Jewish Family SERVICES

Life Plan Comprehensive Assessment

Grant Source: ❒CSS ❒CFJS ❒JFS/SE

Name: _____DOB: ____/_____/____ Today's Date: ____/_____/____

Initial Assessment: In Home_____ Phone_____ Other_____

(1=excellent, 5=poor)

General Home Environment: **1 2 3 4 5**

Notes (Cleanliness, Safety Concerns, etc.): _____

_____

Supplies (Food, Meds, etc.): **1 2 3 4 5**

Notes: _____

Client's Physical Status: **1 2 3 4 5**

Notes (use of mobility device, self-care, etc.):

_____

_____

Client's Mental Status: **1 2 3 4 5**

Notes: _____

Client's Social Engagement: **1 2 3 4 5**

Notes (family involvement, community supports, etc.)_____

_____

Support(s) provided by family (local or long-distance):_____

_____

Any recent changes in above? _____

Financial Need? ❒Yes ❒No **In-home Care?** ❒Yes ❒No **Frequency/duration: _____**

Provided by: _____

Transportation Needs? ❒Yes ❒No _____

Other Community Services? ❒Yes ❒No _____