Transition Supported Assessment Questionnaire

This assessment questionnaire is designed to help us learn about your circumstances and information and advice which may help you to achieve your outcomes, identify whether you are eligible for any support to help you now or to prevent or reduce your need for assistance in the future.

System ID			
Name			
Address			
Telephone		**Gender**	
Date of Birth		**Age**	

CYP Specific Questions

Child / Young Persons contact details if different from above	Daytime Contact Number	
	Home Phone	
	Mobile Phone	
	Email	
	Fax	
	Minicom	
	Emergency Phone	
Child In Need		
Summary of reason for referral		
Agencies contacted during Assessment		

	Yes / No	**Name**	**Contact Date**	**How was this contact made?**
CAMHS				
Community Paediatrician				
Education Welfare Office				
GP				
Health Visitor				
Nursery				
School / Education Provision				
School Nurse				
14 – 19 Team				
Children's Centres				

CAF Lead Professional				
Police				
Youth Offending Team				
Adult Services				
Other Agencies contacted				
Referrals to other agencies				

CareFirst Warnings

Does the client have a CareFirst warning in place on their record (required) *PLEASE CHECK THE WARNING ENTRY SCREEN AND CLOSE WARNING(S) IF NEEDED.* *IF YES, NO LONGER RELEVANT OR NO, ONE NEEDS TO BE ADDED.* *YOU WILL BE PROMPTED TO ENTER THE TEAM ID OF THE ADMIN TEAM THAT WILL UPDATE THE WARNING ENTRY SCREEN*		
Please tick	No	
	No, one needs to be added	
	Yes, no longer relevant	
	Yes, still relevant	
Please give details of why the warning is still relevant or why you are to end it		

Consent and Capacity

Halton Borough Council will treat the information you have provided in confidence and in accordance with the Data Protection Act 1998.
It will be used to help us assess your needs and write a Care and Support plan.
It may be shared with other professionals and agencies that may be involved with you for the same or similar purposes.
If you are not able to consent to this or to the gathering of any information needed in the questionnaire your worker may need to follow the Mental Capacity Act 2005 to consider how we can work in your best interests.

Has the consent form been completed and scanned to ESCR? (Required) *IF NO, STATE DETAILS IN THE NOTES FIELD E.G. MENTAL CAPACITY ASSESSMENT TO TAKE PLACE*		Yes / No
Notes:		
Date form signed		
On the date the assessment took place were any concerns raised about the person's decision making capacity? (Required) *IF YES, STATE THE REASON FOR THE CONCERNS AND WHAT SPECIFIC DECISION MAKING MAY BE IMPAIRED E.G. COPING WITH FINANCIAL AFFAIRS, MAKING DECISIONS IN RELATION TO HEALTH, WELLBEING AND CARE PLANNING.*		
Please tick	No concerns at present	

	Not stated	
	Yes, concerns see notes	
	If yes, detail here :	
Notes for decision making capacity		
Is a Mental Capacity Assessment required? *IF YES, ENTER THE ID OF THE WORKER/TEAM THAT WILL COMPLETE THE ASSESSMENT*		Yes / No

Representation and Advance Planning

Does the person have support/representation of family member, a friend, an advocate or IMCA during this assessment? (Required) *WHERE SUPPORT IS GIVEN PLEASE PROVIDE DETAILS OF THE RELATIONSHIP TOGETHER WITH THE PERSON'S CONTACT DETAILS*		
Please tick	No, Does not require support	
	Not Applicable	
	Yes, Support of a family member see notes	
	Yes, Support of a friend see notes	
	Yes, Support of an advocate see notes	
	Yes, Support of an Imca see notes	
	Yes, Support of an another see notes	
	If yes, detail here:	
In line with the 2005 Mental Capacity Act is an Independent Mental Capacity Advocate (IMCA) Required		Yes / No
If the answer to the above question is Yes, please enter the course of action to be taken.		
In line with the Care Act 2014 is a Care Act Advocate required? *IF THE PERSON HAS SUBSTANTIAL DIFFICULTY WITH THE ASSESSMENT AND THERE IS NO ONE ELSE APPROPRAITE TO ASSIST THEM AN INDEPENDENT ADVOCATE MAY BE REQUIRED.*		Yes / No
If the answer to the above question is Yes, please enter the course of action to be taken.		
Does anyone have Power of Attorney (Lasting or Ordinary) to deal with your affairs or do you have an Appointee or Court-Appointed Deputy?		Yes / No
If the answer to the above question is Yes, please state details of any such arrangements, including the name(s) and contact details of anyone with decision-making powers. You must also state what evidence has been provided to legitimise the arrangements.		
Are there any other documents that relate to your health, wellbeing or affairs which you wish to make others aware of? *FOR EXAMPLE - HEALTH ACTION PLAN; HEALTH PASSPORT; DNAR; PREFERRED PLACE OF CARE; ADVANCED DECISION.*		

Are you already known to the memory clinic or older peoples mental health team as a result of memory problems *IF YES, PLEASE ANSWER THE FOLLOWING QUESTIONS*	Yes / No

	What year is it	Correct / Incorrect
	What is your date of birth	Correct / Incorrect
	How old are you	Correct / Incorrect
	What is your current address (If at home)	Correct / Incorrect
	What is the name of the place you are currently living in (if residential or respite/hospital)	Correct / Incorrect

A TICK TO ANY OF THESE AS INCORRECT INDICATES A POSSIBLE MEMORY ISSUE.
PLEASE REQUEST A MEMORY ASSESSMENT VIA THE GP SERVICE IF NOT ALREADY KNOWN TO MEMORY CLINIC OR TEAMS

Worker/Team Relationship

Worker Relationship (Required)	
Team Relationship (Required)	

About Me

Worker Relationship (Required)		
Team Relationship (Required)		
Date of Visit (Required)		
Is this a Reassessment (Required) *I.E FOR SOMEONE WITH AN ESTABLISHED LONG TERM PACKAGE OF CARE*	Yes / No	
Date of Birth (Required)		
Current address - if different from above records *IF THE ADDRESS IS DIFFERENT FROM THAT ON THE PERSON RECORD, RECORD THE CHANGES AND SELECT THE APPROPRIATE ADMIN TEAM WHO WILL COMPLETE THE CHANGES*		
Select which Admin Team will update the address *A NOTIFICATION WILL BE SENT TO THE APPROPRIATE ADMIN DESKTOP FOR ACTION*	Complex Care Runcorn Admin	
	Complex Care Widnes Admin	
	Hospital Admin	
	Initial Assessment Admin	
	Mental Health Admin	
	Older People Mental Health Admin	
NHS Number		
Medical Conditions		
Ethnicity (Required)		
Religion (Required)		
Sexual Orientation		
Marital Status		

Living arrangements	Accommodation type	
	Tenure type	
	Household composition	

Preferred first language	
Do you have any communication needs?	
How would you like to be contacted? *USE THE NOTES FIELD TO RECORD ACTUAL TELEPHONE/MOBILE/EMAIL ADDRESS ETC*	
Preferred Contact (Husband, Wife, Sister etc)	
Information Only - Display summary of known services the individual is receiving	
Detail any other services the individual is receiving	
Personal Relationships *E.G. EVERYONE THAT LIVES IN MY HOUSEHOLD, CARER NEXT OF KIN ECT*	
Is the next of kin the main keyholder	
Is the main carer the keyholder	

Who lives with me in my household?

	Surname	First Name	Age	Sex	Relationship to service user
1					
2					
3					
4					
5					

Additional Household members if the above table is full	
Record all current Professional Relationships	
Do your needs arise from, or are related to, a physical or mental impairment or illness?	
During the past month have you been affected by feeling down depressed or hopeless?	Yes (Score 1) / No
During the past 12 months have you been affected by little interest or pleasure in doing things?	Yes (score 2) / No

A SCORE OF 1 OR MORE TO THE ABOVE QUESTIONS INDICATES THAT A REFERRAL TO GP SERVICES IS REQUIRED IF NOT ALREADY KNOWN TO GP/MENTAL HEALTH TEAM IN RELATION TO MOOD DISORDER

Tell us about your current situation?
What outcomes do you hope to achieve from this assessment?
Tell us about your day-to-day life (this may include hobbies, interests, activity, interactions, routine, or any other relevant information)

Falls/Mobility/Safer Handling

THE ANSWERS TO THE NEXT FIVE QUESTIONS INDICATE THE NEED TO ENTER ONTO THE FALLS PREVENTION OR INTERVENTION PATHWAY.	
Have you had a fall in the past 12 months? *ASK THE CLIENT ABOUT THEIR FALLS, THE SEVERITY, WHAT ASSESSMENT HAS TAKEN PLACE AS A RESULT. ANY NOTES SHOULD INCLUDE THE NUMBER OF FALLS WITHIN THE PAST YEAR AND ANY RELEVANT DETAILS THAT NEED TO BE CAPTURED.*	Yes / No
Notes	
IF THE ANSWER TO 8.1.1 IS 'NO' PLEASE PROCEED TO 9.1.1	
Do you have a diagnosis of Parkinson's disease or have you ever had a stroke?	Yes / No
Do you have problems with your balance?	Yes / No
Are you UNABLE to rise from a chair of knee height? *IF UNSURE CONDUCT ASSESSMENT- ASK THE PERSON TO STAND FROM A CHAIR OF KNEE HEIGHT WITHOUT USING THEIR ARMS OR ASK THE PERSON TO DESCRIBE HOW THEY RISE FROM THE CHAIR*	Yes / No
Do you take four or more medications per day?	Yes / No
THREE OR MORE 'YES' ANSWERS - ENTER FALLS INTERVENTION PATHWAY / ONE OR TWO 'YES' ANSWERS - ENTER THE FALLS PREVENTION PATHWAY	

Safer handling Transfers			
	Previous Level	Present Level / Potential	Comments (aids / equipment / safety concerns)
Indoors			
Outdoors			
Bed			
Chair			
Toilet			
Bath / Shower			
Stairs			
Access to property			

Medications Management

Do you have any known allergies to anything including medicines and food?	Yes	
	No	
	Don't know	
If yes, detail here		
Are you currently taking medication or using medical devices and do any of your medicines require specialist administration techniques such as injections, suppositories, percutaneous	Yes	
	No	

endoscopic gastrostomy (PEG) etc... *MEDICAL DEVICES INCLUDE EYE DROPS, INHALERS, CATHETERS, BLOOD GLUCOSE TEST STRIPS ETC...... (PRESCRIBED OR BOUGHT OVER THE COUNTER, CONSIDER AMOUNT, TIMES OF DAY, LENGTH OF TIME)*	Don't know	
If yes, give details		
Do you have any concerns/difficulties in regards to taking your medication? *DISCUSS WITH THE CLIENT WHAT SUPPORT THEY MAY REQUIRE, CONSIDER ABILITY TO READ DIRECTIONS ON LABELS, OPENING CONTAINERS, DO THEY FORGET TO TAKE MEDICATION, RECEIVING MEDICINES ON TIME, INFORMAL CARERS SUCH AS FRIENDS OR FAMILY WHO ASSIST WITH MEDICINE, MEDICINE WHICH IS ONLY TAKEN WHEN REQUIRED, DIFFICULTY USING DEVICES SUCH AS INHALERS EYE DROPS ETC...*		

Achieving Desired Outcomes

MANAGING & MAINTAINING NUTRITION		
Please use this section to explain your day-to-day experience of achieving this outcome *EXPLANATION SHOULD ALSO BE GIVEN WHERE THE OUTCOME IS NOT APPLICABLE AND WHY. THE OUCTOME INCLUDES: CHOOSING FOOD THAT IS NOURISHING; UNDERSTANDING THE NEED FOR A BALANCED DIET; IDENTIFYING FOOD AND DRINK; READING FOOD LABELS; READING AND UNDERSTANDING INSTRUCTIONS AND USE BY DATES; PREPARING MEALS, SNACKS AND DRINKS; MAINTAINING A SPECIAL DIET; MAINTAINING DIABETES; EATING DRINKING AND AVOIDING CHOKING.* *(THIS IS NOT AN EXHAUSTIVE LIST)*		
Please tick		
A	I do not need any support in this area (go to the next area of need)	
B	I need occasional support to eat/drink or prepare my meals (for example, very little or no more than once a week or verbal prompting)	
C	I often need some support to eat/drink or prepare my meals (for example, a few times a week or some practical assistance)	
D	I always need support to eat/drink or prepare my meals (for example, several times a day or a lot of support)	
How are your support needs currently met? *CONSIDER STRENGTHS/ASSETS - THIS WOULD INCLUDE THINKING ABOUT WHAT RESOURCES THE PERSON CURRENTLY ACCESS (INCLUDING HELP FROM OTHERS, WHOM AND WHEN)*		
MAINTAINING PERSONAL HYGIENE		
Please use this section to explain your day-to-day experience of achieving this outcome *EXPLANATION SHOULD ALSO BE GIVEN WHERE THE OUTCOME IS NOT APPLICABLE AND WHY. THIS DOMAIN INCLUDES: AVOIDING SELF-NEGLECT; MAINTAINING PERSONAL APPEARANCE; WASHING; USING BATH OR SHOWER, MANAGING SKIN CONDITIONS AND GROOMING* *(THIS IS NOT AN EXHAUSTIVE LIST)*		
Please tick		
A	I do not need any support in this area (go to the next area of need)	
B	I need occasional support/encouragement with my personal care	

	(for example, no more than once or twice a week or verbal prompting)	
C	I need some support/encouragement with my personal care (for example, once a day or supervision or checking)	
D	I often need support/encouragement with my personal care (for example, twice a day or more or a lot of support)	
E	I frequently need support/encouragement with my personal care (for example, more than twice a day or a lot of support)	

13.1.6: How are your support needs currently met?

CONSIDER STRENGTHS/ASSETS - THIS WOULD INCLUDE THINKING ABOUT WHAT RESOURCES THE PERSON CURRENTLY ACCESS (INCLUDING HELP FROM OTHERS, WHOM AND WHEN)

MAINTAINING TOILET NEEDS

Please use this section to explain your day-to-day experience of achieving this outcome

EXPLANATION SHOULD ALSO BE GIVEN WHERE THE OUTCOME IS NOT APPLICABLE AND WHY. THE OUTCOME DOMAIN INCLUDES; MOBILITY AND ACCESS TO TOILET E.G. NO DOWNSTAIRS TOILET; CONTINENCE NEEDS; COLOSTOMY OR STOMA.
(THIS IS NOT AN EXHAUSTIVE LIST)

Please tick

A	I do not need any support in this area (go to the next area of need)	
B	I need occasional support/encouragement with my personal care (for example, no more than once or twice a week or verbal prompting)	
C	I need some support/encouragement with my personal care (for example, once a day or supervision or checking)	
D	I often need support/encouragement with my personal care (for example, twice a day or more or a lot of support)	
E	I frequently need support/encouragement with my personal care (for example, more than twice a day or a lot of support)	

How are your support needs currently met?

CONSIDER STRENGTHS/ASSETS - THIS WOULD INCLUDE THINKING ABOUT WHAT RESOURCES THE PERSON CURRENTLY ACCESS (INCLUDING HELP FROM OTHERS, WHOM AND WHEN)

13.1.10: Do you have trouble with your bladder	Yes / No
Do you lose urine when you don't want to?	Yes / No
Do you wear pads that have not been prescribed by your GP or district nurse?	Yes / No

ANSWERING YES TO ANY OF THE ABOVE THREE QUESTIONS INDICIATES THE NEED TO REFER TO A GP OR DISTRICT NURSE FOR A CONTINENCE ASSESSMENT. IF THIS ASSESSMENT IS BEING COMPLETED FOR A CHILD TRANSITION CASE AND THE ANSWER IS YES REFER ONTO THE CHILDRENS AND CONTINENCE TEAM

BEING APPROPRIATELY CLOTHED

Please use this section to explain your day-to-day experience of achieving this outcome

EXPLANATION SHOULD ALSO BE GIVEN WHERE THE OUTCOME IS NOT APPLICABLE AND WHY. THE OUTCOME DOMAIN INCLUDES; GETTING DRESSED; WEARING SUITABLE CLOTHES FOR THE TIME OF YEAR OR TIME OF DAY; CLEANING AND MAINTAINING SPECTACLES OR HEARING AIDS/ETC.
(THIS IS NOT AN EXHAUSTIVE LIST)

Please tick		
A	I do not need any support in this area (go to the next area of need)	
B	I need occasional support/encouragement with my personal care (for example, no more than once or twice a week or verbal prompting)	
C	I need some support/encouragement with my personal care (for example, once a day or supervision or checking)	
D	I often need support/encouragement with my personal care (for example, twice a day or more or a lot of support)	
E	I frequently need support/encouragement with my personal care (for example, more than twice a day or a lot of support)	

How are your support needs currently met?
CONSIDER STRENGTHS/ASSETS - THIS WOULD INCLUDE THINKING ABOUT WHAT RESOURCES THE PERSON CURRENTLY ACCESS (INCLUDING HELP FROM OTHERS, WHOM AND WHEN)

BEING ABLE TO USE THE HOME SAFELY

13.1.16: Please use this section to explain your day-to-day experience of achieving this outcome
EXPLANATION SHOULD ALSO BE GIVEN WHERE THE OUTCOME IS NOT APPLICABLE AND WHY. THE OUTCOME DOMAIN INCLUDES: USING A COOKER; USING THE STAIRS; AVOIDING RISK OF INJURY TO SELF; SETTING UP AND MANAGING TELECARE; KEEPING THE HOME SAFE FROM FIRE; USING CENTRAL HEATING/WASHER/SHOWER CONTROLS/ETC.

Please tick		
A	I do not need any support in this area (go the next area of need)	
B	I need some support to move around my home safely	
C	I need some support to move around my community safely	
D	I need some help or support to move around my home and community safely	

How are your support needs currently met?
CONSIDER STRENGTHS/ASSETS - THIS WOULD INCLUDE THINKING ABOUT WHAT RESOURCES THE PERSON CURRENTLY ACCESS (INCLUDING HELP FROM OTHERS, WHOM AND WHEN)

MAINTAINING A HABITABLE HOME ENVIRONMENT

Please use this section to explain your day-to-day experience of achieving this outcome
EXPLANATION SHOULD ALSO BE GIVEN WHERE THE OUTCOME IS NOT APPLICABLE AND WHY. THIS OUTCOME DOMAIN INCLUDES: MAINTAINING THE HOME TO A SAFE TO A AND HABITABLE STANDARD; MANAGING THE HOUSEHOLD BUDGET AND PAYMENT OF BILLS; BALANCING A BANK ACCOUNT; USING A CASH MACHINE; MAKING AND RECEIVING PHONE CALLS; READING CORRESPONDENCE AND NOT RESPONDING APPROPRIATELY (E.G. FINANCIAL SCAMMING)
(THIS IS NOT AN EXHAUSTIVE LIST)

Please tick		
A	I do not need any support in this area (go the next area of need)	
B	I need occasional support to run and maintain my home (for example, very little or no more than once a week or verbal prompting)	
C	I often need some support to run and maintain my home	

	(for example, up to once or twice a week or supervision or checking)	
D	I frequently need support to run and maintain my home (for example, more than twice each week or a lot of support)	
E	I need support in all aspects of running and maintaining my home (for example, daily)	
How are your support needs currently met? *CONSIDER STRENGTHS/ASSETS - THIS WOULD INCLUDE THINKING ABOUT WHAT RESOURCES THE PERSON CURRENTLY ACCESS (INCLUDING HELP FROM OTHERS, WHOM AND WHEN)*		
DEVELOPING & MAINTAINING FAMILY OR OTHER PERSONAL RELATIONSHIPS		
Please use this section to explain your day-to-day experience of achieving this outcome *EXPLANATION SHOULD ALSO BE GIVEN WHERE THE OUTCOME IS NOT APPLICABLE AND WHY.* *THIS OUTCOME DOMAIN INCLUDES: SOCIALLY ACTIVE; CONSIDERATION OF ANY CARING RESPONSIBILITIES FOR OTHER ADULTS.* *(THIS IS NOT AN EXHAUSTIVE LIST)*		
Please tick		
A	I do not need any support in this area	
B	I need occasional support to help me manage my actions (for example, very little or no more than once a week or verbal prompting)	
C	I often need support to help me manage my actions (for example, several times each week)	
D	I always need support to help me manage my actions (for example, a lot of support)	
How are your support needs currently met? *CONSIDER STRENGTHS/ASSETS - THIS WOULD INCLUDE THINKING ABOUT WHAT RESOURCES THE PERSON CURRENTLY ACCESS (INCLUDING HELP FROM OTHERS, WHOM AND WHEN)*		
ACCESSING & ENGAGING IN WORK, TRAINING, EDUCATION OR VOLUNTEERING		
13.1.25: Please use this section to explain your day-to-day experience of achieving this outcome *EXPLANATION SHOULD ALSO BE GIVEN WHERE THE OUTCOME IS NOT APPLICABLE AND WHY. THIS DOMAIN INCLUDES: LEARNING AT COLLEGE OR IN COMMUNITY SETTINGS; FORMAL VOLUNTEERING WITH A REGISTERED CHARITY OR INFORMALLY ACROSS THE COMMUNITY; PAID AND UNPAID WORK.*		
Please tick		
A	I do not need any support in this area (go to the next area of need)	
B	I need occasional support to work or learn or both (for example, very little or no more than once a week or verbal prompting)	
C	I often need support to work or learn or both (for example, several times each week or supervision or checking)	
D	I would like to work or learn or both and regularly need support to do this (for example, daily or several times a day or lots of support)	
How are your support needs currently met?		

CONSIDER STRENGTHS/ASSETS - THIS WOULD INCLUDE THINKING ABOUT WHAT RESOURCES THE PERSON CURRENTLY ACCESS (INCLUDING HELP FROM OTHERS, WHOM AND WHEN)

ACCESSING COMMUNITY FACILITIES AND SERVICES
Please use this section to explain your day-to-day experience of achieving this outcome *EXPLANATION SHOULD ALSO BE GIVEN WHERE THE OUTCOME IS NOT APPLICABLE AND WHY. THIS OUTCOME DOMAIN INCLUDES: USING THE LOCAL SHOPS; USING THE LIBRARY; MEETING FRIENDS FOR LUNCH; ATTENDING ACTIVITIES AT A COMMUNITY VENUE; GOING TO PLACES OF WORSHIP; CATCHING A BUS; USING THE LEISURE CENTRE.* *(THIS IS NOT AN EXHAUSTIVE LIST)*

Please tick		
A	I do not need any support in this area (go to the next area of need)	
B	I need occasional support to be part of my community (for example, very little or no more than once a week)	
C	I often need some support to be part of my community (for example, up to once a week)	
D	I frequently need support to be part of my community for example, several times a week or a lot of support)	
E	I want to be part of my community and regularly need a lot of support to do this (for example, daily or several times each day)	

How are your support needs currently met? *CONSIDER STRENGTHS/ASSETS - THIS WOULD INCLUDE THINKING ABOUT WHAT RESOURCES THE PERSON CURRENTLY ACCESS (INCLUDING HELP FROM OTHERS, WHOM AND WHEN).*

CARRYING OUT CARING REPONSIBILITIES THE ADULT HAS FOR A CHILD (UNDER 18)
Please use this section to explain your day-to-day experience of achieving this outcome *EXPLANATION SHOULD ALSO BE GIVEN WHERE THE OUTCOME IS NOT APPLICABLE AND WHY. THIS OUTCOME DOMAIN INCLUDES: CARING FOR A CHILD OR A GRANDCHILD. CONSIDER THE NEEDS OF ANY UNBORN CHILDREN/PREGNANCIES.* *(THIS IS NOT AN EXHAUSTIVE LIST)*

Please tick		
A	I am not a carer or a parent of dependent children (go to the next area of need)	
B	I am able to fulfil my caring role/parenting of dependent children without support	
C	I need occasional support with my caring role/parenting of dependent children (for example, at least once a day or supervision or verbal prompting)	
D	I need some support with my caring role/parenting of dependent children (for example, at least once a day or supervision or checking)	
E	I need some support with my caring role/parenting of dependent children (for example, at least once a day or supervision or checking)	
F	I frequently need support with my caring role/parenting of dependent children (for example, several times a day or a lot of support)	

How are your support needs currently met? *CONSIDER STRENGTHS/ASSETS - THIS WOULD INCLUDE THINKING ABOUT WHAT RESOURCES THE PERSON*

CURRENTLY ACCESS (INCLUDING HELP FROM OTHERS, WHOM AND WHEN)	
Is a Referral to Children's Services Required? *IF YES, THE ICART CONTACT WILL ASSIGN TO YOU FOR COMPLETION. PLEASE COMPLETE SECTION 1, SAVE AND EXIT AND THEN REASISGN TO ICART*	Yes / No
CARE ACT 2014 ELIGIBILITY CRITERIA COVERS QUESTIONS 11.1.1 - 11.1.30 IN ADDITION THERE MAY BE OTHER OUTCOME NEEDS OR DETAILS OF THE PERSON'S CURRENT CIRCUMSTANCES WHICH MAY NEED TO BE CAPTURED TO CONSIDER THEIR CARE AND SUPPORT NEEDS.	
ADDITIONAL CONSIDERATIONS AND CIRCUMSTANCES	
Additional Consideration *INCLUDE DETAILS OF NEEDS RELATING TO THE MENTAL HEALTH, DOMESTIC ABUSE, PHYSICAL HEALTH, HOUSING ISSUES, SENSORY IMPAIRMENTS, OR OTHER RELEVANT INFORMATION IN RELATION TO THEIR ABILITY TO LIVE THEIR DAY-TO-DAY LIVES*	
Are there any other people significant to your life, including your care and support, which you would like us to be aware of? *FOR EXAMPLE, OTHER PROFESSIONALS INVOLVED IN YOUR CARE AND SUPPORT; OTHERS OFFERING A HELPING RELATIONSHIP (NOT ALREADY MENTIOED AS CARERS, REPRESENTATIVES, HOUSEHOLD MEMBERS, ETC.); OR COMPANIONS/WIDER FAMILY/FRIENDS WHO THEY WOULD LIKE TO COMMENT ON. PLEASE GIVE DETAILS OF THE PERSON(S) INCLUDING THE NATURE OF THE RELATIONSHIP.*	
Is a DASH (Domestic Abuse, Stalking, Harassment and Honour based violence Assessment Tool) recommended?	Yes / No
WELLBEING THE CARE ACT 2014 DOES NOT DEFINE A PRESCRIPTIVE APPROACH TO WHAT THE CONCEPT OF 'WELLBEING' INCLUDES. WELLBEING SHOULD BE CONSIDERED AS A HOLISTIC APPROACH TO ENHANCING A PERSON'S 'QUALITY OF LIFE'. THE ACT DESCRIBES 'WELLBEING' AS RELATING TO THE FOLLOWING AREAS: • PERSONAL DIGNITY - WHETHER THE PERSON RECEIVES RESPECT • PHYSICAL AND MENTAL HEALTH AND EMOTIONAL WELLBEING • PROTECTION FROM ABUSE OR NEGLECT - SAFEGUARDING • CONTROL BY THE INDIVIDUAL OVER DAY-TO-DAY LIFE (INCLUDING CARE AND SUPPORT PROVIDED AND THE WAY THIS IS PROVIDED) • PARTICIPATING IN WORK, EDUCATION, TRAINING AND RECREATIONAL ACTIVITY • SOCIAL AND ECONOMIC WELLBEING • DOMESTIC, FAMILY AND PERSONAL • SUITABILITY OF LIVING ACCOMMODATION • THE INDIVIDUAL'S CONTRIBUTION TO SOCIETY (CARE ACT 2014 - PART ONE)	
As a consequence of difficulty described throughout Section Seven, and in achieving two or more of the outcomes which constitute Care Act Eligibility (11.1.1 to 11.1.30) is there, or is there likely to be, a significant impact on your wellbeing?	Yes / No

Carers

Do you have any unpaid carers? *A CARER IS SOMEONE WHO SPENDS A SIGNIFICANT PROPORTION OF THEIR TIME PROVIDING UNPAID SUPPORT TO A FAMILY MEMBER, PARTNER OR FRIEND WHO IS ILL, FRAIL, DISABLED OR HAS MENTAL HEALTH OR SUBSTANCE MISUSE PROBLEM. ***CONSIDER THE IMPACT, CONTINUATION & BREAKS AND ANY YOUNG CARERS****	Yes / No
If you have unpaid carers detail who they are	
Has a Carers Assessment been offered?	Yes / No
Has a Young Carers Assessment been offered?	Yes / No

Personal Financial Circumstances

Has an 'Agreement to Pay' form been completed, scanned to ESCR and sent to Finance? (For over 18s only) *IF YES, BY SOMEONE OTHER THAN THE SERVICE USER PLEASE ENSURE THIS IS SOMEONE WITH POWER OF ATTORNEY; AN APPOINTEE; OR A COURT-APPOINTED DEPUTY - AS PER DETAILS CAPTURED IN SECTION TWO. WHERE NO LEGITIMATE FINANCIAL ARRANGEMENTS ARE IN PLACE PLEASE ADVISE THE SERVICE USER THAT THIS WOULD NEED TO BE IN PLACE FOR US TO DICUSS FINANCIAL INFORMATION WITH ANOTHER PERSON.*			
Please tick	No		
	Yes (by another party) supply notes		
	Yes (by service user)		
Notes in relation to 'Agreement to Pay' form.			
Date form signed			
Taking into account your assessed needs your estimated budget calculation is: (required) *PLEASE NOTE THIS AMOUNT IS YOUR ESTIMATED BUDGET. YOUR SUPPORT PLAN WILL DETAIL YOUR ACTUAL BUDGET*			
Taking into account your assessed needs your estimated client contribution is: *IF REQUIRED CALL FINANCE TO OBTAIN CHARGES*			
Have the charges and client contribution estimates been discussed with the service user? (required)	Yes / No		
If the charges and client contributions estimates have not been discussed with the client detail why (required)			

Assessment Outcome

Primary Support Reason Adult Long Term Support (required) *PERFORMANCE MANAGEMENT REQUIREMENT.* ***GUIDANCE NOTE:*** *FOR LONG TERM SUPPORT ONLY 1 PRIMARY SUPPORT REASON (PSR) IS REQUIRED, IF YOU NEED TO END AN EXISTING CLASSIFICATION IT MUST BE ENDED ON THE DAY BEFORE THE NEW ONE STARTS ALTHOUGH PSR MAY BE REPORTED FOR BOTH LTS AND STS, AN IMPORTANT DISTINCTION NEEDS TO BE MADE. PRIMARY SUPPORT REASON (PSR) REPLACES THE CURRENT PRIMARY CLIENT TYPE AND DESCRIBES WHY THE INDIVIDUAL REQUIRES SOCIAL CARE SUPPORT. THE PRIMARY SUPPORT REASON REPORTS FOR LONG TERM SUPPORT (LTS) AND SHORT TERM SUPPORT (STS) SHOULD BE DETERMINED AND AGREED BY SOCIAL CARE TEAMS EACH TIME A NEW ASSESSMENT IS MADE OR A REVIEW TAKES PLACE.* *FOR LTS ONLY ONE PSR, THE PSR AGREED FOR THE INDIVIDUAL CLIENT AT THE POINT OF ASSESSMENT FOR LONG TERM SUPPORT, IS REPORTED. AT BOTH PLANNED AND UNPLANNED REVIEWS OF THEIR LONG TERM SUPPORT THE PSR SHOULD BE REVIEWED. THE PSR MAY OR MAY NOT CHANGE DEPENDING ON THE RESULTS OF THE REASSESSMENT.*					
Lts Learning Disability Support		Lts Mental Health Support		Lts Physical Support - Access and Mobility Only	
Lts Physical Support - Personal Care Support		Lts Sensory Support - For Dual Impairment		Lts Sensory Support - For Hearing Impairment	
Lts Sensory Support - For Visual Impairment		Lts Social Support – Asylum Seeker support		Lts Social Support - Isolation/Other Support	
Lts Social Support – Substance Misuse Support		Lts Support with memory & cognition		Not applicable Short Term PRS only	

Primary Support Reason Adult Short Term Support *FOR SHORT TERM SUPPORT (STS), ONE OR MORE PSRS ARE REPORTED: A PSR IS AGREED FOR EACH EPISODE OF SHORT TERM SUPPORT AT THE POINT OF ASSESSMENT.* *(IF THERE IS ALREADY A CLASSIFICATION LOADED FOR THE STS SUB CLASS YOU HAVE IDENTIFIED, PLEASE CHECK WITH THE WORKER WHO LOADED THE PSR TO ESTABLISH IF THIS IS STILL VALID; IF NO LONGER VALID, THE WORKER SHOULD END THE CLASSIFICATION ON THE DATE THE STS ENDED).*					
Sts Learning Disability Support		Sts Mental Health Support		Sts Physical Support - Access and Mobility Only	
Sts Physical Support - Personal Care Support		Sts Sensory Support - For Dual Impairment		Sts Sensory Support - For Hearing Impairment	
Sts Sensory Support - For Visual Impairment		Sts Social Support – Asylum Seeker support		Sts Social Support - Isolation/Other Support	
Sts Social Support – Substance Misuse Support		Sts Support with memory & cognition			

Reported Health Conditions (required) PERFORMANCE MANAGEMENT REQUIREMENT. **GUIDANCE NOTE:** WHEN ASSESSING A CLIENT, SOCIAL WORK STAFF SHOULD ASK ABOUT ANY RELEVANT LONG-TERM (CHRONIC) REPORTED HEALTH CONDITIONS: IF THE CLIENT (OR CARER) DISCLOSES ANY REPORTED HEALTH CONDITIONS THAT ARE RELEVANT TO THE PROVISION OF CARE, THE SOCIAL WORKER SHOULD THEN ASK IF THESE HAVE BEEN FORMALLY DIAGNOSED BY A HEALTH PROFESSIONAL. IF THE ANSWER IS YES, THE CONDITION SHOULD BE RECORDED. IF NO (I.E. THE CONDITION HASN'T BEEN FORMALLY DIAGNOSED BY A DOCTOR OR HEALTH PROFESSIONAL) THEN IT SHOULD NOT BE RECORDED.					
No Relevant LT Reported Health Conditions		LD – Aspergers Syndrome/High Functioning Autism		LD – Autism Excl Aspergers Syn/High Functioning	
LD – Learning Disability		LD – Other Learning/Development/Intellectual		Mental Health – Dementia	
Mental Health – Other Mental Health Condition		Neurological – Acquired Brain Injury		Neurological – Motor Neurone Disease	
Neurological – Other Long Term Health Condition		Neurological – Parkinson's		Neurological - Stroke	
Physical – Acquired Physical Injury		Physical – Cancer		Physical – Chronic Obstructive Pulmonary Disease	
Physical – Hiv /Aids		Physical – Other Long term Health Condition		Sensory Impairment – Hearing Impaired	
Sensory Impairment – Other Sensory Impaired		Sensory Impairment – Visually Impaired			

Summary of Service User Views
Summary of carer(s) view (if applicable)
Summary of Assessment and Eligibility *THIS SHOULD INCLUDE A BRIEF SUMMARY OF THE ASSESSMENT AND HOW THE SERVICE USER MEETS (OR DOES NOT MEET) THE ELIGIBILITY CRITERIA.*
Are the worker and the service user in agreement?

Proceed to Support plan summary *IF YES THIS WILL ASSIGN TO YOU FOR COMPLETION*	Yes / No	
Eligibility Notification	**Eligible**	
	Not Eligible	

Who needs a copy of the assessment? (including the service user and/or other relevant persons) *PLEASE INCLUDE DETAILS OF WHO NEEDS THE ASSESSMENT, WHY AND OF ANY INFORMATION TO BE REDACTED OR RESTRICTED.*

Select which Administration Team will distribute the Assessment	Complex Care Runcorn Admin	

A NOTIFICATION WILL SENT TO THE SELECTED TEAM FOR ACTION	Complex Care Widnes Admin	
	Hospital Admin	
	Initial Assessment Admin	
	Mental Health Admin	
	Older People Mental Health Admin	
Close the case if not eligible for service? *IF YES, AN END OF WORKER FORM WILL ASSIGN TO YOU FOR COMPLETION*	Yes / No	