Non-Medical Home Care Assessment Form

CLIENT INFORMATION AND CONTACT DETAILS
Client's Full Name:
Date of Birth:
Address:
Phone Number:
Email Address:
Primary Contact Person:
Relationship to Client:
Referral Source:
HEALTH ASSESSMENT
Chronic Conditions:
Medications:
Allergies:
Recent Surgeries:
Other Medical Concerns:

FUNCTIONAL ASSESSMENT

Activities of Daily Living (ADLs) Assessment

Activity	Yes	No	Notes
Bathing	◯	◯	
Dressing	◯	◯	
Toileting	◯	◯	
Mobility	◯	◯	
Eating	◯	◯	

Instrumental Activities of Daily Living (IADLs) Assessment

Activity	Yes	No	Notes
Meal Preparation	◯	◯	
Housekeeping	◯	◯	
Managing Finances	◯	◯	
Transportation	◯	◯	

Safety Assessment

Activity	Yes	No	Notes
Fall Risks	◯	◯	
Fire Hazards	◯	◯	
Accessibility Issues	◯	◯	
Need for Adaptive Equipment or Modifications	◯	◯	

SOCIAL AND EMOTIONAL ASSESSMENT

Social Support Network:

Emotional Well-being:

Signs of Depression or Anxiety:

Caregiver Support Needs:

PERSONALIZATION AND PREFERENCES

Client Preferences:

Goals for Care:

Special Requests or Considerations:

CONSENT FOR SERVICES AND AUTHORIZATION FOR INFORMATION SHARING STATEMENT

I,_____, hereby authorize and consent to receive non-medical home care services provided by _____ for myself/my family member [if applicable].

Consent for Services

I understand that the non-medical home care services may include but are not limited to assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), companionship, meal preparation, housekeeping, transportation, and other supportive services deemed necessary by _____ and agreed upon by me/my family member [if applicable]. I acknowledge that the purpose of these services is to support and enhance my/my family member's independence and well-being while residing at home.

Authorization for Information Sharing

I authorize _____ to collect, use, and disclose personal and health information as necessary for the provision of non-medical home care services. This may include sharing information with healthcare providers, family members, and other authorized individuals involved in my/my family member's care, as well as coordination with insurance providers or other relevant entities. I understand that this information will be handled in accordance with applicable privacy laws and regulations.

I also authorize _____ to communicate with my/my family member's primary care physician, specialists, and other healthcare professionals as needed to ensure continuity of care and to address any health-related concerns or emergencies that may arise during the course of receiving services.

Revocation of Consent

I understand that I have the right to revoke this consent at any time by providing written notice to _____. I acknowledge that revoking consent may impact the ability to receive non-medical home care services.

Client's Full Name:

Client’s Signature:

Date: