RESET

Veteran Directed Care Program
VDC

VDC Comprehensive Needs Assessment Form

Veteran Name:

Veteran ID:

Assessment: **Initial**

Date:

Agency:

Options Counsleor:

Agency Address:

Agency Phone Number:

☐ **Options counselor indicates that the prior assessment and plan of care has been reviewed. Reassessments, please note changes from last assessment of** ☐

I. DEMOGRAPHICS

Assessment location:	Face to Face Date:	Options Counselor:
Veteran name:	Veteran ID :	SS#: Phone:
Address:	County:	Rural: **No**
D.O.B. Gender: **Male**	Race: **White**	Ethnicity: **Not Hispaic/Latino**
Marital Status: **Married**	Number in Household: **2**	Living Arrangement **w/spouse** **Single Dwelling**
Visual Impairments **NA**	Communication Barriers **No**	
Describe Visual &/or Communication Issues:		
English As Second Language? **No**	If yes, what is primary language?	
Does the veteran have an Authorized Representative? **No**		
Name:	Address:	Phone #:
Person(S) Present Other Than Client & OC And Relationship To Client		

EMERGENCY CONTACTS/SUPPORTS:

Name	Relationship	Address	Phone #	Email

Veteran/AR Email:

Does Veteran have any of the following? ☐ VA provided tablet for Telehealth ☐ Personal computer/tablet device for accessing interenet

☐ Smart Phone ☐ Internet Access, phone data, home internet

Veteran's Expressed Goals of Care:

☐ No Change Since Last Assessment

II PHYSICAL HEALTH HISTORY AND ASSESSMENT

PRESENTING PROBLEM(S) (Check All That Apply) Hospitalization Use, Emergency Use, Physician Visit In Last 90 Days Or Since Last Assessment:

- ☐ Inpatient Acute Hospital W/ Overnight Stay (Reason)
- ☐ Emergency Room Visit (Not Counting Overnight Hospital Stay) (Reason)
- ☐ Physician Visit/Purpose:
- ☐ Change(s) In Medical Condition:
- ☐ Change(s) In Household Composition:
- ☐ Change(s) In Support(s):
- ☐ Other:

Please Indicate Non-VA Primary Care Physician &/or Specialist (Name & Telephone #):

Falls

☐ No Falls in Last 90 Days ☐ No Falls in Last 30 Days but Fall in 31-90 Days ☐ 1 Fall in Last 30 Days ☐ 2 or More Falls in Last 30 Days
☐ 1 or more Falls in the Last 6 Months

Skin Conditions

☐ Pressure Sores ☐ Open Lesions ☐ Skin Tears or Cuts ☐ Bruises, Rashes ☐ Foot Problems that Interfere with Gait

Prevention

☐ Influenza Vaccine ☐ Pneumonia Vaccine (Last 5 Years) ☐ Shingles Vaccine ☐ COVID-19 Vaccine

Tobacco – Smokes Tobacco Daily **No** Wants to Quit? **No**

Home Health Services – Do you Currently or Have You in the Past Six Months Received Home Health Services? **No**

How Often? Agency Name:

☐ No Change Since Last Assessment

II PHYSICAL HEALTH HISTORY AND ASSESSMENT (CONTINUED)

Yes	No	Health conditions and Diseases	Current Medical History	Source of Report Veteran	Records	Other
		Allergy To Food / Medications				
		Alzheimer / Confusion / Dementia				
		Arthritis/Osteoporosis				
		Cancer				
		Dental Needs				
		Diabetes				
		Visual Impairments				
		Gastrointestinal Disorders				
		Hearing Problems				
		Heart Disease/High Blood Pressure				
		Infectious Disease / Tuberculosis				
		Kidney /Bladder Problems				
		Neurological Disease				
		Prostate / Incontinent Problems				
		Respiratory Disease				
		Sleep Disorders / Insomnia				
		Speech Difficulties				
		Stroke / Paralysis				
		Pain				
		History of Suicide				
		Other				

Summary of Needs Identified:

☐ No Change Since Last Assessment

III BEHAVIORAL HEALTH

Observation of Client - Indicators of Possible Depression, Anxiety, Sad Mood (Other Mood Types) Check All That Apply:	
☐ Makes Negative Statements	☐ Persistent Anger With Self Or Others
☐ Expresses What Appear To Be Unrealistic Fears	☐ Repetitive Anxious Complaints/Concerns -Not Health Related
☐ Repetitive Health Complaints	☐ Insomniac/Changes In Usual Sleep Patterns
☐ Sad, Pained, Worried Facial Expressions	☐ Repetitive Verbalizations (E.G. Calling Out For Help - 'God Help Me')
☐ Crying, Tearfulness ☐ Withdrawal From Activities Of Interest	☐ Recurrent Statements That Something Terrible Is About To Happen
☐ Expressions Of A Lack Of Pleasure In Life (E.G. 'I Do Not Enjoy Anything Anymore')	

Cognitive Observations of Client			
☐ Alert	☐ Confused	☐ Forgetful	☐ Disoriented
☐ Lonely	☐ Hopeless	☐ Happy	☐ Content

Is depression suspected? **No** **Bmcq Ajgc1r F_tc_l Cvgqrg1e Nqwafg_rpga Bg_e1mqgq=** **No**

If Yes, What Is Being Reported or Documented?

Expression - Making Self-Understood (Check Only One):

☐ Understood - Client Expresses Ideas Without Difficulty
☐ Usually Understood - Client Has Difficulty Finding Words Or Finishing Thoughts BUT If Given Time, Little Or No Prompting Required
☐ Often Understood - Client Has Difficulty Finding Words Or Finishing Thoughts, Prompting Usually Required
☐ Sometimes Understood - Ability Is Limited To Concrete Requests
☐ Rarely/Never Understood

Comprehension - Ability To Understand Others (Check Only One):

☐ Understands - Clear Comprehension
☐ Usually Understands - Misses Some Part/Intent Of Message BUT Comprehends Most Conversation With Little Or No Prompting
☐ Often Understands - Misses Some Part/Intent Of Message, With Prompting Can Often Comprehend Conversation
☐ Rarely/Never Understands

Cognitive Skills For Daily Decision Making (Decisions Regarding Tasks Of Daily Life, E.G. When To Get Up/Have Meals, What Clothes To Wear/Activities To Do) (Check Only One):

☐ Independent (Decisions Consistent/Reasonable/Safe)
☐ Modified Independence (Some Difficulty In New Situations Only)
☐ Minimally Impaired (In Specific Situations, Decision Become Poor Or Unsafe; Cues/Supervision Necessary At Those Times)
☐ Moderately Impaired (Decisions Consistently Poor Or Unsafe, Cues/Supervision Required At All Times)
☐ Severely Impaired (Never/Rarely Makes Decisions)

III BEHAVIORAL HEALTH (CONTINUED)

Significant Life Changes - Check All That Are Observed or Reported:

	Recent Life Changes (6-12 Months)		Various Behaviors
☐	Loss Of Significant Other	☐	Wandering
☐	Change In Health Condition	☐	Repetitive Actions
☐	Change In Living Condition/Arrangements	☐	Rummaging, Hoarding, Hiding, Losing Items
☐	Change In The Ability To Care For Self	☐	Suspicious
☐	Change In Sleeping Patterns	☐	Sundowning
☐	Change In Behavioral Pattern	☐	Inappropriate Behaviors; Specify:
☐	Other:	☐	Dementia Suspected? ☐ Yes ☐ No
☐	Other:	☐	Dementia Diagnosis? ☐ Yes ☐ No
		☐	Other:

Substance Use – Substance Abuse Suspected? ☐ Yes ☐ No

Client Appears To Be:

☐	Mixing Medications	☐	Excessively Using Pain Medication
☐	Receiving Medications From Multiple Physicians	☐	Excessively Using Over The Counter Meds.
☐	Taking Medications With Alcohol	☐	Mixing Medicine With Over The Counter/Herbal Remedies

Elder Abuse/Protective Services Need Suspected? (Physical, Sexual, Emotional, Passive Neglect, Deprivation, Confinement, Financial)

Do You Feel Someone Is or Has Been Taking Advantage Of You? ☐ Yes ☐ No

If You Identify Yourself As Spiritual And/Or Religious, Are These Needs Being Met? ☐ Yes ☐ No

How Can the Options Counselor Assist? Please Describe in Summary Of Needs.

Summary of Needs Identified:

☐ No Change Since Last Assessment

IV VETERANS MEDICATIONS

Does Veteran Need/Take Medication? **Yes** Does Veteran Understand The Need And Usage Of Your Medications? **Yes**

If Veteran Needs Medications But Is Not Taking Medications, Check All Appropriate Reasons:

- ☐ Trouble Taking The Medications
- ☐ No Access To The Pharmacy Or No One To Shop For Medications
- ☐ Needs Additional Education/Information On Medications
- ☐ Forgets To Take The Medications
- ☐ Does Not Like Side Effects
- ☐ Other:

Describe Any Additional Problems Veteran May Have Taking Prescribed Medications.

List Of Client/Informant Reported Current **NON VA** Prescribed Medications:

Medication	Dosage/Frequency	Prescribing Physician	Pharmacy	Purpose Of Medication
1				
2				
3				
4				
5				

Can You Set Up Your Own Medications? **Yes**

If Veteran Requires A Medication Set-Up, Who Is Responsible For This Set-Up?

Name: Relationship To Veteran: **Nurse**

Summary of Needs Identified:

☐ No Change Since Last Assessment

V VETERAN NUTRITIONAL SCREENING

Difficulty With: ☐ Swallowing ☐ Indigestion ☐ Heartburn ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ No Difficulties

On A Special Diet? ☐ Yes ☐ No If Yes, Identify:

Follows Diet (Special) ☐ Yes ☐ No If No , Explain:

What Are The Client Dietary Preferences And/Or Personal Restrictions?

Observed Problems With Spoiled Food? ☐ Yes ☐ No Does Anyone Assist The Client With Meal Preparation? ☐ Yes ☐ No

NUTRITION RISK SCREEN	YES	NO	COMMENTS
1. Have You Made Changes In The Way You Eat Because Of An Illness Or Medical Condition?			
2. Do You Eat Fewer Than Two Meals Per Day?			
3. Do You Eat Few Fruits, Vegetables Or Milk Products?			
4. Do You Have Three Of More Drinks Of Beer, Liquor Or Wine Almost Every Day?			
5. Do You Have Tooth Or Mouth Problems That That Make It Hard For You To Eat?			
6. Do You Always Have Enough Money To Buy The Food You Need?			
7 Do You Eat Alone Most Of The Time?			
9. Have You Lost Or Gained Ten Pounds In The Last Six Months Without Wanting To?			
10. Are You Usually Physically Able To Shop, Cook, And Feed Yourself?			

Who Does The Grocery Shopping? Relationship: **Self**

Is There A Need For Home Delivered Meals? **No**

Is There A Need For Congregate Meals? **No**

Is there a need for emergency food? **No**

Summary of Needs Identified:

☐ No Change Since Last Assessment

VI. VETERAN'S CAREGIVER

Do you care for a Dependent other than the veteran? **No**

Identify Person: **Dependent Child** with a **Developmental Disability**

Does someone provide/assist with your care? Yes ☐ No ☐ If Yes, Who Is Primary? Relationship: **Significant Other**

Do You Need Any Support? ☐ Yes ☐ No OC discussed Caregiver Support information? ☐ Yes ☐ No

Summary of Needs Identified: ☐ No Change Since Last Assessment

VII VETERANS TRANSPORTATION

Does the Veteran Own a Vehicle? ☐ Yes ☐ No

Does the Client Presently Drive? ☐ Yes ☐ No

Does the Veteran Have a Valid Driver's License? ☐ Yes ☐ No

Has Anyone Asked the Veteran Not to Drive? ☐ Yes ☐ No Who? **Other**

Does the Veteran Have Any Special Needs (Wheel Chair, Etc.)?

How Does Veteran Get to Where He/She Need to Go?

Summary of Needs Identified: ☐ No Change Since Last Assessment

VIII VETERANS ENVIRONMENT

Assistive Devices

	Has	Needs		Has	Needs		Has	Needs
Brace			Special Telephones			Raised toilet seat		
Cane/Crutches			Dentures			Adaptive eating utensils		
Prosthesis			Emergency Response Device			Hospital bed		
Walker/Wheelchair			Bath bench			Oxygen		
Hearing Aids			Commode			Other 1:		
Vision aids			Grab Bars			Other 2		
Transfer Device			Lift Seat			Other 3:		

VIII VETERAN'S ENVIRONMENT (CONTINUED)

Environmental Needs/Problems

	GROUNDS/STRUCTURE OF THE HOME:		SANITATION OF HOME:
☐	Unsafe Flooring	☐	Unusual Odor
☐	Needs Home Repairs/Structural Hazards	☐	Infestation
☐	Difficulty with knobs, locks levers	☐	Uncared Pets
☐	Problems with access to house or apartment	☐	Clutter/Hoarding
☐	Laundry; not on the same floor	☐	Unsanitary Conditions
	HAZARDS: ***(Check for Yes)***		**NECESSARY RESOURCES:*(Are these working?)***
☐	Smoke Detector?	☐	Stove
☐	Carbon Monoxide Detectors?	☐	Refrigerator
☐	Evacuation Plan	☐	Microwave
☐	Heat/Air Condition	☐	Electricity
☐	Adequate Lighting	☐	Broken Water Pipes/Leaking Plumbing
		☐	Gas
		☐	Telephone
☐	**OTHER:**		

Is Client at Risk for Eviction? **No**

Do you have any goals for your enviroment? **No**

Summary of Needs Identified:

☐ **No Change Since Last Assessment**

IX VETERAN'S FINANCIAL

Are You Interested In Referrals Based On Your Financial Information? ☐ Yes ☐ No

Income (Amounts and Sources):

Assets (Amounts and Sources):

Summary of Needs Identified:

☐ No Change Since Last Assessment

X VETERAN'S LEGAL STATUS

	Has Document Or Program In Place	Veteran Expresses Satisfaction With Current Arrangements	Needs Assistance	Comments (Indicate Who Is Appointed And The Type Of Authority, If Appropriate)
Power Of Attorney – Estate / Financial	☐ Yes ☐ No	☐ Yes ☐ No		
Power Of Attorney – Healthcare	☐ Yes ☐ No	☐ Yes ☐ No		
Living Will	☐ Yes ☐ No	☐ Yes ☐ No		
Do Not Resuscitate (DNR)	☐ Yes ☐ No	☐ Yes ☐ No		
Guardianship	☐ Yes ☐ No	☐ Yes ☐ No		
Representative Payee	☐ Yes ☐ No	☐ Yes ☐ No		
Burial Plan	☐ Yes ☐ No	☐ Yes ☐ No		
Will / Estate Planning	☐ Yes ☐ No	☐ Yes ☐ No		
Other	☐ Yes ☐ No	☐ Yes ☐ No		

☐ No Change Since Last Assessment

XI OPTIONS PLAN FORM: Veteran Name:_____ I.D.#_____ Case Mix_____

Write in specific Needs Identified/Tasks Required	VETERAN'S OPTIONS PLAN	SERVICE PROVIDER/ADDRESS/PHONE	TOTAL MONHTLY SERVICE BUDGET $_____ Cost Per Month	In Place
Personal Assistant				☐
Homemaker				☐
Adult Day Care				☐
Assistive Technology				☐
Home Delivered Meals				☐
Respite Care				☐
Caregiver Support				☐
Transportation				☐
Environmental				☐
Disposable Medical Supplies				☐
Expenses related to community integration				☐
Savings: Emergemcy___ If for Specific Item_____				☐
Other				☐

ACCEPT VDC SERVICES? ☐ **YES** ☐ **NO**

SIGNATURE APPROVALS

Veteran or Authorized Representative: _____ **Date:** _____

Options Counselor: _____ ***Date:*** _____

SUPERVISOR'S APPROVAL: _____ ***Date:*** _____

Veterans ID_____

XI ADDITIONAL NARRATIVE