COUNTY SOCIAL SERVICES
LEVEL 2
OPTIONS COUNSELING

Name:	CSN Client ID#:
Date:	Options Counselor:

Options Counseling: _____ (entering into services and support)
Section Q _____ (nursing home discharge planning)
Care Transitions _____ (discharge from other level of support)

Primary Diagnosis:
Secondary Diagnosis:
Other Diagnoses or conditions:

Currently In:

☐ Hospital – Admission Date: _____ Discharge Date: _____

☐ Nursing Home - Admission Date: _____ Discharge Date: _____

☐ Other : Specify _____

Health Conditions: Overall, how would you rate your physical health?

☐ Excellent	☐ Poor
☐ Good	☐ No Response
☐ Fair	

Presenting Concerns:

Priorities:
1.

2.

3.

Health Care Provider Information:

Who is your Primary Care Provider? ☐ None

Name	Address	Phone
Date of last visit (if known):	Reason:	

Are you seeing any other doctors, such as a psychiatrist, or specialists of any kind?

☐ Yes (list below) ☐ No ☐ Don't know

Name	Specialty	Address	Phone

Comprehensive Assessment

Response Definitions:

No help: Client can perform activity without assistance from another person.
Some help/supervision: Needs physical help, reminders or supervision during part of the activity.
Can't do it at all: Client cannot complete activity without total physical assistance.

Would you say that you need:

		No Help	Some Help/ Supervision	Can't do it at all	Comments
1	**Dressing** (includes getting out clothes and putting them on and fastening them, and putting on shoes.)	☐	☐	☐	
2	**Bathing** (includes running the water, taking the bath or shower and washing all parts of the body, including hair.)	☐	☐	☐	
3	**Eating** (includes eating, drinking from a cup and cutting foods.)	☐	☐	☐	
4	**Transferring** (includes getting in or out of a bed or chair.)	☐	☐	☐	
5	**Toileting** (How well can you manage using the toilet?) (Using the toilet independently includes adjusting clothing, getting to and on the toilet and cleaning one's self. If accidents occur and person manages it alone, count it as independent. If reminders are needed to use the toilet; this counts as some help.)	☐	☐	☐	
6	**Bladder/Bowel Control** (How well can you control your bladder or bowel?) **Would you say you have accidents**: ☐ Never ☐ Occasionally ☐ Often ☐ Always				
7	**Transportation Ability** (includes using local transportation or driving to places beyond walking distance)	☐	☐	☐	

		No Help	Some Help/ Supervision	Can't do it at all	Comments
8	**Prepare Meals** (includes preparing meals for yourself including sandwiches, cooked meals and TV dinners.)	☐	☐	☐	
9	**Light Housekeeping** (includes dusting, vacuuming, sweeping, etc. but not laundry.)	☐	☐	☐	
10	**Telephone Ability** (operates on own initiative; looks up and dials numbers appropriately.)	☐	☐	☐	
11	**Shopping Ability** (Takes care of all shopping needs.)	☐	☐	☐	

12	**Laundry** (does personal laundry completely.)	☐	☐	☐	
13	**Medications** (is responsible in taking medication in correct dosages at correct time.)	☐	☐	☐	
14	**Personal Finances** (manages financial matters independently [budgets, writes checks, pays rent and bills, goes to bank], collects and keeps track of income.)	☐	☐	☐	

Court Committal: ☐ Yes ☐ No	Date in Effect:	County:
Legal Guardian: ☐ Yes ☐ No Name:	Date in Effect:	County:
Legal Conservator: ☐ Yes ☐ No Name:	Date in Effect:	County:
Representative Payee: ☐ Yes ☐ No Name:	Date in Effect:	County:
Power Of Attorney (POA) for Health Care: ☐ Yes ☐ No Name:	Date in Effect:	County:
Power Of Attorney (POA) for Financial: ☐ Yes ☐ No Name:	Date in Effect:	County:
Iowa Physician Order for Scope of Treatment (IPOST): ☐ Yes ☐ No Information:	Date in Effect:	

OUTCOMES ASSESSMENT

Housing : Are you residing in safe, affordable, accessible housing?	☐ Homeless	☐ In Placement	☐ Staying w/friends or family	☐ Housed	Safe? Yes☐ No ☐ Affordable? Yes☐ No ☐ Accessible? Yes☐ No ☐
Medical Care : How often do you see a primary care physician?	☐ Never	☐Less than once a year	☐ Once a year	☐ More than once a year	If never or less than once a year, why?
Employment : Are you successfully employed?	☐ Unemployed	☐ Sheltered Work	☐ Supported Employment	☐ Community Employment	Hourly Wage: $_____ Hours / Week _____
Community Integration : Are you participating in integrated community activities?	☐ Clubs/ Social Groups	☐ Church	☐ Community Activities/Events	☐ Volunteer	☐ Other : describe

Date Referred	
☐ None/closed	Date: _____
☐ Options Counseling	Date: _____
☐ Care Transitions	Date: _____
☐ Elder Abuse Intervention	Date: _____
☐ Family Caregiver	Date: _____
☐ Integrated Health Home	Date: _____
☐ County Social Services	Date: _____
☐ Request denied (must include reasons in Notes Section)	Date: _____
NOTES:	

Has this consumer given verbal consent to share this information with the above program staff? : ☐ Yes ☐ No

Minutes spent on this call/meeting: _____

_____ _____

Signature of Person Completing Form Date

Integrated Care Management Notes: Admitted to CSS Integrated Care Management: ___Yes ___ No

Date Admitted: _____ Case Manager/Service Coordinator Assigned:

_____

Reasons for Not Admitting to CSS Integrated Care Management: