**Virginia Public Guardian & Conservator Program**

**PGP Assessment Form**

**Instructions**

This PGP Assessment Form is available to be used as a client assessment instrument to satisfy the requirements of 22VAC30-70-50.B and Section 3.7 of the contract dated as of July 1, 2022 that operators of a local PGP entered into with DARS, as amended, if applicable. It may be used as the required assessment when a local PGP is unable to obtain a current acceptable assessment from another provider (*e.g*., an MDS from a skilled nursing facility, a DSS prepared UAI from an ALF, or a VIDES & SIS from a CSB overseeing Medicaid waiver services to PGP client’s with an ID or DD Diagnosis). A local PGP may choose to complete a PGP Assessment Form for any client, but is not required to do so if a current acceptable assessment from third-party provider is included in the client’s file. The guardian representative for the client and/or the local PGP Program Director will be responsible for completing this form.

**THIS FORM IS ONLY FOR INTERNAL USE. IT SHOULD NOT BE SHARED WITH ANY OTHER PERSON OR ENTITY PROVIDING SERVICES TO, OR BEING ASKED TO PROVIDE SERVICES TO, A PGP CLIENT.**

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| **Virginia Public Guardian & Conservator Program**  **PGP Assessment Form**  **THIS FORM IS ONLY FOR INTERNAL PGP USE. IT SHOULD NOT BE SHARED WITH ANY OTHER PERSON, ENTITY, OR PROVIDER.** | | | | | |
| Public Guardian/Conservator Program:  Click or tap here to enter text. | | | Assessment Date:  Click or tap to enter a date. | | |
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| **Demographics** | | | | | |
| Name: Click or tap here to enter text. | | Date of Birth: Click or tap to enter a date. | | Gender: Choose an item. | |
| Social Security Number: Click or tap here to enter text. | | | Marital Status: Click or tap here to enter text. | | |
| Address: Click or tap here to enter text. | | | Type of Living Environment: Click or tap here to enter text. | | |
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| **Services Being Received** | | | | | |
| Current Service: Click or tap here to enter text. | | Provider Name: Click or tap here to enter text. | | Frequency: Click or tap here to enter text. | |
| Current Service: Click or tap here to enter text. | | Provider Name: Click or tap here to enter text. | | Frequency: Click or tap here to enter text. | |
| Current Service: Click or tap here to enter text. | | Provider Name: Click or tap here to enter text. | | Frequency: Click or tap here to enter text. | |
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| **Health Insurance** | | | | | |
| Does the client have health insurance? Choose an item.  If “Yes,” list name(s) of the insurance provider(s): Click or tap here to enter text.  Member Number(s): Click or tap here to enter text. | | | | | |
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| **Physical/Mental Health and Substance Abuse** | | | | | |
| Current Medical Diagnosis(es): Click or tap here to enter text. | | | | | |
| Current Medical Treatment Plan (include medications): Click or tap here to enter text. | | | | | |
| Current Physicians and Contact Information: Click or tap here to enter text. | | | | | |
| Current Mental Health Diagnosis(es): Click or tap here to enter text. | | | | | |
| Current Mental Health Treatment Plan (include medications): Click or tap here to enter text. | | | | | |
| Substance Abuse Disorders: Click or tap here to enter text. | | | | | |
| Current Treatment Plan for Substance Abuse (include therapies): Click or tap here to enter text. | | | | | |
| Current Mental Health and Substance Abuse Professionals and Contact Information (*e.g*.,  psychologist, psychiatrist): Click or tap here to enter text. | | | | | |
| Other: (*e.g*., speech, hearing impairments, nutrition, behaviors): Click or tap here to enter text. | | | | | |
| Community Services Board/Behavioral Health Authority (if applicable): Click or tap here to enter text. | | | | | |
| Case Manager/Support Coordinator and Contact Information: Click or tap here to enter text. | | | | | |
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| **Treatment Compliance** | | | | | |
| Medical: Choose an item. | | | Substance Abuse Disorders: Choose an item. | | |
| Mental Health: Choose an item. | | | Other: Choose an item. | | |
| If Noncompliant in any areas listed above, please explain: Click or tap here to enter text. | | | | | |
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| **Hospital Admissions** | | | | | |
| In the past 12 months has the client been admitted to?  Hospital  REACH  Other temporary residential facility (*e.g.,* for alcohol or substance abuse, TBI, or mental health disorder): Click or tap here to enter text. | | | | | |
| Name: Click or tap here to enter text. | Admit Date: Click or tap to enter a date. | | Discharge Date: Click or tap to enter a date. | | Reason: Click or tap here to enter text. |
| Name: Click or tap here to enter text. | Admit Date: Click or tap to enter a date. | | Discharge Date: Click or tap to enter a date. | | Reason: Click or tap here to enter text. |
| Name: Click or tap here to enter text. | Admit Date: Click or tap to enter a date. | | Discharge Date: Click or tap to enter a date. | | Reason: Click or tap here to enter text. |
| Name: Click or tap here to enter text. | Admit Date: Click or tap to enter a date. | | Discharge Date: Click or tap to enter a date. | | Reason: Click or tap here to enter text. |
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| **Psycho-Social Status** | | | | | |
| Behavior Pattern:  Wandering/Passive – Less than weekly  Wandering/Passive – Weekly or more  Abusive/Aggressive/Disruptive – Less than weekly  Abusive/Aggressive/Disruptive – Weekly or more  Comatose  N/A  Describe Inappropriate Behaviors: Click or tap here to enter text. | | | | | |
| Orientation:  Disoriented – Some spheres, some of the time  Disoriented – Some spheres, all the time  Disoriented – All spheres, some of the time  Disoriented – All spheres, all of the time  Comatose  N/A  Spheres Affected: Click or tap here to enter text. | | | | | |
| Current psychiatric or psychological evaluation needed: Choose an item. | | | | | |
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| **Everyday Functioning (may attach documentation)** | | | | | |
| Ambulating: Choose an item. | | | Bathing: Choose an item. | | |
| Dressing: Choose an item. | | | Eating: Choose an item. | | |
| Grooming: Choose an item. | | | Toileting: Choose an item. | | |
| Transferring: Choose an item. | | | Medication Administration: Choose an item. | | |
| Meal Prep: Choose an item. | | | Housekeeping: Choose an item. | | |
| Additional Information (if needed): Click or tap here to enter text. | | | | | |
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| **Family/Friends Contact** | | | | | |
| Are family and/or friends actively involved in the client’s life? Choose an item. | | | | | |
| If “Yes,” list names, relationship, frequency of contact and contact information: Click or tap here to enter text. | | | | | |
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| **Public Guardian Program Summary** | | | | | |
| Public Guardian Program Staff Name and Title: Click or tap here to enter text. | | | | | |
| Public Guardian Program Staff Signature: Click or tap here to enter text. | | | | | |