

Care Recipient Assessment

Date this form completed:

HACC

CACP

EACH

EACHD

1. Details of the person seeking care

Surname:		Given Name(s):	
Home Address: Postcode:			
Daytime Telephone No:		A/Hrs Telephone No:	
Gender (Male/Female):		Date of Birth:	
Country of birth:		Marital Status:	
Interpreter needed for everyday English? (Y/N)		Second Language:	
Living Arrangements:		Indigenous Origin:	
Medicare No:	Expiry Date:	Ambulance Fund:	
Private Health Fund:		Private Health No:	

2. Details of spouse or formal carer

Surname:		Given Name(s):	
Home Address: Postcode:			
Daytime Telephone No:		A/Hrs Telephone No:	
Mobile No:		Centrelink Carer Allowance:	
Relationship with care recipient:			
Interpreter needed for everyday English? (Y/N)		Second Language:	
First Contact : (Y/N)			

3. ACAT Details

Contact name:	Hospital:		
Phone No:	Fax No:		
Expiry Date:			
Residential Care (Permanent):	High <input type="checkbox"/>	Low <input type="checkbox"/>	
Residential Respite Care:	High level respite care <input type="checkbox"/>	Low level respite care <input type="checkbox"/>	
Community Care:	CACP <input type="checkbox"/>		
Flexible Care:	EACH <input type="checkbox"/>	EACH Dementia <input type="checkbox"/>	Transition care <input type="checkbox"/>

4. People to contact

4.1 Guardian/person responsible for care decisions/next of kin

Surname:	Given Name(s):		
Organisation(if applicable):			
Home Address:			
			Postcode:
Daytime Telephone No:	A/Hrs Telephone No:		
Mobile No:	Fax No:		
Email:	Relationship:		

Tick here if this person has been formally appointed by the Guardianship Board

4.2 Administrator / person responsible for finances

Surname:	Given Name(s):		
Organisation(if applicable):			
Home Address:			
			Postcode:
Daytime Telephone No:	Billing Address:		
Mobile No:			
	Postcode:		
Email:	Relationship:		

Tick here if this person has been formally appointed by the Guardianship Board

Does this person hold a Power of Attorney or enduring PoA for the Applicant?
(Yes/No)

Check the original and make arrangement to make a copy for our records.

5. Financial Details

Using the UCH CACP and EACH Fee Guide, which includes the current values of the threshold values for the income estimate, tick the relevant boxes below:

5.1 Pension

Do you receive a pension?

Pension type:	Pension No:
---------------	-------------

5.2 Home Ownership

a) Currently living in own home?

b) Not living in own home and has not owned a home in the last two years?

c) Does care recipient wish to contribute fee (y/n)?

If answer to 5.1 and 5.2 (b) is yes – no fee should be charged (please see Fee Policy)

5.3 Living expenses (only to be considered when reducing fees)

Tick the relevant boxes below when the person seeking care has **higher than normal** expenses in the following areas due to their care needs.

1. Prescriptions and medications
2. Physiotherapy, podiatry, occupational therapy or like services
3. Specialist medical care
4. Special aids, appliances or products such as items you need to help with mobility or continence
5. Special food or clothing
6. Gas, water or electricity bills
7. Transport
8. Fees for services to other community care agencies
9. Other. Please specify: _____

6. Care Fee

Fill in the dollar value of the fees agreed with the client in the relevant box (below):

Standard Care Fee of 17.5% of the Basic Pension \$
Higher Care Fee (up to twice the Standard Fee) on the basis of higher income \$
Reduced Care Fee on the basis of higher than normal living costs \$

Functional Screening

1. Communication: Comments	Hearing deficit [] Sight deficit [] Speech disorder [] Language difficulty [] See specific care plan []	Wears hearing aid (l) [] Wears hearing aid (r) [] Wears glasses [] STM Loss [] Prompts []
2. Location Change, Mobility, Transfers: Comments	Push wheelchair [] Zimmer frame [] Wheely walker [] Walking stick [] Tray mobile []	Elbow crutches [] Supervise mobility [] See specific care plan []
3. Meals, Food, Drinks: Comments	Meals on wheels [] Prepare meals [] Heat up meals [] Shopping [] See specific care plan []	Individual diet [] Diabetic [] Swallowing []
4. Showering: Comments	A.M. [] P.M. [] Assistance with: Turn taps on [] Washing [] Cleaning teeth [] Cutting/cleaning fingernails [] Full assistance []	Adjust water temp [] Drying [] Hair washing [] Shaving [] See specific care plan []
5. Dressing: Comments	Assistance with Selecting clothes [] Buttons [] Support stockings [] Cleaning and fitting glasses [] See specific care plan []	Dressing [] Undressing [] Zippers [] Tying shoe laces [] Comb hair [] Fitting hearing aid []
6. Toileting: Comments	Commode [] Raised toilet seat [] Urinal bottle [] See specific care plan []	Physical support [] Toilet hygiene [] Adjust clothing []
7. Elimination: Comments (e.g. continence/catheter products etc)	Continence aids in use [] Place pad in situ [] Place commode by bed at night [] Prompt to toilet [] every ____ hours Bowel Management required [] See specific care plan []	Supra pubic catheter [] Urethral catheter [] Urodome []
8. Wandering Absconding:	Wanders [] History of wandering [] See specific care plan []	
9. Verbally Aggressive: Comments	Verbal noise [] Loud speech [] Argues with others [] See specific care plan []	
10. Physically Aggressive: Comments	Toward staff [] Toward family [] See specific care plan []	

11. Other Behaviour Comments			
12. Danger to self/others Comments	Walking without required aids [] Wandering [] History of falls [] See specific care plan []	Smoking []	
13. Medications: Comments	Webster [] Eye drops [] Ear drops [] See specific care plan [] Pharmacy Name: Pharmacy No:	Self administer [] Administer by staff [] Prescribed creams []	
14. Technical and Nursing procedures:	Blood sugar testing [] Basic Wound care [] Other [] See specific care plan []		
15. Allied Health/Therapy: Comments	Physiotherapist [] Occupational Therapist [] Alternative therapies []	Podiatry [] See specific care plan []	
16. Pain Management:	<u>Treatment</u>		
17. Allergies:			

Social Screening

The information collected below will provide a holistic approach to the care planning process, the care recipient is to be given the option of providing information pertaining to some/all of the questions below.

Goals/Expectations of Care Recipient

Previous Home Environment

Past life (Aust., country, metropolitan, where born and grew up, overseas – when migrated, any difficulties).

Religious Background

Do you come from a particular religious/spiritual background?

Details of observance. Are there special occasions you may wish to celebrate?

Do you wish to attend church services or other spiritual support?

Cultural Background

Is there a specific ethnic group that you identify with?

Describe any cultural practices and special occasions that should be continued.

Need for further cultural assessment: Y/N

Personal Rituals and Habits – How day is spent? What is important in daily routine?

Education – was school enjoyable? What are some special memories from childhood?

Occupation(s), (List) Was work enjoyed? When did you retire and what did you do during retirement?

War Service/Experience

Other Significant Life Events – travel, celebrations

Please tick activity/activities of interest		
Activity	Previous	Specific Information
Listening to music/radio-pref.		
Watching TV - preferences		
Singing		
Playing an instrument		
Theatre / opera		
Reading		
Poetry		
Writing		
Art / craft		
Knitting / sewing		
Carpentry		
Photography – family photos		
Sports – golf, cricket, etc		
Exercise/walking		
Bowls		
Games/cards - specify		
Computers		
Bingo		
Clubs/Day Centre		
Cars/motor bikes/boating		
Driving		
Dancing		
Entertaining		
Outings – where to		
Gardening		
Homemaking		
Cooking		
Personal Grooming		
Animals - specify		
Politics		
Voluntary work		
Social drinking - preference		
Collecting eg stamps, coins		

Entered in Progress Notes: _____ Date: _____

Care Plan Need Identified Yes No Further Assessment Needed Yes No

Referred to: _____

Signed: _____ Print Name: _____

Position Title _____

History given by: Care Recipient Relative Friend Other (specify)



Proposed Service Plan for New Care Recipient/Review of Care Recipient

Care Recipient Name _____ Co-ordinator Name _____ Date _____

Care Recipient DOB: _____ Care Recipient Address: _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM							
Lunch							
PM							

Comments- Include roster alerts eg: hoist trained staff , any reason why times not flexible to the ½ hour

Prefer Male or Female Community Support Worker? _____

ONLY ESSENTIAL SERVICES AT WEEKENDS and PUBLIC HOLIDAYS

Suggested commencement date: _____

7. Declaration

I, _____

Of _____
(Address of person making declaration)

Do solemnly and sincerely declare that all of the information in this Application is true to the best of my knowledge and is in no way false, inaccurate or misleading, or intended to be false, inaccurate or misleading.

Signature of person making the Declaration: _____

Date: _____

Assessor Details

Name of Assessor: _____

Signature of Assessor: _____