Name:
DOB:
MR:

SOCIAL ASSESSMENT

Home Address:	Home ph: Alt/cell: Email:	Legal Guardian:
Primary language: Interpreter needed Y/N:		
Parents/Guardians status: Single / Married / Separated / Divorced / Living w partner / Widowed / Other:		
Custody Issues:		
Employment/income:		Estate planning:

Primary Family Members & Extended Supports Full Name:	Resides w/ patient?	Age or DOB	Relationship to patient	Trained
	Y/N			
	Y/N			
	Y/N			
	Y/N			
	Y/N			
	Y/N			
	Y/N			

Family Stressors:

- ☐ Change in home environment
- ☐ Change in marital status
- ☐ Death in family
- ☐ Difficulty acquiring medications
- ☐ Distance from home
- ☐ Home care issues
- ☐ Employment issues/FMLA
- ☐ financial concerns
- ☐ Hospitalizations
- ☐ Illness of family member
- ☐ Limited support
- ☐ Concerns about the diagnosis
- ☐ Peer pressure
- ☐ School issues
- ☐ Substance use
- ☐ Transportation
- ☐ Safety
- ☐ Other

Family Dynamics /Comments:

INSURANCE

Primary: Policy copy obtained?:	ID#:
Known issues/ Limitation	Contact Info:

Name:
DOB:
MR:

INSURANCE	
Secondary: Policy copy obtained?: Known issues / Limitations	ID#: Contact Info:
Medicaid:	ID#: Contact Info:
BCMH/Title V: Qualifying Diagnosis:	ID#: Contact Info:
Waiver type: Services provided: On Waiting list?:	Case Manager: Contact Info:
Waiver type: Services provided: On Waiting list?:	Case Manager: Contact Info:

MEDICAL SPECIALISTS	
Name/Specialty: Contact Info: Next Appointment:	**Name/Specialty**: Contact Info: Next Appointment:
Name/Specialty: Contact Info: Next Appointment:	**Name/Specialty**: Contact Info: Next Appointment:
Name/Specialty: Contact Info: Next Appointment:	**Name/Specialty**: Contact Info: Next Appointment:
Name/Specialty: Contact Info: Next Appointment:	**Name/Specialty**: Contact Info: Next Appointment:

Name:
DOB:
MR:

HOME CARE	
Agency / Supervisor: Contact Info: Funding Source:	Skilled Visits (frequency): Private Duty (hours): Aide:
Agency / Supervisor: Contact Info: Funding Source:	Skilled Visits (frequency): Private Duty (hours): Aide:
Independent Contact Info: Funding Source:	Skilled Visits (frequency): Private Duty (hours): Aide:

THERAPISTS	
Provider/Therapist: Contact Info: Frequency:	**Provider/Therapist**: Contact Info: Frequency:
Provider/Therapist: Contact Info: Frequency :	**Provider/Therapist**: Contact Info: Frequency:
Provider/Therapist: Contact Info: Frequency:	**Provider/Therapist**: Contact Info: Frequency:

PROGRAMS	
School/grade: Contact Info:	IEP/504: Goals (therapies/behavior/academic):
MRDD or EI: Case Manager: Contact Info:	Services provided:
ODJFS: Case Manager: Contact Info:	Financial Benefits: TANF/Food Stamps/Child Care Subsidy?

Name:
DOB:
MR:

PROGRAMS	
	Protection Issues: Open Case/Foster Care/Adoption
SSI: Elegibility: Application Status: Benefit:	**Vocational/Employment**: Program: Services: Contact Info:

UTILITIES / EMS	
Phone: notes –	Outstanding Bill? Disconnection? Priority Reconnection Letter?
Energy: notes –	Outstanding Bill? Disconnection? Priority Reconnection Letter?
Water: notes –	Outstanding Bill? Disconnection? Priority Reconnection Letter?
Local EMS: Contact Info:	

TRANSPORTATION		
Methods	**Considerations**	
Family Vehicle: Public: Rides from others: Transport Company:	Handicap Placard: Wheelchair lift: New Vehicle needed: Car Seat – needs Eval/Fitting: Stretcher: Nurse needed:	