INDEPENDENT LIVING SERVICES ASSESSMENT TOOL

Consumer's name:	UCI# :	DOB:
Today's Date	CSC's Name:	ILS requested by:

Status of ILS services (check applicable box)

First time request	**Currently receives**	**Received in the past**
Yes ( ) No ( )	Yes ( ) No ( )	Yes ( ) No ( )
Number of hours#:	Number of hours#:	Number of hours#: Reason for termination:

Living Arrangement (check applicable box)

Lives at family's home ( )	Lives independently ( )	Lives in residential facility ( )
Homeless ( )	Being discharged from hospital ( )	Other ( )
Lives in an apartment ( )	Lives with other consumers ( )	Planning to live independently ( )

Skill levels (check level as appropriate):

Category	**None**	**Some**	**Skilled**	**Not applicable**
Cooking				
Cleaning				
Shopping				
Menu planning				
Meal preparation				
Money management				
Use of public transportation				
Personal Health & Hygiene				
Independent recreation				
Use of medical services				
Access to community resources				
Assist with access to generic resources (IHSS, Medi-Cal, SSI)				
Forensically Involved				

IHSS yes ( ) no ( )	Number of Hours: