

HAFOD CARE ASSOCIATION

NEEDS ASSESSMENT FORM

Name of Applicant:
Address:
Date:

Principal Referring Agency

Name:
Job Title:
Organisation:
Telephone No:
<i>Referring agency only</i> <i>Was this form completed with your client? Yes <input type="checkbox"/> No <input type="checkbox"/></i>

This Needs Assessment contains a series of questions about your support needs. We need to ask them so that we can provide the best possible service to meet your needs.

Please give us as much information as possible. It will only be shared with those people who need to know about it.

NEEDS ASSESSMENT FORM

For each question below, please tick the box which best describes you.

SECTION 1 – GENERAL SUPPORT NEEDS

1. We normally offer support during the day time. We do not offer nursing care and usually offer on average 2 –3 hours support per person per week. However we can offer support on a 12 hour or 24 hour basis in supported housing. Please indicate what would suit your needs?

I need LESS support than 2-3 hours

I need 2 – 3 hours support

I need MORE support

Please give more details:

--

2. Please give details of any additional help you receive.

Person who gives me support (<i>tick as many Boxes as apply to you</i>)	How often I see them
---	----------------------

Social Worker <input type="checkbox"/>	Daily <input type="checkbox"/> 2/3 times a week <input type="checkbox"/> Once a Week <input type="checkbox"/> 1 / 2 times a week <input type="checkbox"/> Less than a Once a Month <input type="checkbox"/> Name: _____ Tel: _____
Nurse <input type="checkbox"/>	Daily <input type="checkbox"/> 2/3 times a week <input type="checkbox"/> Once a Week <input type="checkbox"/> 1 / 2 times a week <input type="checkbox"/> Less than a Once a Month <input type="checkbox"/> Name: _____ Tel: _____
Friend <input type="checkbox"/>	Daily <input type="checkbox"/> 2/3 times a week <input type="checkbox"/> Once a Week <input type="checkbox"/> 1 / 2 times a week <input type="checkbox"/> Less than a Once a Month <input type="checkbox"/> Name: _____ Tel: _____
Psychiatrist <input type="checkbox"/>	Daily <input type="checkbox"/> 2/3 times a week <input type="checkbox"/> Once a Week <input type="checkbox"/> 1 / 2 times a week <input type="checkbox"/> Less than a Once a Month <input type="checkbox"/> Name: _____ Tel: _____

More options:

Person who gives me support (<i>tick as many Boxes as apply to you</i>)	How often I see them					
Psychiatric Nurse <input type="checkbox"/>	Daily <input type="checkbox"/>	2/3 times a week <input type="checkbox"/>	Once a Week <input type="checkbox"/>	1 / 2 times a week <input type="checkbox"/>	Less than a Once a Month <input type="checkbox"/>	Name: _____ Tel: _____
Probation Officer <input type="checkbox"/>	Daily <input type="checkbox"/>	2/3 times a week <input type="checkbox"/>	Once a Week <input type="checkbox"/>	1 / 2 times a week <input type="checkbox"/>	Less than a Once a Month <input type="checkbox"/>	Name: _____ Tel: _____
Volunteer <input type="checkbox"/>	Daily <input type="checkbox"/>	2/3 times a week <input type="checkbox"/>	Once a Week <input type="checkbox"/>	1 / 2 times a week <input type="checkbox"/>	Less than a Once a Month <input type="checkbox"/>	Name: _____ Tel: _____
Network Team <input type="checkbox"/>	Daily <input type="checkbox"/>	2/3 times a week <input type="checkbox"/>	Once a Week <input type="checkbox"/>	1 / 2 times a week <input type="checkbox"/>	Less than a Once a Month <input type="checkbox"/>	Name: _____ Tel: _____

I receive help from the above person(s) with the following:

Help with taking medication
 Help with personal care
 Help with transport and going out
 Counselling
 Befriending

The questions in the following sections are to give us more information about your individual needs.

SECTION 2 – YOUR PHYSICAL HEALTH

1. Do you have an illness or disability which means you need a lot of help with your life?

Never
Sometimes
Most of the time
Always

Please give more details:

2. Do you need any special aids or adaptations to help you move around?

Never Sometimes Most of the time Always

Please give more details:

3. Do you need physical help at night?

Never Sometimes Most of the time Always

Please give more details:

4. Do you need nursing care in relation to your physical health?

Never Sometimes Most of the time Always

Please give more details:

5. Do you always ask for medical help when you think you need it?

Always Most of the time Sometimes Never

Please give more details:

SECTION 3 – YOUR MENTAL HEALTH

1. Do you suffer from mental ill health?

Never Sometimes Most of the time Always

Please give more details:

If the answer to the above question is “never”, you do not need to complete the remainder of this section. Please move to Section 4.

2. Have you been admitted to hospital due to mental ill health?

Never Longer than 5 years ago Within the last 5 years Within the last 12 months

Please give more details:

3. Does your mental ill health affect your ability to cope with daily life?

Never Sometimes Most of the time Always

Please give more details:

4. If you are left alone, do you get depressed or have panic attacks, or any other problems ?

Never Sometimes Most of the time Always

Please give more details:

5. Do you harm yourself or try to harm yourself?

Never Sometimes Most of the time Always

Please give more details:

6. Do you need help at night because of your mental illness?

Never Sometimes Most of the time Always

Please give more details:

7. Do you forget to look after yourself (e.g. have a wash, get something to eat etc.) because of your mental illness?

Never Sometimes Most of the time Always

Please give more details:

8. Do you go to the doctor or speak to your keyworker whenever you need medical help with your mental illness?

Always Most of the time Sometimes Never

Please give more details:

SECTION 4 – YOUR MEDICATION

1. Do you take any medication? If yes, please specify which medication you take and how long you have been taking it.

Never Sometimes Most of the time Always

Please give more details:

If the answer to the above question is “never”, you do not need to complete the remainder of this section. Please move to Section 5.

2. Do you need someone to help you take your medication?

Never Sometimes Most of the time Always

Please give more details:

3. Do you get side effects from your medication which make it difficult for you to cope?

Never Sometimes Most of the time Always

Please give more details:

4. Do you think that your medication helps to control your illness?

Always Most of the time Sometimes Never

Please give more details:

5. Do you forget or omit to take your medication?

Never Sometimes Most of the time Always

Please give more details:

SECTION 5 – SUBSTANCE USAGE

1. Do you have a drinking habit which is difficult to control?

Never Sometimes Most of the time Always

Please give more details:

2. Do you use drugs (other than those prescribed for a physical/mental illness) or solvents?

Never Sometimes Most of the time Always

Please give more details:

3. Are you taking medication to control your substance dependency?

Never Sometimes Most of the time Always

Please give more details:

4. Do you have contact with other people who are substance users?

Never Sometimes Most of the time Always

Please give more details:

5. Are you taking steps to address your substance abuse?

Always Most of the time Sometimes Never

Please give more details:

SECTION 6 – SELF CARE

1. Can you get out of bed without someone assisting you?

Always Most of the time Sometimes Never

Please give more details:

2. Can you wash and dress yourself without someone's help and without being reminded?

Always **Most of the time** **Sometimes** **Never**

Please give more details:

3. Are you able to clean your room and keep it safe (according to agreed Health & Safety standards) without someone's help and without being reminded?

Always **Most of the time** **Sometimes** **Never**

Please give more details:

4. Can you do your personal laundry (clothes/bedlinen) without assistance and without being reminded?

Always **Most of the time** **Sometimes** **Never**

Please give more details:

5. Are you incontinent?

Never **Sometimes** **Most of the time** **Always**

Please give more details:

6. Do you have special dietary needs/allergies/eating disorders which means that you need a special diet?

Never **Sometimes** **Most of the time** **Always**

Please give more details:

7. Can you cook and clean and/or can you keep the kitchen clean after preparing food without assistance/reminding?

Always **Most of the time** **Sometimes** **Never**

Please give more details:

8. Can you shop for yourself without support?

Always **Most of the time** **Sometimes** **Never**

Please give more details:

9. Do you need help with other aspects of your day to day life?

Never **Sometimes** **Most of the time** **Always**

Please give more details:

10. Do you need help to read, write or add things up or deal with official forms?

Never **Sometimes** **Most of the time** **Always**

Please give more details:

SECTION 7 – SINGLE PARENTS

1. Do you need help with issues raised by being a single parent?

Never Sometimes Most of the time Always

Please give more details:

If the answer to the above question is “never”, you do not need to complete the remainder of this section. Please move to Section 8.

2. Do you currently receive any help?

Always Most of the time Sometimes Never

Please give more details:

SECTION 8 – LEAVING CARE FOR THE FIRST TIME

1. Do you need help with the issues by leaving care for the first time?

Never Sometimes Most of the time Always

Please give more details:

SECTION 9 – SEXUAL OR PHYSICAL ABUSE

1. Do you need skilled help and do you have particular support needs because of previous sexual or physical abuse and/or because of your past experiences, would you find it difficult to share with certain people?

Never Sometimes Most of the time Always

Please give more details:

SECTION 10 – REFUGEES (ASYLUM SEEKERS)

1. Do you need help with the issues raised by being a refugee or asylum seeker?

Never Sometimes Most of the time Always

Please give more details:

2. Do you need support because you have communication difficulties, problems caused by cultural differences or have experienced discriminatory behaviour?

Never Sometimes Most of the time Always

Please give more details:

SECTION 11 – YOUR ABILITY TO COPE IN EMERGENCIES/WHEN STAFF OFF DUTY

1. Can you use the telephone without help?

Always **Most of the time** **Sometimes** **Never**

Please give more details:

2. Would you know what to do if there was an emergency in the house (eg fire, flood, gas leak)?

Always **Most of the time** **Sometimes** **Never**

Please give more details:

3. Can you check that everything is switched off and that the house/flat is secure before you go to bed?

Always **Most of the time** **Sometimes** **Never**

Please give more details:

SECTION 12 – GOING OUT INTO THE LOCAL COMMUNITY

1. Do you need someone with you when you go to the doctor, dentist, hospital, etc.,?

Always Most of the time Sometimes Never

Please give more details:

2. Do you need someone with you to go out in familiar and unfamiliar surroundings?

Never Sometimes Most of the time Always

Please give more details:

3. Do you need help in accessing support services and activities?

Never Sometimes Most of the time Always

Please give more details:

SECTION 13 – YOUR FINANCES

1. Do you need help to manage your money?

Never Sometimes Most of the time Always

Please give more details:

SECTION 14 – LIVING IN SHARED HOUSING

You only need to complete this section if you have applied for accommodation which has shared areas. Otherwise, please tick box and move on to Section 15

1. Do you get irritated if you have to share kitchens, bathrooms, lounges, with other people and does this make it difficult for you to control your behaviour?

Never Sometimes Most of the time Always

Please give more details:

2. Do you tend to shut yourself away and not communicate with other people?

Never Sometimes Most of the time Always

Please give more details:

3. Do you find it difficult to share with people from a wide range of backgrounds, abilities and behaviour?

Never **Sometimes** **Most of the time** **Always**

Please give more details:

SECTION 15 – LIVING IN SELF-CONTAINED ACCOMMODATION

You only need to complete this section if you have applied for accommodation which has shared areas. Otherwise, please tick box and move on to Section 16

1. Do you like contact with other people and can you become depressed if you spend too much time alone?

Always **Most of the time** **Sometimes** **Never**

Please give more details:

SECTION 16 – COLLEGE/WORK EXPERIENCE/DAY CARE

This section asks whether you attend a college, day care centre or work experience programme. It also asks a few questions about your daily routine. We need this information so that we can find out when you are usually at home needing support, and when you are usually out.

1. College/work experience/day care

I attend the following (<i>tick as many Boxes as apply</i>)	How often I attend
College <input type="checkbox"/>	Daily <input type="checkbox"/> 2/3 times <input type="checkbox"/> once a <input type="checkbox"/> 1-2 times <input type="checkbox"/> Less <input type="checkbox"/> A week a week a month than Once A mth
Name of College I Attend:	
When I attend College, it is usually	All Day <input type="checkbox"/> Mornings only <input type="checkbox"/> Afternoons only <input type="checkbox"/>
Day Care <input type="checkbox"/>	Daily <input type="checkbox"/> 2/3 times <input type="checkbox"/> once a <input type="checkbox"/> 1-2 times <input type="checkbox"/> Less <input type="checkbox"/> A week a week a month than Once A mth
Name of Care Centre I attend:	
When I attend day care, it is usually	All Day <input type="checkbox"/> Mornings only <input type="checkbox"/> Afternoons only <input type="checkbox"/>
Work Experience <input type="checkbox"/>	Daily <input type="checkbox"/> 2/3 times <input type="checkbox"/> once a <input type="checkbox"/> 1-2 times <input type="checkbox"/> Less <input type="checkbox"/> A week a week a month than Once A mth
Details of work experience	
When I attend work experience, It is usually	All Day <input type="checkbox"/> Mornings only <input type="checkbox"/> Afternoons only <input type="checkbox"/>

2. Daily Routine

- Are you usually at home at the weekend ? Yes/No
- Are you usually at home in the evenings? Yes/No
- If so, would you prefer your Support Worker to be around later? Yes/No
- Do you usually stay up very late at night (*ie after midnight*) Yes/No
- What time do you usually get up?

Before 6am 6am to 9 am 9am to midday After midday

NEEDS ASSESSMENT FORM – SUMMARY

(to be completed by Referring Agency)

Name of Applicant:	
Date of application:	

Please write below any additional comments you wish to make in connection with the above named application. This may include instances where you disagree with the applicant's views. You may detach this page from the rest of needs assessment booklet if you wish.

Signed:		Date:	
Job Title:			
Organisation:			