

(BLANK)
1-11

ACCOMMODATION STATUS

3.1 Client's present address.

Name of Establishment...

No. and road or street...

Borough and District...

12-14

15-18

3.2 Approximate date s/he moved here...

19-24

3.3 a) What type of establishment is this?
(SEE CARD 3.3)

25-26

3.3 b) What agency is the establishment managed by?
(CIRCLE NUMBER OF RESPONSE)

- National Health Service 1
- Social Services Department 2
- Voluntary Organization 3
- Private Agency 4
- Other (specify) 5

27

3.3 c) How many clients live in this establishment? _____

28-30

3.4 a) In total how many care staff work in this establishment?

Full-Time _____ Part-Time _____ Volunteers _____

31-32

33-34

b) How many staff are usually on duty at one time? (incl. Volunteers)

35-36

Night-Time _____ Day-Time _____

37-38

39-40

- c) Are the night staff - (CIRCLE NUMBER OF RESPONSE)
- Waking 1
 - Sleeping-In 2
 - On Call 3
 - Other 4
 - Not Provided 5

41

d) During the day, (6 am to midnight) how many hours are covered by staff? (0 - 18 Hours)

Weekdays _____ Weekends _____

42-43

44-45

79-80

(BLANK)
(1-14)

3.5 Tenure of Client - (CIRCLE NUMBER OF RESPONSE)

- Council Rent 1
- Privately Rented 2
- Board and Lodging 3
- Housing Association 4
- Owner / Occupied 5
- Residential/Nursing Home 6
- Adult fostering 7
- Not Applicable 8

15

- 3.6 a) Amount s/he pays for accommodation per week _____
 b) What services does this payment cover?
 c) Source of payment: Own resources 1
 DHSS 2
 Both 3

16-20

- d) Does client receive housing benefit or rate reduction?
 Yes 1
 No 2

21

- 3.7 Is the accommodation: Furnished 1
 (CIRCLE NUMBER OF RESPONSE) Unfurnished 2

22

3.8 What facilities are available to the client?

| Facility | Whether Available | Number that share |
|-----------------|-------------------|-------------------|
| Bedroom/Bedsit | | |
| Living-room | | |
| Bathroom | | |
| Separate Toilet | | |
| Laundry | | |
| Kitchen | | |
| Other (specify) | | |
| Other (specify) | | |
| Other (specify) | | |

23-25

26-28

29-31

32-34

35-37

38-40

41-43

44-46

47-49

50

- 3.9 Has s/he lived anywhere else over the last twelve months, including short-term hospital stays?
 (CIRCLE ANSWER) Yes No

51

If YES:

| Type of Residence | Approximate Length of Stay |
|-------------------|----------------------------|
| | |

52-54

55-57

58-60

FINANCES

4.1 Is s/he employed - including Sheltered employment or Homeworker schemes? (CIRCLE ANSWER) Yes No

If YES:

a) What type of job is s/he doing...

b) When did s/he start this job...

c) Approximately how much does s/he earn per week...

4.2 Does s/he receive any Social Security Benefits. (SEE CARD 4.2) (CIRCLE ANSWER) Yes No

| Benefit | Amount Per Week | Benefit | Amount Per Week |
|---------|-----------------|---------|-----------------|
| | | | |
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| | | | |

Total Benefit per week =

4.3 Has s/he received any other benefits over the last twelve months? (CIRCLE ANSWER) Yes No

| Benefit | Amount Per Week | Benefit | Amount Per Week |
|---------|-----------------|---------|-----------------|
| | | | |
| | | | |
| | | | |

4.4 Has s/he any other sources of income? (CIRCLE ANSWER) Yes No

If YES:

Approximately how much in total per week _____

4.5 Has s/he have any regular outgoings (excluding housing cost) e.g. H.P., maintenance, or repayment of fines or debts. (CIRCLE ANSWER) Yes No

If YES:

Approximately how much in total per week _____

RECORD IV

(BLANK)

1-14

15

16

17-22

23-27

28

29-33

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35-39

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41-45

46

47-51

79-80

5.1 Has s/he used any of these services over the last month? (SEE CARD 5.1) Yes
No
(CIRCLE ANSWER)

| Name of Establishment | Type and Agency for Establishment | Professional Involvement | Frequency of Attendance | Duration of Attendance | Average Time Per Week | Actual Hours Attended | Travel - Mode/Time Spent | Amount of Charge Made |
|-----------------------|-----------------------------------|--------------------------|-------------------------|------------------------|-----------------------|-----------------------|--------------------------|-----------------------|
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(1. Agency - N.H.S., S.S.D., Voluntary, Private Organization or Other - specify)
(2. Mode of Travel - Transport provided, Public Transport, Taxi, Other - specify)

5.2 Has s/he used any of these services over the last twelve months, not including those already mentioned? (SEE CARD 5.1) (CIRCLE ANSWER) Yes No

| Name of Establishment | Type and Agency for Establishment | Professional Involvement | Period of Use (weeks) | Frequency of Attendance | Duration of Attendance | Average Time Per Week | Actual Hours Attended | Travel - Mode/Time Spent | Amount of Charge Made |
|-----------------------|-----------------------------------|--------------------------|-----------------------|-------------------------|------------------------|-----------------------|-----------------------|--------------------------|-----------------------|
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(1. Agency - N.H.S., S.S.D., Voluntary, Private Organization or Other - specify)
 (2. Mode of Travel - Transport provided, Public Transport, Taxi, Other - specify)

6.1 Has s/he received any domiciliary services during the last month?
 (SEE CARD 6.1) (CIRCLE ANSWER) Yes
No

| Service | Who service is Provided by (see below) | Frequency of Visit | Duration of Visit | Average Time Per Week | Total No. Sharing Service | Amount of Charge Made |
|---------|--|--------------------|-------------------|-----------------------|---------------------------|-----------------------|
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(Service Provided by - N.H.S., S.S.D., Voluntary, Private Organization, or Other - specify)

6.2 Has s/he received any of these services during the last twelve months,
not including those already mentioned? (SEE CARD 6.1) (CIRCLE ANSWER) Yes No

| Service | Who service is Provided by (see below) | Period of Use (weeks) | Frequency of Visit | Duration of Visit | Average Time Per Week | Total No. Sharing Service | Amount of Charge Made |
|---------|--|-----------------------|--------------------|-------------------|-----------------------|---------------------------|-----------------------|
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(Service Provided by - N.H.S., S.S.D., Voluntary, Private or Other - specify)

6.3 Has s/he any aids or adaptations for his/her own use? Yes No
(SEE Card 6.3) (CIRCLE ANSWER)

| Description | Supplier | Paid for by | Cost |
|-------------|----------|-------------|------|
| | | | |
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6.4 Do any friends/neighbours/relatives visit the client, Yes No
or are visited by the client on a regular basis
(CIRCLE ANSWER).

If YES:

| Relationship to Client | Frequency of Visits | Duration of Visits | Average time Per Week | Activity (see below) |
|------------------------|---------------------|--------------------|-----------------------|----------------------|
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(Activities - Shopping, Housework, Providing transport, Personal care, Laundry, Other - specify).

6.5 How many hours have you, as the principal carer, spent with the client (inclusive of travelling time):

- a) Over the last month...
- b) Over the last twelve months...

6.6 How many hours have you spent on other activities related to him/her: (e.g. meetings, finding accommodation, telephone calls, administration, record keeping, visiting relatives, or arranging services.)

- a) Over the last month...
- b) Over the last twelve months...

RECORD V

(BLANK)
1-14

15

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 16-19 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 20-23 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 24-27 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 28-31 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 32-35 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 36-39 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 40-43 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 44-47 |

48

49-53

54-58

59-63

64-68

69-73

5 79-80

RECORD VI
1-14 (BLANK)

15-18

19-22

23-26

27-30

6.7 In working with this client has there been any above average administration or managerial involvement: (SEE CARD 6.7) (CIRCLE ANSWER) Yes No 31

If YES:

a) At what level...

b) Approximately how much time...

6.8 Having described the services that your client receives how satisfied are you with the availability and quality of these provisions? (SEE CARD 6.8) (CIRCLE APPROPRIATE RESPONSE)

a) Psychiatrist...

Availability 1 2 3 4
Quality of Contact 1 2 3 4

32
 33

b) Community Psychiatric Nurse...

Availability 1 2 3 4
Quality of Contact 1 2 3 4

34
 35

c) Field Social Worker...

Availability 1 2 3 4
Quality of Contact 1 2 3 4

36
 37

d) General Practitioner...

Availability 1 2 3 4
Quality of Contact 1 2 3 4

38
 39

e) Other - Specify

Availability 1 2 3 4
Quality of Contact 1 2 3 4

40
 41

f) Other - Specify

Availability 1 2 3 4
Quality of Contact 1 2 3 4

42
 43

g) Other - Specify

Availability 1 2 3 4
Quality of Contact 1 2 3 4

44
 45

6.9 Are there any services which s/he is not receiving that you think are needed? (CIRCLE ANSWER) Yes No

If YES- specify

46

THANK YOU