

Capacity Assessment for Self-Care and Financial Management

Assessor's Initials: _____

Section A – Background Information

Reason for Assessment

Identifying Information

Name of Assessee (Last/First)

Social Security No.	Date of Birth (mm/dd/yyyy)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Type of Residence
<input type="checkbox"/> Nursing facility <input type="checkbox"/> Foster or other supervised care <input type="checkbox"/> The person's home, which is
<input type="checkbox"/> Group home (4 or more beds) <input type="checkbox"/> Living in family member's home <input type="checkbox"/> rented/leased <input type="checkbox"/> owned
<input type="checkbox"/> Other, describe: _____

Residential Information

Name of Residence or Provider (if applicable)

Current Residential Address (Street Address, City, State, ZIP Code)

Residential Telephone No. (include area code)	Previous Placement (if applicable)
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Reason for Admission (if applicable)

Language

Primary Language	Primary Form of Communication
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Ability to Read (check all that apply)	<input type="checkbox"/> Does not read <input type="checkbox"/> Reads common signs	<input type="checkbox"/> Reads simple stories <input type="checkbox"/> Reads adult newspaper stories
Ability to Write (check all that apply)	<input type="checkbox"/> Does not write <input type="checkbox"/> Prints or writes own name	<input type="checkbox"/> Writes simple sentences <input type="checkbox"/> Writes letters

Physical or Sensory Impairments

<input type="checkbox"/> Visual Impairment:

<input type="checkbox"/> Hearing Impairment:
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<input type="checkbox"/> Mobility Impairment:

<input type="checkbox"/> Communication Impairment:
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<input type="checkbox"/> Other:

<input type="checkbox"/> Comatose:

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Medications

Medication	Dosage	Schedule	Medication	Dosage	Schedule

Major Medical and Psychiatric Diagnoses

Diagnosis	Code No.	<input type="checkbox"/> ICD-CM <input type="checkbox"/> DSM
Diagnosis	Code No.	<input type="checkbox"/> ICD-CM <input type="checkbox"/> DSM
Diagnosis	Code No.	<input type="checkbox"/> ICD-CM <input type="checkbox"/> DSM
Diagnosis	Code No.	<input type="checkbox"/> ICD-CM <input type="checkbox"/> DSM

Financial Assets

Real Estate Does the person own his or her own home? **Yes** **No**
 Does the person own any other real estate? **Yes** **No**
 If yes, list:

Monthly Income Monthly Income and Sources:

Other Assets (check all that apply)
 Will Bonds Trust fund Savings account
 Stocks Annuity Checking account
 Insurance – Describe type(s):

Employment Status Does the person work? **Yes** **No**
 If yes, describe:

Financial Management Assistance
 Bill Payor Trustee Representative Payee Power of Attorney
 If yes, identify name and relationship:

Natural Support System Describe the natural support system of the individual.

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Informant Information

Staff Informant

1.	Name of Informant (Last/First)
	Title and Duties of Informant
	How long has the staff informant known the person?
	How frequently has staff informant interacted with the person? <input type="checkbox"/> Daily — (live-in arrangement or 7 days a week contact) or times per <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> year

Assessed Person's View of Informant

2.	Name of Informant (Last/First)
	Title and Duties of Informant
	How long has the staff informant known the person?
	How frequently has staff informant interacted with the person? <input type="checkbox"/> Daily — (live-in arrangement or 7 days a week contact) or times per <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> year

Assessed Person's View of Informant

3.	Name of Informant (Last/First)
	Title and Duties of Informant
	How long has the staff informant known the person?
	How frequently has staff informant interacted with the person? <input type="checkbox"/> Daily — (live-in arrangement or 7 days a week contact) or times per <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> year

Assessed Person's View of Informant

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Additional Informant Information (Use for any informant other than staff.)

Absence of Additional Informant Information (explain):

Informants

1.	Name of Informant (Last/First)	Telephone No.
Address (Street, City, State, ZIP Code)		
Relationship to Person (check one)		
<input type="checkbox"/> Friend <input type="checkbox"/> Relative, type:		Length of Relationship:
<input type="checkbox"/> Other (explain):		
Type of Contact (check all that apply)		
<input type="checkbox"/> Mail <input type="checkbox"/> Telephone <input type="checkbox"/> Visit <input type="checkbox"/> Other (explain):		
Frequency of Contact		
<input type="checkbox"/> Daily or times per <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> year		

Assessed Person's View of Informant

2.	Name of Informant (Last/First)	Telephone No.
Address (Street, City, State, ZIP Code)		
Relationship to Person (check one)		
<input type="checkbox"/> Friend <input type="checkbox"/> Relative, type:		Length of Relationship:
<input type="checkbox"/> Other (explain):		
Type of Contact (check all that apply)		
<input type="checkbox"/> Mail <input type="checkbox"/> Telephone <input type="checkbox"/> Visit <input type="checkbox"/> Other (explain):		
Frequency of Contact		
<input type="checkbox"/> Daily or times per <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> year		

Assessed Person's View of Informant

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Section B – Self-Care and Financial Management

I. Self-Care

A. Mental Status			
1. Can the person identify who he or she is?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
2. Can the person identify where he or she is?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
3. Can the person identify the approximate date?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
4. In the area of mental status, the assessor must summarize any problems or any assistance needed. Document any disagreement among informants or by the assessee. If No is checked for any item, give a brief explanation.			

B. Personal Safety			
1. Is the person aware of dangers or unsafe practices that could cause harm, injury or death?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
2. Does the person take appropriate action to avoid dangers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
	<input type="checkbox"/> Yes, with assistance		
3. Does the person know when to seek shelter?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
4. Can the person identify the consequences of unsafe conditions and practices in the home environment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
5. Does the person show proper caution with strangers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
6. Can the person identify abuse (physical, emotional or sexual)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
7. Does the person know what to do if he or she is threatened or abused?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
8. Can the person identify neglect?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
9. Does the person know what to do if neglected?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
10. In the area of personal safety, summarize any problems regarding skills, opportunity to perform skills or decision-making ability, as well as additional assistance needed. Document any disagreement among informants or by the assessee.			

C. Nutrition			
1. Can the person communicate the need to eat to others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
2. Does the person know the difference between food and non-food items?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
3. Does the person understand that an inadequate diet can lead to malnutrition or illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
4. Can the person acquire, store and prepare food?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
	<input type="checkbox"/> Yes, with assistance		
5. In the area of nutrition, summarize any problems regarding skills, opportunity to perform skills or decision-making ability, as well as additional assistance needed. Document any disagreement among informants or by the assessee.			

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D. Clothing			
1.	Is the person aware of the necessity for clothing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Disagreement
2.	Can the person dress himself or herself appropriately?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Disagreement
3.	Does the person understand the need to wear clothing consistent with temperature and weather conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Disagreement
4.	Can the person communicate that he or she is too hot or too cold for personal comfort?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Disagreement
5.	Can the person acquire and maintain clothing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Disagreement <input type="checkbox"/> Yes, with assistance
6.	In the area of clothing, summarize any problems regarding skills, opportunity to perform skills or decision-making ability, as well as additional assistance needed. Document any disagreement among informants or by the assessee.		

E. Health Care			
1.	Can the person communicate that he or she needs treatment for an illness or injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Disagreement
2.	Can the person communicate his or her health needs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Disagreement
3.	Does the person understand the consequences of not accepting health assistance or medical treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Disagreement
4.	Can the person take care of or obtain treatment for his or her health condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Disagreement <input type="checkbox"/> Yes, with assistance
5.	In the area of health care, summarize any problems regarding skills, opportunity to perform skills or decision-making ability, as well as additional assistance needed. Document any disagreement among informants or by the assessee.		

F. Medications			
1.	Is the person aware of the purpose of medications and when they should be taken?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Disagreement
2.	Can the person take medications correctly without supervision or assistance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Disagreement
3.	Does the person understand the consequences of not taking medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Disagreement
4.	Can the person communicate medication problems or needs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Disagreement
5.	Can the person acquire medications, store them properly and take them as directed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Disagreement <input type="checkbox"/> Yes, with assistance
6.	In the area of medications, summarize any problems regarding skills, opportunity to perform skills or decision-making ability, as well as additional assistance needed. Document any disagreement among informants or by the assessee.		

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G. Travel Safety			
1. Does the person routinely travel in the community?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
2. Can the person avoid common dangers when traveling in the community?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
3. Can the person identify his or her address?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
4. Can the person demonstrate the ability to return home or call for assistance if lost or stranded?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
5. Can the person independently travel to familiar locations in the local community using public or other forms of transportation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
6. Can the person plan trips, access transportation and arrive safely at his/her destination routinely when traveling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
	<input type="checkbox"/> Yes, with assistance		
7. In the area of travel safety, summarize any problems regarding skills, opportunity to perform skills or decision-making ability, as well as additional assistance needed. Document any disagreement among informants or by the assessee.			

H. Motor Vehicle Safety			
1. Does the person operate a motor vehicle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
2. Can the person operate a motor vehicle in a safe and legal manner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
3. In the area of motor vehicle safety, summarize any problems regarding skills, opportunity to perform skills or decision-making ability, as well as additional assistance needed. Document any disagreement among informants or by the assessee.			

II. Financial Management

1. Is the person aware of the purpose of money?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
2. Does the person know the values of different denominations of money?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
3. Does the person know the source and amounts of monetary benefits he or she receives on a weekly, monthly or annual basis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
4. Can the person protect and independently spend a small amount of money? If yes, indicate the amount.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
	<input type="checkbox"/> up to \$5 per week <input type="checkbox"/> up to \$50 per week <input type="checkbox"/> more than \$50 per week		
5. Can the person determine the cost of an item and know the proper change?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
6. Can the person exercise judgment when making decisions on how to budget money? ...	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
7. Does the person understand the concept of a debt?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
8. Can the person receive a bill and pay it?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
	<input type="checkbox"/> Yes, with assistance		
9. Can the person protect his or her income in a safe manner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
	<input type="checkbox"/> Yes, with assistance		
10. Is the person vulnerable to financial exploitation from others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
11. Can the person communicate the concept of gift giving?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
12. Does the person understand the concept of a will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement

Assessor's Initials: _____

II. Financial Management (continued)

13. Can the person identify his or her real and personal property and estimate its value?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
14. Can the person communicate the concept of selling property, real or personal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
15. Can the person communicate the purpose of insurance?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
16. Is the person capable of exercising sound judgment as to the type and amount of insurance that would be appropriate for his or her circumstances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
17. Can the person manage and insure his or her property?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
18. Is the person able to request the services of a lawyer and communicate preferences and/or wishes regarding legal instructions, documents and services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Disagreement
19. In the area of financial management, summarize any problems regarding skills, opportunity to perform skills or decision-making ability, as well as additional assistance needed. Document any disagreement among informants or by the assessee.			

III. General Summary: Self-care capacity and financial management capacity

