

## Assessment Checklist to Determine the Needs of a Care Receiver Pg. 1 of 3

NAME \_\_\_\_\_ DATE \_\_\_\_\_

This form will assist family members or a designated care manager to assess the needs and physical capacity of a care receiver. This will help match the care receiver with a caregiver who has the required skills and abilities.

**Ambulation.** The care receiver is:

- YES NO Bedridden
- YES NO Able to walk unassisted
- YES NO Uses a cane or a walker (with occasional wheelchair assistance)
- YES NO Dependent on a wheelchair or electric-power chair

**Mobility**

- YES NO Able to use their arms and hands Full Partial Right hand Left hand
- YES NO Able to use their legs Full Partial Right leg Left leg

**Transferring** The care receiver requires:

- YES NO Transfers (to a chair, wheelchair, bed, commode/toilet, vehicle, etc.)
- YES NO Lifting skills and strength for heavy lifting
- YES NO Use of a Gait Belt or Kelly Lift

**Repositioning** (for those who are bedridden or are unable to move unassisted)

- YES NO Requires repositioning every two or three hours

**Bathing and personal hygiene.** Assistance required with:

- YES NO Bathing (Shower, bath)
- YES NO Brushing teeth
- YES NO Shaving
- YES NO Shampooing hair

**Continence**

- YES NO The care receiver is incontinent
- YES NO Currently uses disposable pads or pull-ups
- YES NO Pads/pull-ups need monitoring/changing Occasional Frequent

**Toileting** The care receiver requires:

- YES NO Clothes adjusted before and after toilet use; wiping and cleaning
- YES NO Soiled briefs changed and body cleaned, especially if bedridden

**Dressing**

- YES NO Able to get clothes from the closet or dresser unassisted
- YES NO Able to dress/undress unassisted
- YES NO Needs assistance with buttoning and/or fastening garments
- YES NO Needs assistance putting on shoes, tying laces or fastening clasps

## Assessment Checklist to Determine the Needs of a Care Receiver Pg. 2 of 3

### Eating

- YES NO Able to eat unassisted  
YES NO Needs food to be cut into small pieces or mashed  
YES NO Special diet: No salt  Soft diet  Liquid diet  Other \_\_\_\_\_  
YES NO Needs to be spoon feed or a have a cup (with or without straw) raised to drink

### Agitation

- YES NO Gets agitated  Occasional  Frequent

### Confusion and Disorientation

- YES NO Gets confused  Occasional  Frequent

### Cognitive Supervision

- YES NO Care receiver has dementia (Alzheimer's or other form)  
(If known) Beginning Stage Mid-Stage Advanced Stage

### Medication

- YES NO Medication needs to be administered

### Homemaker Services

- YES NO Light house cleaning (wash dishes, laundry, sweep, mop, vacuum)  
YES NO Serve already prepared meals  
YES NO Prepare/cook meals  
YES NO Grocery shop, pick up medication, run job related errands

### Transportation

- YES NO The caregiver is required to have a valid driver's license and drive  
YES NO The caregiver is required to have automobile insurance  
YES NO The caregiver can use client's vehicle for work related activities  
YES NO The caregiver will need to use their own vehicle to take client to the doctor, have medical exams, and other job related activities. The caregiver will be reimbursed at the established IRS per-mile rate.

### Special Needs Assessment

- YES NO Hard of hearing. Uses hearing aid YES NO  
YES NO Change bandage or dressing  
YES NO Enema  Occasional  Regular basis  
YES NO Change/clean catheter bag (or condom catheter)  
YES NO Change colostomy bag  
YES NO Oxygen using a tank and cannula

**Live-in Care**

- Necessary  Preferred
- Weekend  Regular relief for a live-in caregiver

**Shift Options**

- Morning: Start \_\_\_\_\_ End \_\_\_\_\_  Afternoon: Start \_\_\_\_\_ End \_\_\_\_\_
- Evening: Start \_\_\_\_\_ End \_\_\_\_\_  Night: Start \_\_\_\_\_ End \_\_\_\_\_
- Shifts:  12 hours  24 hours  48 hours

**Language(s)** The care receiver speaks the following language(s)

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**Preferences (interests, activities, hobbies)**

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**Strongly dislikes**

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**Additional Comments/Preferences**

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