Chapter 2

Intake, Screening, and Face Sheet

As the King of Hearts told Alice in Wonderland, the best course is usually to begin at the beginning. This advice is as appropriate for social work record keeping as for telling a story. Just as excellent social work begins with good intake and screening, so an excellent case record begins with careful documentation of those steps using good tools. This chapter will discuss the Adult Services Intake/Inquiry Information Tool and the Face Sheet as tools for recording the intake process and for maintaining an up-to-date summary of relevant information about the client in the front of the record. Thus, it covers both the beginning of the Family Assessment and Change Process and the beginning of the physical client record.

The Social Work behind the Record

A Model for Excellence in Adult Services Administration and Social Work Practice makes seven key points about excellent intake social workers. These points are transformed below to describe the process rather than the worker. Excellent intake and screening:

- require as much or more skill and experience as other social work tasks
- require understanding of the difficulties inherent in asking for and receiving help
- use interviewing skills, awareness of cultural diversity and how it shapes communication, and ability to focus the potential client's attention on the problem at hand while allowing expression of associated emotion
- use consistent methods to see whether the agency has appropriate help to offer the potential client
- require a working knowledge of the agency's resources and a familiarity with eligibility guidelines
- are based on good relationships with other human services providers within the community and knowledge of their missions
- call for deft handling of diverse short-term cases as well as the ability to turn them over readily to other workers for longer-term interventions (based on pp. 62–63).

A Model for Excellence also says that intake social workers are to the DSS what emergency room doctors are to a hospital (p. 54). In other words, their work is demanding, unpredictable, and essential. Like every other social worker in the DSS, the intake worker, or the social worker taking a turn doing intake, has more important things to think about than paper work. Nevertheless, getting the paper work right is an essential part of intake and screening because it provides the foundation on which the case record is built.

An Overview of the Tools and Their Use

This chapter will present two tools, "Adult Services Intake/Inquiry Information" and "Face Sheet." They were developed especially to support the *Model* and, thus, good social work practice at the Intake/Screening stage. You will need to use your social work judgment about the order in which information on these two tools is collected. Does the interviewee need to talk

about the problem immediately, or will asking the "easy questions" on the Face Sheet (such as client's name, address, and phone number) help break the ice? In general, we recommend waiting to collect this descriptive information (other than the potential client's name and some identifier such as date of birth or social security number) until you have some understanding of the problem and consider it likely that a case will be opened or an application taken. However, in practice, you will usually have both tools in front of you, moving back and forth between them according to the flow of conversation with the client or family member. Although you will often work on these two tools at the same time, we will present them separately to avoid confusion.

The Intake/Inquiry Tool

Why Is This Tool Important?

The Intake/Inquiry Tool serves several purposes. It is a screening tool, a log for short-term cases, and a preassessment resource for ongoing ones. Let's look briefly at each of these three purposes.

Screening

A Model for Excellence defines screenings as "brief and generally standardized procedures for identifying variables and risk factors that indicate the need for referral and help identify the level at which any service intervention should begin" (p. 58). In a loose sense, every time you conduct an intake interview and refer the case to a social worker in some specific service area for assessment, you have performed a type of screening. You have sifted through the intake information and made a brief preliminary assessment that suggests that the client should be seen by a placement worker, or an in-home services worker, or a social worker who deals with payee cases. The thing that is missing from this type of informal screening is standardization. If you are relying entirely on sorting out the information in your head, you may not be making consistent choices from client to client or from day to day. Documenting your findings in a structured way, using the Intake/Inquiry Tool adds an element of consistency while still leaving you room to be flexible in your approach.

Cases Handled at Intake

Many of the people who come into or call a county DSS and talk to a social worker will not become ongoing DSS clients. They may be looking for services that are provided by another agency and will be referred accordingly, or they may be looking for short-term help for an emergency situation and will receive the assistance they want in a single interaction. For these cases, the Intake/Inquiry Tool is important because it represents all or most of the documentation the agency collects about these visits. If the client returns, it is useful to have a record of previous visits. Aside from giving you a starting point for the interview, information about past visits will help you spot underlying chronic problems that may be generating periodic emergencies or crises.

Background for the Assessment

For those cases which will not be handled in a single contact, you may be the social worker obtaining the intake information but will not be, or need not be, the social worker who follows up on that case. Therefore, it is particularly vital that you record information in a clear, concise, and organized way on the Intake/Inquiry Tool so that the next worker will have a sound basis for continuing. This demonstrates not only courtesy for colleagues, but also respect for the client, who may find it annoying, embarrassing, or painful to keep repeating the same information. Sometimes filling out the tool may actually help ease anxieties for the client or his representative by giving a structure in which to explain the problem and giving the two of you a shared task.

Information on the Intake/Inquiry Tool con-

tinues to be useful long after the initial interview. It is invaluable in evaluating long-term outcomes for clients by providing baseline information about the reasons the client or family initially contacted the DSS.

Adult Protective Services

We ***do not*** recommend the Adult Services Intake/Inquiry tool for documenting APS reports. Although some agencies have experimented successfully with using it for this purpose, it was not designed for recording the specific information required in taking such a report. We recommend that APS workers continue to use the tool their agencies have been using for APS reports.

Using the Adult Services Intake/Inquiry Tool

With the exception of APS, we recommend using this tool for everyone who comes to the DSS to ask about any adult services. It may also serve as a telephone inquiry tool. Agencies may elect to keep this tool (or its electronic equivalent) filed separately for phone-in and walk-in cases, or for cases that are opened versus those which are handled entirely at intake.

The Intake/Inquiry Information Tool focuses on the presenting problem and on the client's role in the initial contact with your DSS. It provides space to record any initial information about the client's functional abilities you might learn in the intake interview and a checklist for documenting interview outcomes. It also gives you space to record any information needed to prepare the social worker who first visits the client for potential risks or dangers suggested by the initial interview.

The order of items on the Intake/Inquiry tool itself is designed to convey information logically, but the intake interview need not, *and probably should not*, be completed in that order. When you do intake, you are probably accustomed to using some general lead in, after introductions, such as, "And what did you want to talk to me about, Mrs. X?" or "What can I help you with?" The answer may spontaneously yield information about that person's relationship to the potential client, about his expectations, as well as the presenting problem and information about the client's functional status. Pages 17 and 18 show a sample of the tool completed with information from a hypothetical case. Let's examine that example, section by section.

Identifying Information

The level of detail you record in the identifying information section of this tool will depend on your agency's requirements and how the filing system in your agency is set up. You will want to record enough unique information to identify a recurring short-term client if your agency is using this tool as an inquiry log. In cases you open, on the other hand, you will only need enough information so that if this tool becomes separated from the record, you will be able to refile it without difficulty. These are the purposes of the identifying information on this tool. The Face Sheet (discussed later) is the place where your colleagues and supervisors will look for demographic information on the client.

Type of Contact/Other Person(s) Involved

In the next section you have space to record the type of contact (e.g., office visit or phone call) and who was involved in the initial interview other than the client. The case example given here, "Mrs. Johnson," shows that her son, Robert W. Johnson, made the initial contact. In most cases you will want to include everyone involved in the initial contact or referral, which might mean more than one category is checked, or more than one name is listed in the same category, or both. Notice that referrals from a physician, facility, or other agency can be documented on this tool as easily as an inquiry from family or friends.

Client's Level of Involvement

In most cases you will best be able to record the "client's level of involvement" checklist at the end of the interview. It will quickly be apparent

whether or not the client is present, but it may take some time to see if a client accompanied by family members will participate in the interview. Similarly, if the client is not present, information about whether the client knows about the visit may come out slowly in the conversation.

You will want to use the checklist in the way that makes the most sense to you and the colleagues who will receive intake information from you. However, we will share our own thoughts about the meanings of these categories. If the client only says "hello" and signs things when the social worker or the family member requests a signature, most of us would check "client was present but did not participate." However, if the client had any involvement in the conversation, even if coaxed, most of us would check "present and participating." If the client participated, but some of the conversation seemed unrelated to the topic or events at hand, so that we had doubts about her or his understanding, we would still check "present and participating," but we would also make a note under preliminary mental health information (on the back) that the client seemed confused or did not always seem to answer questions appropriately.

If the client did not participate, it may help you or the person who takes the case if you describe and explain this. For example, we might record that the client was "silent, but cried during the interview," or "showed flat affect," or "talked to herself but not to social worker." If we had a clear impression that the client was attentive even though not talking, we would record that.

As you can see from these examples, we generally find it more useful to record behavior than our initial guesses about the cause of the behavior. In many cases, we are unable to distinguish between shy, depressed, or sullenly angry in one brief meeting. If that is all of the evidence we have, we feel safer writing, "client looked at the floor through the entire interview" than writing "client seemed angry" or "client seemed very shy."

We would only check the "client not present, but desires referral/contact" response when the family member or other person making the contact said something that explicitly reflected the client's own desire. For example, "My mother asked me to come down here for her to see if we could get some help," or "My parishioner, Mr. Smith, heard about your home-delivered meals program and asked me to find out whether he might be able to get into that," or "We talked to my brother about the possibility of a job in a sheltered workshop, and he seemed to like the idea."

If it was less clear that the client wanted this involvement with the DSS, but it *was* clear that he or she was aware that the interview was taking place, we would check "client not present, but aware of referral/contact." For most of us, this response does not imply that the client opposes the inquiry, but only that there is no clear information that it is wanted. In the example for Mrs. Johnson, the "client unaware of contact" category is checked with the elaboration that the son did not want the client to know. While the social worker doing the intake interview with Mr. Johnson might have inferred that the reason for this is because the son is interested in placement and knows the mother does not want to be placed, she chose not to record that because the son did not make it explicit.

Presenting Problem and Additional History

The "presenting problem" is perhaps the most important screening question of the intake documentation because it is the basis for your decisions about whether the DSS can help the client, whether the case can be handled at intake, and who within the DSS will be assigned to this case if it goes beyond intake. Further, it is often in eliciting the presenting problem and beginning to reframe problems and discover strengths that the intake social worker begins building the professional relationship that will help clients achieve their goals.

According to *A Model for Excellence*, excellent social workers begin building this relationship by (1) recognizing how difficult it may be for clients to ask for help; (2) using empathic

Adult Services Intake/Inquiry Information

Use for all adult services intakes except APS referrals.

Client's name *Mary Foster Johnson* Date *1/23/95*

If assigned: Case # *95-10019* ID # *18937485368*

Date of Birth *11/23/17* Social Security Number *223-66-6080*

Type of contact

- [x] Office visit
- [ ] Phone call
- [ ] Home intake
- [ ] Other: _____

Persons other than client involved in initial referral/contact: (check all that apply)

- [ ] Family member(s) *Robert W. Johnson*
- [ ] Neighbor(s)/friend(s) _____
- [ ] Physician _____
- [ ] Agency _____
- [ ] Facility _____
- [ ] Other: _____

Client's level of involvement in referral/contact:

- [ ] client was present and participating
- [ ] client not present, but desires referral/contact
- [ ] client not present, but aware of referral/contact
- [ ] client was present but did not participate (explain) _____
- [x] client unaware of contact (explain) *Son initially did not want Mrs. F. to know of visit*
- [ ] uncertain (e.g. telephone contact) _____

Presenting problem(s) *Mr. Johnson is worried that his mother is becoming forgetful. He has found the stove left on more than once. He says he is afraid for her to be by herself and wants to know "what it would take" to put her in a nursing home. He also says she won't want to go.*

Additional history (duration/efforts/outcomes) *Family has noticed problem for several months. Precipitating event over weekend—Mr. Johnson found empty pan smolgering on a burner. He and his wife decided they had to act.*

Expectation of person(s) at intake interview, including services requested *Initially expected placement without client's consent. Now understands that client must consent to placement unless incompetent or incapacitated. Is willing to explore other solutions as well.*

Urgent?

- [ ] Yes
- [x] No

Preliminary information in functional domains

Social *Widow, lives alone. Son and daughter-in-law and 3 grandchildren (2 in teens), live about 5 miles away. Close relationships, frequent visits and phone calls, but son shows some stress about his role. Elderly sister in town. The sisters are not talking due to an argument shortly after Mrs. J's husband's funeral. She no longer visits with neighbors.*

DSS-6218 (8-1-94)
Adult Services

Environmental

Mental health *Son suspects dementia (says she is getting "senile"). She has never been evaluated for this.*

Physical health *Generally good health, but has arthritis. Son doesn't think Mrs. J. has seen a doctor for a long time.*

ADL/IADL *Has been "doing for herself," but son doesn't think she keeps her house or her person as neat as she once did. son or daughter-in-law take her to the store and help with other errands.*

Economic *Social Security is only income son knows about. Amount not known.*

DISPOSITION (check all that apply)

- ☒ Opened case/accepted referral (specify) *Social worker will do assessment*
- ☐ Wrote/phoned referral to other agency (specify) _____
- ☐ Advised of food stamp program
- ☒ Advised of Medicaid application procedure
- ☐ FL-2 given
- ☐ Application for eye exam
- ☐ Application for transportation
- ☐ Application for fuel assistance
- ☐ Other:
- ☐ Application for emergency financial assistance
- ☐ Application for senior nutrition/home-delivered meals
- ☐ Family planning information
- ☒ Explained other DSS services (specify) *Placement, in-home aide, adult day care, APS*
- ☐ Bus ticket provided
- ☐ Closed/handled at intake
- ☐ Unable to assist client (reason) _____

Did anything during the initial interview suggest that the client may live in an environment dangerous to the social worker visiting? (Check all that apply and explain below.) Be sure to note dangers in the directions to home section of the face sheet.

- ☐ Dangerous neighborhood
- ☐ Violence in home
- ☐ Other:
- ☐ Guns/weapons in home
- ☐ Biting dog/other dangerous pets
- ☐ Drug use/transactions in home

Describe (include source of information and impression of the seriousness of the danger)

Additional comments (if needed) *Told Mr. Johnson that a social worker would call his mother and ask for an appointment. Suggested that he make her aware of this visit before that call. Got his permission to tell his mother that he was worried about her safety.*

Intake social worker's signature *Yolanda Nicely*

listening to elicit the problem; and (3) demonstrating genuineness through sincere and respectful responses to the client (p. 55). Clients sometimes ask for a specific service because that is easier (less personal, less emotional, less likely to seem to them like an admission of failure) than talking about the underlying problem. It will often take your best diplomacy to sincerely convey your respect for the client's right to ask for and receive a service for which he is eligible, while making it clear that you may be able to help him find better, richer alternatives if you have a fuller understanding of his problems and strengths.

In recording the presenting problem, you will probably find it useful to reflect the views of the client or the person you are interviewing on the client's behalf, rather than writing a social work summary using professional jargon. The nuances of these words may help convey information to colleagues not only about the nature of the perceived problem, but also about the emotional connotations and the preferred or expected solutions. For example, "We don't know what we're going to do with Mama when she comes home from the hospital" conveys a very different message from "I'm here to find out what it would take to put my Mother in a nursing home" even though both cases may ultimately involve choices among similar sets of service options. The "additional history" section gives you a place to document any relevant background information you want to note about the problem, such as how long it has been going on, why the person decided to try to get help now, what has been tried in the past, and how that worked, as well as how the client, family, or friends have been coping with the situation. It is also important to consider and document strengths here and under the domains, in order to begin developing a hopeful and positive viewpoint about the perceived problem. This information will help both the client and the next social worker plan a strategy that builds on past successes and avoids old pitfalls.

Expectations of Person(s) at Intake Interview/Urgency

This gives you space to document exactly what the client or his representative wants you to do about the situation, *whether or not you believe the DSS can or should meet that expectation.* Some people will have very specific ideas such as "My mother is going to be thrown out of the rest home where she lives because she throws things at the aides. You have to find another place that will take her by Friday," while others may be less focused, "You've just got to do something to help my neighbor!"

Sometimes the person's expectations might change in the course of the interview. For example, a person seeking in-home aide services as a form of respite might become interested in adult day care when the intake worker talks about it among the possible service options. Similarly, on the sample tool, the son who at first wants placement for his mother without her consent comes to understand that such an action is not permitted while his mother is competent and that the real problem may be solved with much less drastic action. If such changes occur during the intake interview, it may be helpful to record both the initial and modified expectations as shown in the example.

In this same section there is a space to record whether or not the need is urgent. We designed this for use in emergencies where, for the safety or essential well-being of the client, some service or intervention must be put in place immediately. Counties or individual work groups within county agencies may want to develop guidelines for what constitutes such an emergency.

Preliminary Information Gathered in Functional Domains

If information about the client's social, environmental, mental, physical, ADL/IADL, or economic functioning emerges from the interview, it can be recorded under the appropriate domain. How much or little the intake worker documents in this section will vary with the nature of the case, the knowledge of the person(s) present at the intake

interview, and the agency's or personal expectations about the thoroughness of intake.

A slight knowledge of all or most of the domains is often helpful in screening for the most appropriate social worker or unit to handle the case. When clients or their representatives are seeking a specific service, a more focused effort may be needed in some domains. For example, for a client seeking in-home services the intake social worker will probably want to document ADL/IADL functioning in some detail. On the other hand, these questions might or might not come up in conversation with someone applying for fuel assistance.

In the example, the nature of Mrs. Johnson's problem has led her intake worker to ask about all of these domains to help decide who should be assigned to make the home assessment visit. Thus, most of the domains have a few notes recorded. Although the nature of the environment is important to a case like Mrs. Johnson's, the son had nothing very helpful to say about that subject, and the intake social worker in this example simply drew a line to indicate that she had nothing significant to document in this area. (She could equally well have written "N/A" or just left it blank, according to her own style.)

Disposition

The disposition section is the place to summarize the outcome of the inquiry or intake. You may be documenting a single outcome such as "wrote/phoned referral to other agency," but in most cases you will have more than one action to document at this point. For example, in the sample case the social worker used the disposition box to indicate that she has opened the case and that she has explained specific DSS services—placement, in-home aide services, and APS. She explained about protective services to Mrs. Johnson's son in order to show him that, even though she understood his concerns, people with capacity to consent cannot be placed against their will. (In cases such as this one, it may be almost as important to explain the services for which the client will not qualify as those for which she might.) The worker also documented here that she advised the son how to apply for Medicaid for his mother.

If a person came in to ask for fuel assistance, by contrast, this same social worker might simply record some identifying information, and check "Case handled/closed at intake." If she had any documentation requirements to show eligibility, she could write them under the appropriate domain or in the additional comments section. In such a case, this tool would constitute all of her documentation for the case.

Potential Dangers

Sometimes, when you are interviewing clients or family members, you will learn something about the client, home, family, or neighborhood that could pose a threat to the social worker's health or safety. This tool gives you a place to alert your colleagues or remind yourself to take appropriate precautions when visiting the client for the first time. We are not suggesting that you run down this checklist at the interview, but only that you record any potentially dangerous situations you can anticipate. In the example here, there was nothing said that alerted the social worker of any health or safety problems, so she left this section blank. Another option would be to record "none noted" to let the next social worker know that this had been thought about.

Final Touches

The additional comments section gives you a place to include anything that is not covered in the other sections of the tool that you think it is important to document. In our sample case, the client does not know about her son's visit. Therefore, the social worker tells the son that she (or another social worker, depending on agency policy), will contact the mother and, if she is willing, make an appointment for an assessment visit. She asks him to set the stage by talking to his mother about why he came to the DSS today. She then uses the additional comments block to record what she told the son. Remember that this series of tools was designed to replace dictation or narrative, so include anything here that you

have not already covered that you would have thought it important to document if you were still doing dictation.

The Face Sheet

Why a Face Sheet?

The "Face Sheet" is for you and your colleagues. It goes in the very front of the record, and gives you a quick, easy-to-find listing of the information you will need to use over and over again both in your paperwork and in reaching the client, family, or collateral contacts. If you are sick or on vacation, the worker covering your cases will know exactly where to find this information.

It is for use with all of your adult services cases, including those referred for an adult protective services evaluation. You will begin collecting the information for it at intake and will add to it and modify it as you learn more about the client or as key information changes. If the case is transferred, an up-to-date Face Sheet can be especially helpful to the new worker.

Using the Face Sheet

Because the Face Sheet is for your reference and that of your colleagues, you will find it more useful if it is filled out as completely and legibly as possible. It is not a static document, so you will modify it as changes occur or you learn more information. This will be much easier if your tools are automated or if you have adequate clerical staff to have someone retype the sheet whenever it needs updating. At the time this guide is being written, many social workers will be using correction fluid or tape rather than automation to keep the tool readable for as long as possible. The time and energy you save by having a clear Face Sheet should make the effort of updating worthwhile, even if you have to copy the information over to a new tool from time to time.

The example on pages 23 and 24 shows the face sheet with the information that the intake social worker learned in her initial interview with Mr. Johnson. Remember that she was recording this information and the intake/inquiry information at the same time during the interview.

Client Identifying Information

The face sheet has room for two identified clients. Depending on your agency's policy, you may want to maintain a single record for a family with two adult DSS clients. In such a case, identifying and demographic information on both can be recorded on these first two lines.

Strictly speaking, there are several equally valid ways to report client characteristics. For example, you could code sex with a "W" for woman or an "F" for female. While it is not important which choice is made, it is helpful to those reading paper records, and *vital* to those compiling computer records, that everyone in the agency use the same codes. That way your supervisor or a colleague using your record will not have to stop and wonder whether entry of "S" under marital status means "single" or "separated." For that reason, we have given you suggested codes for recording this information on the Face Sheet. As in every other part of the record-keeping process, you can choose to use this space differently. However, if your agency automates records in the future, you and your supervisors will be very glad if all adult services social workers have been entering information the same way.

Recommended Codes:

- Report the client's sex with the single initial F (female) or M (male)
- Record race, too, using a single letter code for the same categories used on the SIS forms:
  - W = White/Caucasian
  - B = Black/African American
  - H = Hispanic
  - I = American Indian/Alaskan Native
  - A = Asian/Pacific Islander
  - U = Unknown
- Date of birth is reported in standard

month/day/year format.

- Report marital status using the following:
  - M = Married
  - N = Never married/single
  - W = Widowed
  - D = Divorced
  - S = Separated
  - O = Other (e.g., cohabitation)
- Under "education completed," you will see that the social worker in our example recorded "H.S. diploma," rather than 12th grade. Either way of recording would work fine, but this choice emphasizes that certain completion points are more important than single grade level.

Under the demographic data is space to record the client's complete address, phone number(s), and directions to the residence. If you are the social worker assigned to the case, you will want to update the address, phone number, and directions quickly when they change, in case someone else has to reach your client in your absence. It is also useful to document whether the address is a facility, even if it seems obvious to you. You may know that Roseview Manor is a home for the aged, but it may sound like an apartment complex to some of your colleagues.

The block for directions to client's residence may also be used to document other things a visitor should know. For example you might use this space to record that the client speaks Spanish and only understands a little English or that she is slightly deaf. If some potential danger was identified at the intake interview, it would be helpful to document that here. In the example, the intake worker has recorded a note about which door the client uses. You can probably think of other helpful examples from your own cases. Often the social worker who makes the assessment visit will have additional instructions to add after the first visit. Notice that there is room for more comments on the back if you need the space.

Directory of Contacts

The space for an emergency contact person's name, address, and phone number appear directly below the directions block, followed by sections for others in the client's household, significant others not in the client's household, and, on the back, professional contacts.

The emergency contact person is the first person to call in an emergency. In the example, Mr. Johnson suggested himself as that person at the intake interview. (If Mrs. Johnson expresses a different wish at the time of the assessment, her social worker will change the information on the tool.) If the emergency contact person lives in the home, you will want to indicate that in some way, without taking the unnecessary trouble of entering the information twice.

For each person living in the client's household, the tool provides space to document the year of birth, relationship to client, and daytime phone (if it is different from the client's phone number listed above). The reason many social workers choose to document the year of birth is to provide a stable indicator of the age of the person, for example, whether a niece living with the client is a child or an adult. An approximate year, or even a notation such as "child," "young adult," or "elderly" may be an equally useful way to accomplish the same thing. Since Mrs. Johnson, in our example, lives alone, there are no entries in this section.

Other important personal contacts can be listed under "significant others not in household." Notice in the case example that Mr. Johnson remembered his Aunt Dorothy's number, but he did not know his mother's neighbors' number, though he told the social worker that they were once close to his mother. She recorded their names as a prompt to get the neighbors' number from Mrs. Johnson.

Professional contacts can be documented on the back of the face sheet. This section may be used to record information about people with whom the client is involved prior to coming to the DSS, but it may also include professionals you contact in the course of working with the

Case # 95-10019
ID # 18937485368

Face Sheet

(begun at intake, continued at assessment, updated as necessary)

Client name(s)	Sex	Race	DOB	Marital Status	Education completed	Social Security #
Mary Foster Johnson	*F*	*B*	*11/23/17*	*W*	*H.S. grad.*	*223-66-6080*

Address *1411 Bonnie Meadow Road*

City *Kudzu,* State *NC* Zip *27519*

Is this address a facility? Yes (No)
If yes, level of care:

Client's phone number(s): *(919)960-0304*

Directions to client's residence/potential dangers/other notes:

Take Main Street west to 1st traffic light past Plantation Acres Shopping Center. Turn Left on Bragg Ave. Go 0.3 miles and turn right on Bonnie Meadow. Go 2 Blocks—1411 is one-story brick house on right. Number on mailbox.

Go to front door—not door closest to driveway.

Emergency Contact: *Robert W. Johnson* Relationship to client: *Son*

address *1066 Morning Glory Circle*
Kudzu, NC 27517

Phone number(s):
(919) 907-0357 (home)
906-0000(work)

Others in client's household (or significant persons in group settings)

Name	Year of Birth	Relationship to Client	Daytime Phone

Significant others not in client's household

Name	Relationship	Address	Phone(s)
Dorothy Smith	*Sister*	*5711 Fritters Way, #10* *Kudzu, NC 27517*	*(919) 967-7345*
Mr. and Mrs. Elmer Rigsbee	*Neighbors (once close)*	*?? Bonnie Meadow Road* *Kudzu, NC 27517*	*??*

Notes/Comments:

Professional contacts

Name	Professio	Address	Phone

Medicaid # MQB	Medicare # A B
Medicaid Worker	Phone/ext.
Other IM CaseWorker	Phone/ext.
Is client/spouse a veteran? Yes (No)	
Private Insurance: Yes No	Type(s): Medical Long Term Care Life Burial
Insurance information:	
Advance directives/ living will/ burial arrangements:	
Does the client have a guardian, payee, or a person with power of attorney? If yes, complete below.	

Name	status	Phone number(s)
address		
Name	status	Phone number(s)
address		

History of services requested/received:

Notes ***(Counties may wish to identify additional information to be recorded here.)***

client if you or your colleagues may need to call them again. Professionals who might be listed here are doctor(s) (e.g., general practitioner and heart specialist), an in-home aide, a dentist, a psychologist, or a contact in a home care agency. You might choose to list the client's clergyman as a professional contact or a personal one, depending on his/her relationship with the client and involvement in the case.

Insurance and Legal Information

If you want to record insurance and legal information in a handy place for quick reference, the remainder of the face sheet provides space. In the example, Mr. Johnson did not know very much about his mother's affairs. He didn't think she had Medicaid, but he wasn't sure. He knew she had Medicare, but did not know her number or if she had both parts A and B. He knew she was not a veteran. He was pretty sure she had some kind of insurance, but he wasn't sure what kind exactly.

Like the social worker in the example, you will probably want to wait to record this information when you can get it from the client herself or some very reliable source.

The remainder of this section asks whether the client has a legal guardian, a payee, or a person with power of attorney. It leaves space to record two such relationships. The space marked "status" after each name is designed for describing which role the person holds, such as "health care power of attorney" or "guardian of the person," or "payee."

In our example, Mr. Johnson was unaware of any such legal arrangements by Mrs. Johnson or on her behalf, and the space was left blank. The social worker who completes the assessment will update the Face Sheet including information on Medicare, Medicaid, insurance, and advance directives.

The tool ends with a space to record services that Mrs. Johnson has now, has had in the past, or has applied for, as well as additional space for comments. Some agencies, supervisors, or individual social workers may identify other specific information that they want to keep on every face sheet. In such cases, the final comments section provides a spot for documenting these additions.

Frequently Asked Questions

Question: Do I need to fill out every space on the Intake/Inquiry tool?

Answer: No. All of the tools are meant to help support your good practice. That means that you will use your best social work judgment to decide what is and is not helpful on all the tools. You do not have to fill out "every space for every case" on any tool.

On the Intake/Inquiry tool, especially, there are several sections that will not be relevant or useful in every case. For example you will be unlikely to gather information about all the functional domains for a client who only requests a bus ticket, though you might make a note about the clients' financial status under the economic domain.

Question: Do I need to complete an Intake/Inquiry tool for everybody who comes into the office about an adult client? What about phone inquiries?

Answer: This is a decision for each agency to make. Ask your supervisor what your DSS has decided. We recommend that agencies try using this tool for both walk-ins and telephone calls. This does not mean that we think you should record a phone call in which someone just asks the phone number for the senior center, nor that you should fill out every question on the tool when using it for referrals or for cases handled at intake (see the question above).

Question: Why do I need to record whether the client was there and whether/how much the

client participated in the intake interview?
Answer: The first reason is to help reinforce the focus on the client as a vital part of good adult services social work practice. The second is to cue the social worker who performs the assessment (or remind yourself) about the client's knowledge and feelings. You or your colleague will begin your home visit very differently with a client who actively sought your services than you will with one who expressed anger, fear, or reluctance, or with a client who did not seem to understand what the intake interview was about.

Question: In the client information on the Face Sheet, why do you use 'B" for Black instead of 'A" for African American? Why do you use 'N" for never married instead of 'S" for single?
Answer: There is a short answer and a long answer. The short answer is because we needed "A" for Asian under race, and we needed "S" for separated under marital status, but there is more to it than that. We used the same racial/ethnic categories found on the SIS form so that you will not have to use two different ways of classifying this information. We say "Black" instead of "African American" and "American Indian" instead of "Native American," because that is how it appears on SIS.

Otherwise the choices were fairly arbitrary, though they are based, in part, on customary use. What is important is that all social workers in the same agency fill out the Face Sheet in the same way so they can easily understand each other's work. We would also like social workers in different agencies to use the same codes, so that Adult Programs Representatives and other state DSS personnel will be able to move more easily among county systems. If, at some time in the future, all systems are fully automated, this practice will also make it easier to combine data across regions or the state.

Question: Why is there a Face Sheet? I thought we didn't have to use Face Sheets anymore.
Answer: While nothing in this package of record-keeping tools is mandatory, we highly recommend the Face Sheet because we think it helps social workers and supervisors by putting often-needed information in an easy-to-find spot. Several counties that stopped using the Face Sheet for a while went back to it for that reason.

Question: You mean we don't have to do any dictation/narrative at all?
Answer: Everything is recorded on one of the tools. However, every tool has space for comments or notes. Anything that you think is important that is not covered by the tool itself can be added here. We don't want you to give up the kinds of notes that were most useful to you in dictation. We just want to streamline the process. In most cases this will eliminate the need for dictation/narrative.

Key Points

- Good social work record keeping begins with well-documented screening and intake.
- In most cases, the intake social worker will work on the Intake/Inquiry tool and the Face Sheet information simultaneously.
- Clear, concise information on these tools demonstrates courtesy for colleagues and empowers clients.
- The purpose of a Face Sheet is to provide often-needed information in an easy-to-find place. It is only as useful as it is legible, accurate, and up-to-date.