

IN-HOME SUPPORTIVE SERVICES NEEDS ASSESSMENT-FACE SHEET

A. RECIPIENT INFORMATION

NAME:			CASE NO:	TELEPHONE: ()	DOB (MO/DATE/YR)	SEX: (CIRCLE ONE) M F
ADDRESS (NUMBER, STREET):			IHSS COMPANION CASE(S), NAME(S) AND NUMBERS:			
CITY:	STATE:	ZIP CODE:				
RECIPIENT'S STATEMENT OF NEED:			SPECIAL DIRECTIONS:			
EMERGENCY CONTACTS/INSTRUCTIONS:			ALTERNATE RESOURCES USED: (LIST SOURCE AND SERVICE PROVIDED)			
SPECIAL CONDITIONS/MEDICAL PROBLEMS:						

B. MEDICAL INFORMATION

DIAGNOSIS/PROGNOSIS:				DATE OF MEDICAL REQUEST:
PHYSICIAN:	TELEPHONE: ()	PHYSICIAN:	TELEPHONE: ()	
PHYSICIAN:	TELEPHONE: ()	PHYSICIAN:	TELEPHONE: ()	
MEDICATIONS/PURPOSE				
1.	4.	7.		
2.	5.	8.		
3.	6.	9.		

C. OTHER PERSONS IN HOUSEHOLD

NAME	AGE	RELATIONSHIP	RECEIVE IHSS		HOURS AT SCHOOL/WORK	REASON PERSON CANNOT PROVIDE IHSS TO RECIPIENT
			YES	NO		

COMMENTS:

WORKER:	TELEPHONE: ()	DISTRICT OFFICE:	DATE:
---------	-------------------	------------------	-------