State of Illinois Department of Human Services

SPECIFIC LEVEL OF FUNCTIONING ASSESSMENT AND PHYSICAL HEALTH INVENTORY

RATER INFORMATION

Name of Rater: _____

(please print)

Rater's Title: _____

Date on which this form was filled out: _____

INDIVIDUAL INFORMATION

Individual Name: _____

Individual Social Security Number: _____

Date of Birth: _____

Sex: ☐ Male ☐ Female

Home Address: _____

Is this person able to speak, read and understand English?

☐ Yes ☐ No

If No, what language or adaptations does the person ordinarily require?

_____

Specify

On the following pages you will be asked to make some judgments about this individual's skills and abilities. Please remember that your answers should reflect what has been most typical of the individual during the past week, the way the individual has been most of the time. Therefore, do not limit your rating only to the way the individual was the last time you saw him/her. Your rating will have a great deal to do with the service this person will receive, so it is essential that you use your knowledge of the individual's usual condition during the past week.

Base your answers on how persons of similar age, sex, and general background manage these activities in normal daily living. Do not use your program or facility as your only basis for comparison. We are less interested in how well someone has adjusted to your program than we are in how well they could manage outside it.

Above all, use common sense. These items are not too technical or complex, and you should use the best information and best judgment you can in making the assessment.

This assessment was adapted from the New Jersey Specific Level of Functioning and New York Level of Care

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Instructions: Check the number that best describes this person's typical level of functioning on each item listed below. BE AS ACCURATE AS YOU CAN. If you are not sure about a certain rating, ask someone who might know or consult the case record.

MARK ONLY ONE NUMBER FOR EACH ITEM, BE SURE TO MARK ALL ITEMS.

	SELF MAINTENANCE				
A. Physical Functioning	NO PROBLEM	PROBLEM, BUT NO EFFECT ON GENERAL FUNCTIONING	SLIGHT EFFECT ON GENERAL FUNCTIONING	RESTRICTS GENERAL FUNCTIONING SUBSTANTIALLY	PREVENTS GENERAL FUNCTIONING
1. VISION	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
2. HEARING	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
3. SPEECH IMPAIRMENT	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
4. WALKING, USE OF LEGS	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
5. USE OF HANDS AND ARMS	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
B. Personal Care Skills	TOTALLY SELF-SUFFICIENT	NEEDS VERBAL ADVICE OR GUIDANCE	NEEDS SOME PHYSICAL HELP OR ASSISTANCE	NEEDS SUBSTANTIAL HELP	TOTALLY DEPENDENT
6. TOILETING (uses toilet properly; keeps self and area clean)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
7. EATING (uses utensils properly; eating habits)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
8. PERSONAL HYGIENE (body and teeth; general cleanliness)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
9. DRESSING SELF (selects appropriate garments; dresses self)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
10. GROOMING (hair, make-up, general appearance)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
11. CARE OF OWN POSSESSIONS	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
12. CARE OF OWN LIVING SPACE	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

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SOCIAL FUNCTIONING

C. Interpersonal Relationships	HIGHLY TYPICAL OF THIS PERSON	GENERALLY TYPICAL OF THIS PERSON	SOMEWHAT TYPICAL OF THIS PERSON	GENERALLY UNTYPICAL OF THIS PERSON	HIGHLY UNTYPICAL OF THIS PERSON
13. ACCEPTS CONTACT WITH OTHERS (does not withdraw or turn away)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
14. INITIATES CONTACT WITH OTHERS	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
15. COMMUNICATES EFFECTIVELY (speech and gestures are understandable and to the point)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
16. ENGAGES IN ACTIVITIES WITHOUT PROMPTING	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
17. PARTICIPATES IN GROUPS	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
18. FORMS AND MAINTAINS FRIENDSHIPS	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
19. ASKS FOR HELP WHEN NEEDED	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

D. Social Acceptability	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
20. VERBALLY ABUSES OTHERS	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
21. PHYSICALLY ABUSES OTHERS	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
22. DESTROYS PROPERTY	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
23. PHYSICALLY ABUSES SELF	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
24. IS FEARFUL, CRYING, CLINGING	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
25. TAKES PROPERTY FROM OTHERS WITHOUT PERMISSION	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
26. PERFORMS REPETITIVE BEHAVIORS (pacing, rocking, making noises, etc.)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

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COMMUNITY LIVING SKILLS

E. Activities	TOTALLY SELF-SUFFICIENT	NEEDS VERBAL ADVICE OR GUIDANCE	NEEDS SOME PHYSICAL HELP OR ASSISTANCE	NEEDS SUBSTANTIAL HELP	TOTALLY DEPENDENT
27. HOUSEHOLD RESPONSIBILITIES (house cleaning, cooking, washing clothes, etc.)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
28. SHOPPING (selection of items, choice of stores, payment at register)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
29. HANDLING PERSONAL FINANCES (budgeting, paying bills)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
30. USE OF TELEPHONE (getting number, dialing, speaking, listening)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
31. TRAVELING FROM RESIDENCE WITHOUT GETTING LOST	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
32. USE OF PUBLIC TRANSPORTATION (selecting route, using timetable, paying fares, making transfers)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
33. USE OF LEISURE TIME (reading, visiting friends, listening to music, etc.)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
34. RECOGNIZING AND AVOIDING COMMON DANGERS (traffic safety, fire safety, etc.)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
35. SELF-MEDICATION (understanding purpose, taking as prescribed, recognizing side effects)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
36. USE OF MEDICAL AND OTHER COMMUNITY SERVICES (knowing who to contact, how, and when to use)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
37. BASIC READING, WRITING AND ARITHMETIC (enough for daily needs)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

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F. Work Skills	HIGHLY TYPICAL OF THIS PERSON	GENERALLY TYPICAL OF THIS PERSON	SOMEWHAT TYPICAL OF THIS PERSON	GENERALLY UNTYPICAL OF THIS PERSON	HIGHLY UNTYPICAL OF THIS PERSON
38. HAS EMPLOYABLE SKILLS	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
39. WORKS WITH MINIMAL SUPERVISION	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
40. IS ABLE TO SUSTAIN WORK EFFORTS (not easily distracted; can work under stress)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
41. APPEARS AT APPOINTMENTS ON TIME	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
42. FOLLOWS VERBAL INSTRUCTIONS ACCURATELY	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
43. COMPLETES ASSIGNED TASKS	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

OTHER INFORMATION

44. From your knowledge of this person, are there other skills or problem areas not covered on this form that are important to this person's ability to function independently? Is so, please specify.

_____

_____

45. How well do you know the skills and behavior of the person you just rated? (Check one)

VERY WELL		FAIRLY WELL		NOT VERY WELL AT ALL
☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

46. Have you discussed this assessment with the individual? (Check one)

☐ Yes ☐ No

If YES, does the individual generally agree with the assessment? (Check one)

☐ Yes ☐ No

If NO, please comment

_____

_____

Signature of Rater: _____

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PHYSICAL HEALTH INVENTORY

Instructions:
Place an "X" in all boxes which describe this individual

PHYSICAL HEALTH

Current Physical Health Problem of the Individual

- ☐ None
- ☐ Arteriosclerotic Heart Disease (ASHD)
- ☐ Hypertension
- ☐ Other Circulatory Disorder
- ☐ Serious Respiratory Disorder
- ☐ Diabetes
- ☐ Obesity
- ☐ Arthritis
- ☐ Decubitis Ulcer (Bedsores)
- ☐ Seizure Disorder (Epilepsy)
- ☐ Gastro-Intestinal Disorder
- ☐ Organic Brain Syndrome
- ☐ CVA-Stroke
- ☐ Vision Limited
- ☐ Blind
- ☐ Hearing Impaired
- ☐ Speech Impaired
- ☐ Fracture
- ☐ Urogenital Disorder
- ☐ Huntington's Disease
- ☐ Alzheimer's Disease
- ☐ Parkinson's Disease
- ☐ Tardive Dyskinesia
- ☐ Cancer of a Major Organ or System
- ☐ Other

Physical Health Aids Used or Required by the Individual

- ☐ None
- ☐ Eyeglasses
- ☐ Hearing Aid
- ☐ Dentures
- ☐ Other

Skilled Nursing Procedures Required by the Individual

- ☐ None
- ☐ Daily Vital Signs
- ☐ Insulin Injection
- ☐ Preventive Care for Pressure Sores
- ☐ Treatment for Decubitus Ulcers
- ☐ Catheter/Ostomy Care
- ☐ Aseptic Dressing
- ☐ Physiotherapy
- ☐ Continence Training
- ☐ Lesion Irrigation
- ☐ Suctioning
- ☐ Inhalation Therapy
- ☐ I.V. Feeding Fluids
- ☐ Tube Feeding
- ☐ Others

Incontinence of Urine:

- ☐ Never
- ☐ Less than Once a Day
- ☐ Night Only
- ☐ 1-3 Times a Day
- ☐ More than 3 times a Day
- ☐ Uses Catheter

Incontinence of Feces:

- ☐ Never
- ☐ Less Than Once a Day
- ☐ More Than Once a Day
- ☐ Once a Day
- ☐ Has a Colostomy

Which of the following best describes the individual's ability to walk:

- ☐ Fully Independent
- ☐ Unsteady
- ☐ Uses Cane or Walker
- ☐ Walks Only with Staff Assistance

Uses Wheel Chair

- ☐ Independently
- ☐ Must be Pushed
- ☐ Chair Fast or Needs Possy Support
- ☐ Bed Fast

Personal Care Activities

	Fully Independent	Needs Reminders	Needs Supervision	Some Physical Assist.	Needs Much Physical Assist.	Needs Total Care
Bathing	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐
Grooming	☐	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐	☐
Using Toilet	☐	☐	☐	☐	☐	☐

Comments: (Note and explain areas which require evaluation to determine the amount of physical care this individual requires)

_____

_____

_____

_____

_____

Rater Signature: _____

Rater Title: _____

Date: _____