
ElderCare Across the Miles Needs Assessment

Date: _____

Completed by: _____ Relationship: _____

Address: _____

Phone: _____ Email: _____

Needs Assessment for (name of elder) _____

Address: _____

Health insurance other than Medicare, if any: _____

Retired military veteran or widow of a veteran. What service? _____

Major health issues: _____

Hearing and Vision

- Vision impairment affects ability to perform normal daily activities
- Hearing loss affects ability to understand conversations, TV, radio, etc.

Mobility (please check all that apply):

- Uses a cane
- Uses a walker
- Uses a wheelchair
- Wheelchair is motorized

Transportation

- Currently able to drive
- Driving only during daytime
- No longer driving

Using the following form, please provide details about each area of need that applies to your loved one. Where you know of a particular need, indicate whether your elder is also aware of this need with a checkmark in the second column. You may add areas of need at the end of the list. The Needs Assessment will be used to prepare a personalized Action Plan.

Please check off those items you feel are current concerns or where you feel help is clearly needed. Explain briefly for each item. *All information provided is confidential and will not be shared unless authorized by you and/or your elder.*

Area of Need	Elder is aware?	What are your concerns?
<p>Diet and Nutrition</p> <p><input type="checkbox"/> grocery shopping</p> <p><input type="checkbox"/> meal preparation</p> <p><input type="checkbox"/> Type II diabetes</p> <p><input type="checkbox"/> Other:</p>		
<p>Safety in the Home</p> <p><input type="checkbox"/> bathroom hazards</p> <p><input type="checkbox"/> kitchen hazards</p> <p><input type="checkbox"/> personal emergency alert service</p> <p><input type="checkbox"/> smoke detectors/ CO detector</p> <p><input type="checkbox"/> door locks</p> <p><input type="checkbox"/> door handles</p> <p><input type="checkbox"/> stairs – indoors</p> <p><input type="checkbox"/> stairs – outdoors</p> <p><input type="checkbox"/> outdoor paths, steps</p> <p><input type="checkbox"/> Other:</p>		

Area of Need	Elder is aware?	What are your concerns?
<p>Mobility</p> <p><input type="checkbox"/> unsteady in walking</p> <p><input type="checkbox"/> difficulty standing at sink or stove</p> <p><input type="checkbox"/> difficulty in using walker and/or wheelchair</p> <p><input type="checkbox"/> Other:</p>		
<p>In-Home Caregiver Help</p> <p><input type="checkbox"/> personal grooming, dressing</p> <p><input type="checkbox"/> bathing</p> <p><input type="checkbox"/> toileting</p> <p><input type="checkbox"/> companionship</p> <p><input type="checkbox"/> Other:</p>		
<p>Transportation Needs</p> <p><input type="checkbox"/> doctor and dentist appointments</p> <p><input type="checkbox"/> shopping</p> <p><input type="checkbox"/> Senior Center or other recreation</p> <p><input type="checkbox"/> attend church or temple services</p> <p><input type="checkbox"/> Other:</p>		

Area of Need	Elder is aware?	What are your concerns?
<p>Hearing and Vision</p> <p><input type="checkbox"/> vision problems affect reading, watching TV</p> <p><input type="checkbox"/> vision affected by low lighting in house</p> <p><input type="checkbox"/> vision problems present hazards in using kitchen appliances</p> <p><input type="checkbox"/> hearing loss affects enjoyment of TV or conversations</p> <p><input type="checkbox"/> hearing loss affects ability to converse on phone</p> <p><input type="checkbox"/> hearing loss may require a hearing aid</p> <p><input type="checkbox"/> Other:</p>		
<p>Housekeeping Help</p> <p><input type="checkbox"/> floor cleaning</p> <p><input type="checkbox"/> vacuuming</p> <p><input type="checkbox"/> window washing</p> <p><input type="checkbox"/> bathroom and kitchen cleaning</p> <p><input type="checkbox"/> Other:</p>		