

HOME CARE SURVEY CLIENT INFORMATION

For each home care client that is administered the HCSM subscales, please record the following information.

Client ID: _____

Survey Date: _____

Home Care Services

Please record the services that the client is currently receiving. This information should come from the Master Client List. Administer only the HCSM service subscales that your agency has selected to measure.

Services Enrolled In		Enrollment Date (Optional)
Case Management (CM)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Grocery Service (GS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Home Health Aide (HHA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Homemaker Service (HM)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Home Delivered Meals Service (MS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Basic Demographics Information

The following demographics information is optional, but please try to complete as much as possible.

Age (in years): |__|_|_|

Gender: Male Female

Ethnicity: White/Caucasian
 Black/African American
 Asian
 American Indian
 Native Hawaiian/Other Pacific Islander
 Other

Of Hispanic origin? Yes No

ADL/IADL Status: _____

Date Measured: _____

Comments: