Reset

South Carolina Department of Social Services

FAMILY INDEPENDENCE SELF EVALUATION
ACTIVITIES OF DAILY LIVING

Name: _____ **SSN No.:** _____

Please describe your daily activities in the following areas by checking the appropriate box, circling your response or answering the questions in the space provided. Use additional pages when necessary.

Failure to answer any of these questions may affect the decision regarding your participation in FI work activities.

General Information

1. Please provide us with a brief description of your present condition(s). Describe any physical and/or psychiatric/psychological limitations:

2. Have you been hospitalized in the last 12 months? If so, please list:

Hospital Name	Address	Dates of Admission

3. Please list all doctors you have been referred to or have seen for this condition(s):

Physician's Name	Address	Phone	Specialty

4. Do you take medication for your condition(s)? ❑ Yes ❑ No
Please provide the following:

Medication	Dosage	How Often Taken	Start Date	End Date

If you need help taking medication, please explain:

5. Please indicate any testing that has been performed within the last 12 months: (CT Scan, MRI, stress test, physical/functional capacity evaluation, etc.)

6. Provide us with a detailed description of your daily routine:

7. Do you have family members that depend on you for care? If so, please explain:

8. What time do you get up in the morning? _____ Go to bed? _____
   Have your sleeping habits changed since your condition(s) began? Please explain:

9. Have there been any changes in your ability to care for your personal needs and grooming? Please explain:

10. What kind of job do you think you can do if accommodations were made? Please describe your accommodation needs:

Household Care

1. Have your eating habits changed since your disability began? Please explain:

2. Do you require assistance in preparing your meals? Please explain:

3. What type of housework do you perform? (Please check all that apply)
   ❑ Laundry ❑ Vacuuming ❑ Dusting ❑ Washing Dishes ❑ Mopping ❑ Household Repairs ❑ Lawn Care
   Other: _____
   How often do you do this housework?

   _____

   _____

   Have there been any changes in your ability to care for your household since your disability began? Please explain:

   _____

4. Have you experienced changes in your shopping habits? Please explain:

5. Do you drive? ❑ Yes ❑ No
   Do you take public transportation? ❑ Yes ❑ No
   If you need assistance when you travel, who goes with you and how are you helped?

   Has there been any change in the distance or time you travel? Please explain:

   Has your physician restricted your travel or driving in any way? Please explain:

Interests, Hobbies and Social Activities

1. What kind of interests, hobbies or activities do you participate in? (Please check all that apply)
   ❑ Bowling ❑ Exercising ❑ Fishing ❑ Walking ❑ Knitting ❑ Movies ❑ Swimming ❑ Sewing ❑ Reading
   ❑ Television ❑ Computer ❑ Coaching Sports
   Other: _____
   How often do you do these activities? (Please check one)
   ❑ Daily ❑ Twice A Week ❑ Weekly Approx. time spent:_____
   Have there been any changes in your participation level? Please explain:

2. Are you active with family, church, social or other groups? Please explain:

   How often do you participate in these activities? (Please check one)
   ❑ Daily ❑ Twice A Week ❑ Weekly Other: _____
   What positions/offices do you hold in the club or group?

   Have there been changes in your ability to take part in the above activities since your disability began?
   Please explain:

Signature: _____ Date: _____

INSTRUCTIONS FOR DSS FORM 1247B

Purpose:
DSS Form 1247B may be used as an assessment tool to help determine the individual's ability to participate in FI Work Program activities.

Instructions:
The form should be completed by the FI participant and maintained in the case management file.