Seniors in Service

Senior Companion Program
1380 Greg Str., Ste. 212, Sparks, NV 89431
Phone 775-358-2322 Fax 775-358-3633

CLIENT EVALUATION

Gender: M F
Ethnicity: C B H A I
Birth date: _____
Income: _____
Insurance: _____
Priority: Y N
Protective Services: Y N

Name _____
Address _____
City _____ **Zip** _____
Phone _____
Lives Alone: Y N Lives with: _____

Impairments / Needs

	None	Partial	Severe
Cognitive Ability	☐	☐	☐
Vision	☐	☐	☐
Hearing	☐	☐	☐

Ambulation: Independent Cane Walker Wheelchair
Comments: _____

Emotional / Social Support: None Partial Good
Assistance Required: Transportation Companionship Respite
Other: _____
Companion Preference: Male Female No Preference

Do You Have Pets (Cats, Dogs)? Y N

Medical Status

	None	Partial	Severe
Osteoporosis	_____	_____	_____
COPD	_____	_____	_____
Arthritis	_____	_____	_____
Emphysema	_____	_____	_____
Heart Disease	_____	_____	_____
Hypertension	_____	_____	_____
Diabetes	_____	_____	_____
Cancer	_____	_____	_____

Stroke: _____
Allergies: _____
Other: _____
Smoker: Y N
Veteran: Y N

Activities of Daily Living

	Good	Marginal	Poor
Ability to:			
Bathe	☐	☐	☐
Housework	☐	☐	☐
Climb stairs	☐	☐	☐
Continent	☐	☐	☐
Medication maintenance	☐	☐	☐
Prepare meals	☐	☐	☐

Notes: _____
_____

Other Services

	Receiving	Eligible	Referred	Not Receiving
CHIPS	_____	_____	_____	_____
Commodities	_____	_____	_____	_____
Energy Assist	_____	_____	_____	_____
Food Stamps	_____	_____	_____	_____
Homemaker	_____	_____	_____	_____
Senior Nutrition	_____	_____	_____	_____
CitiLift	_____	_____	_____	_____
Taxi Bucks	_____	_____	_____	_____
Services to the Blind	_____	_____	_____	_____

Other: _____

Appearance & Hygiene:

Poor Acceptable Good
Details: _____
_____

Mental Health:

Confusion / Disorientation:	None	Partial	Severe
Mood Swings:	None	Partial	Severe
Alzheimer or Dementia:	None	Partial	Severe

Diagnosed Disorders _____

Revised 7/25/18

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(OVER)

EMERGENCY CONTACT

Name: _____ Relationship _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

REFERRAL INFORMATION

Referral Date: _____

Person /Agency: _____ Caseworker (if applies): _____

Address: _____ Phone: _____ Ext._____

Transportation Assessment (Circle Yes or No):
Own Transportation? Yes No
Able to transfer self if using transportation? Yes No
Family, Neighbors, Friends Currently Provide Transportation? Yes No
Uses TaxiBucks or RTC Access? Yes No If Yes, which one? _____
Does Client Qualify for Medicaid Transportation (Logisticare)? Yes No If yes, does client need assistance applying for service? Yes No

Other Notes: _____

SCP Office Use:

Interviewer_____ Date: _____

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