Form Approved
OMB No. 0960-0635

FUNCTION REPORT - ADULT - THIRD PARTY

How the disabled person's illnesses, injuries, or conditions limit his/her activities

SECTION A - GENERAL INFORMATION

1. **NAME OF DISABLED PERSON** *(First, Middle, Last)*

2. **YOUR NAME** *(Person completing the form)*	3. **RELATIONSHIP** *(To disabled person)*	4. **DATE** *(Month, Day, Year)*

5. **YOUR DAYTIME TELEPHONE NUMBER** *(If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.)*

( ) – ☐ Your Number ☐ Message Number ☐ None

Area Code *Phone Number*

6. a. How long have you known the disabled person? _____

b. How much time do you spend with the disabled person and what do you do together?

_____

7. a. Where does the disabled person live? *(Check one.)*

☐ House ☐ Apartment ☐ Boarding House ☐ Nursing Home
☐ Shelter ☐ Group Home ☐ Other *(What?)* _____

b. With whom does he/she live? *(Check one.)*

☐ Alone ☐ With Family ☐ With Friends
☐ Other *(Describe relationship.)* _____

SECTION B - INFORMATION ABOUT ILLNESSES, INJURIES, OR CONDITIONS

8. How do this person's illnesses, injuries, or conditions limit his/her ability to work?

_____

_____

_____

SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

9. Describe what the disabled person does from the time he/she wakes up until going to bed.

10. Does this person take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other? ☐ Yes ☐ No

If "YES," for whom does he/she care, and what does he/she do for them?

11. Does he/she take care of pets or other animals? ☐ Yes ☐ No

If "YES," what does he/she do for them?

12. Does anyone help this person care for other people or animals? ☐ Yes ☐ No

If "YES," who helps, and what do they do to help?

13. What was the disabled person able to do before his/her illnesses, injuries, or conditions that he/she can't do now?

14. Do the illnesses, injuries, or conditions affect his/her sleep? ☐ Yes ☐ No

If "YES," how?

15. **PERSONAL CARE** (Check here ☐ if **NO PROBLEM** with personal care.)

a. Explain how the illnesses, injuries, or conditions affect this person's ability to:

Dress

Bathe

Care for hair

Shave

Feed self

Use the toilet

Other

b. Does he/she need any special reminders to take care of personal needs and grooming? ☐ Yes ☐ No

If "YES," what type of help or reminders are needed? _____

_____

c. Does he/she need help or reminders taking medicine? ☐ Yes ☐ No

If "YES," what kind of help does he/she need? _____

_____

16. **MEALS**

a. Does the disabled person prepare his/her own meals? ☐ Yes ☐ No

If "Yes," what kind of food is prepared? (For example, sandwiches, frozen dinners, or complete meals with several courses.) _____

_____

How often does he/she prepare food or meals? (For example, daily, weekly, monthly.)

_____

How long does it take him/her? _____

Any changes in cooking habits since the illness, injuries, or conditions began?

_____

b. If "No," explain why he/she cannot or does not prepare meals. _____

_____

17. **HOUSE AND YARD WORK**

a. List household chores, both indoors and outdoors, that the disabled person is able to do. *(For example, cleaning, laundry, household repairs, ironing, mowing, etc.)*

_____

b. How much time do chores take, and how often does he/she do each of these things?

_____

c. Does he/she need help or encouragement doing these things? ☐ Yes ☐ No

If "YES," what help is needed? _____

d. If the disabled person doesn't do house or yard work, explain why not. _____

_____

18. **GETTING AROUND**

a. How often does this person go outside? _____

If he/she doesn't go out at all, explain why not. _____

_____

b. When going out, how does he/she travel? *(Check all that apply.)*

☐ Walk ☐ Drive a car ☐ Ride in a car ☐ Ride a bicycle

☐ Use public transportation ☐ Other *(Explain)* _____

c. When going out, can he/she go out alone? ☐ Yes ☐ No

If "NO," explain why he/she can't go out alone. _____

_____

d. Does the disabled person drive? ☐ Yes ☐ No

If he/she doesn't drive, explain why not. _____

_____

19. **SHOPPING**

a. If the disabled person does any shopping, does he/she shop: *(Check all that apply.)*

☐ In stores ☐ By phone ☐ By mail ☐ By computer

b. Describe what he/she shops for. _____

_____

c. How often does he/she shop and how long does it take? _____

_____

20. **MONEY**

a. Is he/she able to:

Pay bills	☐ Yes	☐ No	Handle a savings account	☐ Yes	☐ No
Count change	☐ Yes	☐ No	Use a checkbook/money orders	☐ Yes	☐ No

Explain all "NO" answers. _____

_____

b. Has the disabled person's ability to handle money changed since the illnesses, injuries, or conditions began? ☐ Yes ☐ No

If "YES," explain how the ability to handle money has changed. _____

_____

21. **HOBBIES AND INTERESTS**

a. What are his/her hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.) _____

_____

b. How often and how well does he/she do these things? _____

_____

c. Describe any changes in these activities since the illnesses, injuries, or conditions began.

_____

_____

22. **SOCIAL ACTIVITIES**

a. Does the disabled person spend time with others? *(In person, on the phone, on the computer, etc.)* ☐ Yes ☐ No

If "YES," describe the kinds of things he/she does with others. _____

_____

How often does he/she do these things? _____

b. List the places he/she goes on a regular basis. (For example, church, community center, sports events, social groups, etc.) _____

_____

Does he/she need to be reminded to go places? ☐ Yes ☐ No

How often does he/she go and how much does he/she take part? _____

_____

Does he/she need someone to accompany him/her? ☐ Yes ☐ No

c. Does this person have any problems getting along with family, friends, neighbors, or others? ☐ Yes ☐ No

If "YES," explain. _____

_____

d. Describe any changes in social activities since the illnesses, injuries, or conditions began.

_____

_____

SECTION D - INFORMATION ABOUT ABILITIES

23. a. Check any of the following items the disabled person's illnesses, injuries, or conditions affect:

☐ Lifting	☐ Walking	☐ Stair Climbing	☐ Understanding
☐ Squatting	☐ Sitting	☐ Seeing	☐ Following Instructions
☐ Bending	☐ Kneeling	☐ Memory	☐ Using Hands
☐ Standing	☐ Talking	☐ Completing Tasks	☐ Getting Along With Others
☐ Reaching	☐ Hearing	☐ Concentration	

Please explain how his/her illnesses, injuries, or conditions affect each of the items you checked. (For example, he/she can only lift [how many pounds], or he/she can only walk [how far])

_____

_____

_____

b. Is the disabled person: ☐ Right Handed? ☐ Left Handed?

c. How far can he/she walk before needing to stop and rest? _____

If he/she has to rest, how long before he/she can resume walking? _____

_____

d. For how long can the disabled person pay attention? _____

e. Does the disabled person finish what he/she starts? (For example, a conversation, chores, reading, watching a movie.) ☐ Yes ☐ No

f. How well does the disabled person follow written instructions? (For example, a recipe.)

_____

g. How well does the disabled person follow spoken instructions? _____

_____

h. How well does the disabled person get along with authority figures? (For example, police, bosses, landlords or teachers.) _____

_____

i. Has he/she ever been fired or laid off from a job because of problems getting along with other people? ☐ Yes ☐ No

If "YES," please explain. _____

_____

If "YES," please give name of employer. _____

j. How well does the disabled person handle stress? _____

_____

k. How well does he/she handle changes in routine? _____

_____

l. Have you noticed any unusual behavior or fears in the disabled person? ☐ Yes ☐ No

If "YES," please explain. _____

_____

24. Does the disabled person use any of the following? *(Check all that apply.)*

☐ Crutches ☐ Cane ☐ Hearing Aid
☐ Walker ☐ Brace/Splint ☐ Glasses/Contact Lenses
☐ Wheelchair ☐ Artificial Limb ☐ Artificial Voice Box
☐ Other *(Explain)* _____

Which of these were prescribed by a doctor? _____

_____

When was it prescribed? _____

_____

When does this person need to use these aids? _____

_____

25. Does the disabled person currently take any medicines for his/her illnesses, injuries, or conditions? ☐ Yes ☐ No

If "YES," do any of the medicines cause side effects? ☐ Yes ☐ No

If "YES," please explain. (Do not list all of the medicines that the disabled person takes. List only the medicines that cause side effects for the disabled person.)

NAME OF MEDICINE	SIDE EFFECTS PERSON HAS

SECTION E - REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are done with this section (or if you didn't have anything to add), be sure to complete the fields at the bottom of this page.

Name of person completing this form (Please print)	Date *(month, day, year)*
Address (Number and Street)	Email address (optional)
City	State / Zip Code