

Optional: MMSE Score

(5)

(5)

(3)

(5)

Total:

Note: Score of 14 or below implies cognitive impairment.

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?

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

Change in work/employment

Death of someone close

Family conflict

No 0 Yes 1

Financial problems

Major illness- family/friend

Recent move/relocation

No 0 Yes 1

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

_____ 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?

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: _____

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

[Empty box for Client Case Summary]

Unmet Needs

No ₀ Yes ₁ (Check All That Apply)

No ₀ Yes ₁ (Check All That Apply)

- _____ _____ Finances
- _____ _____ Home/Physical Environment
- _____ _____ ADLS
- _____ _____ IADLS

- _____ _____ 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 #: _____