Residential Placement Evaluation Request and Report Template

Page 1: Cover Letter and Instructions

Contains Confidential Materials!

If you are not the intended recipient of this document discard by shredding immediately!

Instructions:

1. The requesting individual will complete page 2 of this document.
2. Fax it with this cover letter and all supporting records to:
3. Healthy Homes will contact you within 24 hours to schedule the evaluation.
4. Once the evaluation is completed it will be faxed to the secured number provided on page 2.
5. Page 3-7 will be included with this initial request.
6. We will contact the case manager to schedule a return visit for installation, training and evaluation.
7. At this time pages 8-10 will be completed as appropriate.

All components of the evaluation from the initial visit to any return visits will be considered one document with multiple contributors. The final report will be kept on file for a period of 3 years. All of our privacy policies apply and the sigining of our HIPPA notice by the client or a legal representitive is a contingency on releasing the report to any outside agency.

Page 2: To be filled out by the referring agency/case manager (requisition)

Demographics and Contact Information	
Requesting Agency:	Case Manager:
Date of Request:	Telephone:
Requesting Case managers fax number (must be secured):	
Requesting Case managers Signature:	
Client's Name:	Telephone:
Age:	DOB:
Current Address:	Address of Evaluation (if different):
Medicaid Number:	
Primary Care Giver:	Telephone:
Reason for Referral:	
What is the desired functional outcome (Level of Independence):	
Have appropriate releases of information been signed: **Yes / No** (If so please include all available medical history, pertinent documentation, and copy of release)	

Included Documents (Please list):
1
2
3
4

Notes:(include your knowledge of challenges for this client):

History and Overall Condition

Date of Evaluation: **Assessor:**

Pertinent Medical History	Existing Disabilities

Current Challenges as vocalized by the client and the primary care giver if present

Existing functional limitations and assistive/adaptive equipment or technology

Independent with Cooking: **Yes / No** Independent with Bathing: **Yes / No**

Independent with Toileting: **Yes / No** Dementia or Confusion **Yes / No**

How is the client currently transferring:

How is the client currently Ambulating:

Able to Drive: **Yes / No** Access to Transportation: **Yes / No**

Challenges with car transfers: **Yes / No** Able transport adaptive equipment: **Yes / No**

Impaired Hearing: **Yes / No** Impaired visual acuity: **Yes / No**

Impaired Manual Dexterity: **Yes / No** Impaired speech or swallowing: **Yes / No**

List existing adaptive equipment and assistive technology:

Describe comfort with and ability to use current adaptive and assistive equipment:

Explain any pertinent challenges noted above:

Overall Physical Space, Safety and Health

APT: ○ House: ○ Number of occupied floors: _____ # Household Members: _____

Overall Condition (include photos): Good Repair: ○ Ill Repair: ○ Clutter: ○

Unsanitary conditions: ○ Means of emergency egress: **Yes / No** Rural: ○

Able to use the emergency means of egress: **Yes / No** Life Line Present: **Yes / No**

Able to use the phone/call for help: **Yes / No** Working fire alarms: **Yes / No**

Working Carbon Monoxide Alarms: **Yes / No** Accessible Washer/Dryer: **Yes / No**

Type of Heat: _____ Accessible Thermostat: **Yes / No**

Able to remove trash: **Yes / No** Able to independently clean: **Yes / No**

Notes and Recommendations:

Physical Space Evaluation

Outdoors:

Entrances: Front: ◯ Back: ◯ Side: ◯ Garage: ◯

Stairs to enter: **Yes / No** Number: _____ Width: _____ Height _____

Measurement from ground to top of platform: _____ Walkway to stairs: **Yes / No**

Type of walkway to stairs: Need for repair/leveling: **Yes / No**

Is the exterior accessible for recreation or leisure: **Yes / No** Accessible Patio or Deck: **Yes / No**

Exterior Doorways Do they lock: **Yes / No** Are they accessible and open able: **Yes / No**

Widths at least 32" **Yes / No** If ramps present: Length _____ Pitch (inch rise over 12" run) _____

How is the mail received: Is this accessible: **Yes / No**

How is the trash removed: Is this accessible: **Yes / No**

How is snow removed: Can walkways be salted: **Yes / No**

Is exterior lighting adequate: **Yes / No** Is a deck or patio accessible: **Yes / No**

Notes and Recommendations:

Hallways, Entryways, Doors, and Floors

Doorway widths minimum of 32": **Yes / No** Are locks and Handles accessible: **Yes / No**

Is the in/out swing accommodating: **Yes / No** Are hallways at 32" wide/clutter free: **Yes / No**

Flooring Type: _____ Condition: Poor ◯ Fair ◯

Thresholds: **Yes / No** Number of thresholds in need of adjustment: _____

Adequate lighting: **Yes / No** Accessible and appropriate Switches: **Yes / No**

Accessible electrical outlets: **Yes / No** Loose Rugs: **Yes / No**

Interior stairs: Number Treads: _____ Tread Height: _____ Tread Width: _____

Tread Material: _____ Condition: Poor ◯ Fair ◯

Railin One side ◯ Two Sides ◯ Number of Landings: _____

Notes and Recommendations:

Living and Dining Room

Is lighting adequate **Yes / No** Are switches and outlets accessible: **Yes / No**

Is furniture and seating usable and comfortable for the client:

Table: **Yes / No** Chairs: **Yes / No** Couch: **Yes / No** TV: **Yes / No**

Is remote control usable: **Yes / No** Phone available: **Yes / No** Wireless: **Yes / No**

Notes and Recommendations:

Kitchen

Flooring Material: _____ Is lighting adequate: **Yes / No**

Are cabinets accessible: **Yes / No** Is the counter top height usable: **Yes / No**

Gas Stove ◯ Electric Stove ◯ Dishwasher ◯ Microwave ◯

Are all appliances usable by the client: **Yes / No** Are they in good repair: **Yes / No**

Can the sink be reached: **Yes / No** Is the faucet usable: **Yes / No**

Garbage Disposal: **Yes / No** Accessible switches and outlets: **Yes / No**

Compost Accessible: **Yes / No** Trash usable and accessible: **Yes / No**

How is the client performing with transporting items in the kitchen: _____

Describe the clients ability to prepare food: _____

Notes and Recommendations:

Bathroom

Accessible: **Yes / No** Adequate Lighting: **Yes / No** Accessible Outlets: **Yes / No**

Accessible Switches: **Yes / No** Exhaust Fan: **Yes / No**

Bath Tub: ◯ Shower Stall: ◯ Threshold Height: _____ Non Slip Flooring: **Yes / No**

Safety Bars: Walls: ◯ Shower: ◯ Toilet: ◯ Sink: ◯

Safety Bars are adequate with mobility challenges: **Yes / No** Space is sufficient: **Yes / No**

Height of the sink: _____ Wheelchair accessible: **Yes / No** Faucet Usable: **Yes / No**

Medicine Cabinet Accessible: **Yes / No** Linen Storage Accessible: **Yes / No**

Toilet Height: _____ Toilet paper dispenser accessible: **Yes / No**

Can the client transfer into the tub or shower: **Yes / No**

Can the client transfer onto the toilet: **Yes / No**

Notes and Recommendations:

Bed Room:

Accessible: **Yes / No** Adequate Lighting: **Yes / No** Accessible Outlets: **Yes / No**

Accessible Switches: **Yes / No** Accessible Bathroom: **Yes / No**

Can the client transfer in and out of bed: **Yes / No** Is closet and dresser usable: **Yes / No**

Is a phone in reach from the bed: **Yes / No** Safety bars or wall railings: **Yes / No**

Flooring Type: _____ Trip Hazards to Bathroom: **Yes / No**

Located on the First Floor: **Yes / No** Located on the second floor **Yes / No**

Notes and Recommendations:

Communication and Technology

TV: ○ PC: ○ Telephone: ○ Alarm System: ○

Video Surveillance: ○ Remote caregiver monitoring: ○ Life Line: ○

Automated Lighting: ○ Automated Thermostat: ○ Smart phone: ○

Able to use existing technology: **Yes / No** Wander Alarms: ○ Fall Alarms: ○

Notes and Recommendations:

Community Resources

Public Transportation: ○ Shopping ○ Meals ○

Social and Recreational ○ Senior Center ○ Family Available: ○

Local Friends: ○ Regular Caregivers: ○ Recreational Activities: ○

Notes and Recommendations:

Summary and Descriptive Narrative of Recommendations:

Specific Quotes for needed work included as an addendum: **Yes / No**

Healthy Homes Product/Installation Billing Sheet included as an addendum: **Yes / No**

Assessor's Printed Name:	Assessor's Signature:

Specific Products Demonstrated or installed on the day of evaluation:	
Product:	Assessment:
	Left with the client: **Yes / No**
	Left with the client: **Yes / No**
	Left with the client: **Yes / No**
	Left with the client: **Yes / No**
	Left with the client: **Yes / No**
	Left with the client: **Yes / No**
	Left with the client: **Yes / No**

Assessor's Printed Name:	Assessor's Signature:

Specific products or equipment in need of installation, demonstration and assessment:	
Product:	Assessment:
Date of Return Visit:	
Date of Return Visit:	
Date of Return Visit:	
Date of Return Visit:	
Date of Return Visit:	
Date of Return Visit:	

Assessor's Printed Name:	Assessor's Signature:

Return Evaluation

Please evaluate the use of all equipment installed as listed on pages 6 and 7 of this document

Is all the equipment being utilized:	**Yes / No**	Does the client/caregivers find it useful:	**Yes / No**
Do they have any concerns or questions:	**Yes / No**	Were you able to address them this visit:	**Yes / No**
Was the initial training adequate:	**Yes / No**	Have any falls been experienced:	**Yes / No**

Does the client/caregivers vocalize any additional concerns: **Yes / No**

Based on this visit are any additional needs recognized: **Yes / No**

Summary and Narrative of Return Visit

Additional Recommendations:

Assessor's Printed Name:	Assessor's Signature:

Specific products evaluated on return visit:	
Product:	Assessment:
	Continue Use of Product: **Yes / No**
	Continue Use of Product: **Yes / No**
	Continue Use of Product: **Yes / No**
	Continue Use of Product: **Yes / No**
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