Adult Foster Care Program Member Safety Assessment

The safety assessment is a thorough examination of significant and observable risk factors to the safety of the member. The assessment helps the MDT to identify and plan for potentially dangerous circumstances that may affect the member's wellbeing. The safety assessment is a section of the Plan of Care that will be reviewed annually and updated upon a significant change in the members status, The Plan of Care will be reviewed, and a copy sent to members Physician, every six months for Level 2 members and annually for Level 1 members.

Members Name _____ Date _____

Others in Attendance _____

Life Skills Check all that applies.

Is the Member able to identify an emergency and response in a way that would ensure their safety? Yes Or No (please provide a brief narrative for all yes responses)

Questions	Answer	Narrative
Dial 911	Yes No	
Clearly state Name	Yes No	
Clearly state phone Number	Yes No	
Clearly state Address	Yes No	
State the nature of emergency	Yes No	
Understand the purpose of the fire alarm	Yes No	
Independent during day hours	Yes No	
Needs verbal prompts during the day	Yes No	
Needs physical assistance during the day	Yes No	
Independent during overnight hours	Yes No	
Needs verbal prompt during overnight	Yes No	

Needs physical assistance during over night	Yes No

Person in Environment

Safety in the home	Answer	Provide a brief narrative for all yes responses
Are you visually impaired?	Yes No	
Is your hearing impaired?	Yes No	
Are you able to ambulate independently?	Yes No	
Do you ever feel unsteady on your feet?	Yes No	
Have you fallen recently?	Yes No	
Are you limiting outings or travel due to fear?	Yes No	
Do you use any adaptive equipment?	Yes No	
Are there modifications to the home?	Yes No	
Are there behavioral/emotional issues that could affect safety?	Yes No	
Would you let strangers into your home?	Yes No	
Are you able to perform simple first aid (burns, abrasions)?	Yes No	
Can you report more acute medical need to the provider?	Yes No	
Would you seek emergency medical help if needed?	Yes No	
Will you follow a doctor's orders?	Yes No	
Do you know what to do if utilities went off?	Yes No	
Would you eat spoiled Food?	Yes No	
Can you answer the phone and accept messages	Yes No	

I-Independent WC-With Cause PA-Physical Assistance C-Cannot NA-Not Applicable

						Narrative
Uses Kitchen supplies	I	WC	PA	C	NA	
Operates Stove	I	WC	PA	C	NA	
Uses Microwave	I	WC	PA	C	NA	
Lock Doors	I	WC	PA	C	Na	
Unlock Doors	I	WC	PA	C	Na	
Uses the washer	I	WC	PA	C	Na	
Safely uses Knives	I	WC	PA	C	Na	
Adjust the water temperature	I	WC	PA	C	Na	

Safety in the Community I-independent S-Supervision D-Dependent on Others NA-Not Applicable

					NARRATIVE
Can Cross at cross walk	I	S	D	NA	
Looks both ways for coming traffic	I	S	D	NA	
Waits for walk sign	I	S	D	NA	
Safely exits a Car	I	S	D	NA	
Uses Sidewalk Appropriately	I	S	D	NA	
Ask for help if lost	I	S	D	NA	
Understands parking lot Traffic	I	S	D	NA	
Uses public Transportation	I	S	D	NA	
Can Walk to Local Stores	I	S	D	NA	
Are you still driving	I	S	D	NA	

How have your driving behavior or in traffic skills changed	I	S	D	NA
Have you had any traffic accidents	I	S	D	NA

Stranger Danger Awareness	Answer	Narrative
Would you talk to strangers?	Yes No	
Would comply with stranger's request?	Yes No	
Do you Carry an ID card?	Yes No	
Would you comply with emergency personal?	Yes No	
Can you make need known/	Yes No	

Emergency Evacuation Plan

Incase of Fire in the Qualified Setting

Primary Exit _____

Secondary Exit _____

Meeting Place _____

Plan for Power Outages

_____

_____

_____

Flood Tornado, Hurricane , Blizard

_____

_____

_____

I Attest to paretic in my safety Assessment. I answered the above questions to the best of my ability. I understand that AFC program will decide based on the answers provided and their observations of my abilities. This determination may change anytime.

Member signature _____ **Date** _____

If Member was unable to participate in this Assessment, please indicate why.

_____

_____

If a member allows another person to answer on their behalf and or has legal guardian, please complete.

Caregiver Name _____

Signature _____

Name Of Guardian _____

Signature _____

Based on the information provided by the Member or their representative, I believe that.

☐ This Person qualifies for up to three hours of alone time in the AFC setting.

☐ This Person does not Qualify for home alone time and can never be left unattended in the AFC setting.

Assessor Name _____

Signature _____Date of Assessment _____