

2025

UNIVERSAL ASSESSMENT TOOL – SHORT FORM



Transforming the way West Virginians
access long-term services and supports.

TABLE OF CONTENTS

Universal Assessment Tool	2
A. Assessment Information	2
B. Contact Information	3
C. Demographics	4
D. Identification Information	5
E. Housing Information	7
F. Health Coverage	8
G. Finances.....	9
H. Functional Needs	10
I. Disability and Medical Status.....	12
J. Informal Supports and Caregivers.....	14
References	15

UNIVERSAL ASSESSMENT TOOL

Throughout this assessment, please note that an “individual” refers to the person seeking services.

A. ASSESSMENT INFORMATION

1. **Assessment date:**

2. **Name of staff person completing the assessment:**

3. **Who is providing the information for the assessment?**

3a. **If other, please specify:**

3b. **If someone other than the individual is providing information for this assessment, is the individual aware that the assessment is taking place?**

Yes No

4. **Is the individual a caregiver seeking respite or other supports?**

Yes

If yes: COMPLETE Sections A-G, SKIP Section H: Functional Needs, and COMPLETE Sections I-J.

No

If no: CONTINUE to Question 5.

5. **Assessment setting:**

5a. **If other, please specify:**

6. **Type of assessment:**

6a. If other, please specify:

7. What is the individual's goal in seeking services? What are they looking for?

8. Has the individual attempted to obtain services from other organizations?

Yes No

8a. If yes, what is the status of those services?

B. CONTACT INFORMATION

9. First name:

10. Middle initial:

11. Last name:

12. Social Security number:

13. Medicare number (if applicable):

14. Medicaid number (if applicable):

15. Primary telephone number:

15a. Please specify the type of phone:

15b. If other, please specify:

16. Secondary telephone number:

16a. Please specify the type of phone:

16b. If other, please specify:

17. Address:

17a. Residential address:

17b. County of residence:

17c. Mailing address (if different than residential address):

18. Email address:

19. How does the individual typically access the internet?

19a. If other, please specify:

C. DEMOGRAPHICS

20. Date of birth:

21. Gender:

22. Race:

23. Ethnicity:

24. Marital status:

25. Primary language:

26. Language or communication needs:

26a. Does the individual require an interpreter to communicate with staff?

Yes No

26a. If yes, which language?

26b. Is the individual hearing impaired?

Yes No

26c. Does the individual use sign language, gestures, or a device to communicate?

Yes No

26d. Is the individual able to understand basic communication?

Yes No

26e. Is the individual able to express needs, wants, and daily routines?

Yes No

27. Education:

28. Current school status:

29. Is the individual eligible for Individualized Education Programs (IEPs)?

Yes No

30. Military service (Select all that apply):

Military service	Mark "X" if applicable
Currently serving	<input type="checkbox"/>
Veteran	<input type="checkbox"/>
Disabled veteran	<input type="checkbox"/>
Enrolled in the VA health system	<input type="checkbox"/>

D. IDENTIFICATION INFORMATION

31. Does the individual have proof of citizenship (i.e., a U.S. Passport, Certificate of Naturalization, Certificate of Citizenship, documentation from a federally-recognized Indian tribe, birth certificate, final adoption decree, evidence of civil service employment, an official military record of service, or U.S. census records)?

Yes No

31a. If yes, specify which document(s):

32. Does the individual have proof of West Virginia residency (e.g., utility bill, rental agreement, or property deed)?

Yes No

32a. If yes, specify which document(s):

33. Does the individual have a Social Security card?

Yes No

34. Does the individual have proof of identity (e.g., driver's license, school identification card with a photograph, identification card issued by the federal, state, or local government, or U.S. military card or draft record)?

Yes No

34a. If yes, specify which document(s):

35. Emergency contact or primary caregiver information:

35a. Name(s):

35b. Phone number(s):

35c. Relationship(s) with the individual:

36. Does the individual have a legal representative, legal guardian, conservator, healthcare surrogate, power of attorney (POA), durable power of attorney (DPOA), medical power of attorney (MPOA), or authorized representative?

Yes No

36a. If yes, name(s):

36b. If yes, phone number(s):

36c. If yes, relationship(s) with the Individual:

E. HOUSING INFORMATION

37. Does the individual currently reside in a community setting (e.g., individual or family home, adult foster care, group home) or an institutional setting (e.g., nursing home, rehabilitation facility, psychiatric hospital)?

If “Institutional setting” is selected, SKIP to Question 41.

38. In which community setting does the individual currently reside?

38a. If other, please specify:

39. Who does the individual currently live with? (Select all that apply.)

Currently living with:	Mark “X” if applicable
Alone	<input type="checkbox"/>
With spouse	<input type="checkbox"/>
With child	<input type="checkbox"/>
With parent	<input type="checkbox"/>
With sibling	<input type="checkbox"/>
With friend	<input type="checkbox"/>
With significant Other	<input type="checkbox"/>
With other residents	<input type="checkbox"/>

40. How many people live in the household (including the individual)?

If the individual resides in a community setting, SKIP to [Section F: Health Coverage](#).

41. In which institutional setting does the individual currently reside?

41a. If other, please specify:

42. How many days has the individual resided in the institutional setting selected in Question 41 during this current stay?

F. HEALTH COVERAGE

43. Does the individual have a primary care provider?

- Yes No

43a. If yes, primary care provider name:

44. What type(s) of health insurance does the individual have? (Select all that apply.)

Health insurance and coverage	Mark "X" if applicable
Medicare Part A	<input type="checkbox"/>
Medicare Part B	<input type="checkbox"/>
Medicare Part C/Medicare Advantage	<input type="checkbox"/>
Medicare Supplement Insurance/Medigap	<input type="checkbox"/>
Medicare - Unknown	<input type="checkbox"/>
Medicaid (MA)	<input type="checkbox"/>
Medicaid application pending	<input type="checkbox"/>
Veterans health care program	<input type="checkbox"/>
Tricare	<input type="checkbox"/>
Marketplace health insurance <ul style="list-style-type: none"> • CareSource WV • Highmark WV 	<input type="checkbox"/>
Employer sponsored health insurance	<input type="checkbox"/>
Other private insurance	<input type="checkbox"/> If selected, specify below: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Health insurance and coverage	Mark "X" if applicable
Other public insurance	<input type="checkbox"/> If selected, specify below: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
No health insurance	<input type="checkbox"/>

45. What is the individual's Medicaid status? (Select all that apply.)

Medicaid status	Mark "X" if applicable
Non-Medicaid	<input type="checkbox"/>
Medicaid applicant	<input type="checkbox"/>
Waiver applicant	<input type="checkbox"/>
Medicaid eligible only	<input type="checkbox"/>
Waiver eligible	<input type="checkbox"/>

46. Has the individual ever applied for or received Medicaid in the past?

Yes No

G. FINANCES

47. What are the individual's current income and benefits sources? (Select all that apply.)

Income source	Mark "X" if applicable
Social Security	<input type="checkbox"/>
VA pension	<input type="checkbox"/>
Other pension (e.g., private, government)	<input type="checkbox"/>
Division of Coal Mine Workers' Compensation (DCMWC) (Black lung benefits)	<input type="checkbox"/>
Supplemental Security Income (SSI)	<input type="checkbox"/>
Social Security Disability Insurance (SSDI)	<input type="checkbox"/>
Temporary Assistance for Needy Families (TANF) program, WV WORKS	<input type="checkbox"/>
United Mine Workers of America (UMWA) benefits	<input type="checkbox"/>
Oil and gas leases	<input type="checkbox"/>
Paid employment	<input type="checkbox"/>
Other source	<input type="checkbox"/>
No income	<input type="checkbox"/>

47a. If “Other source” is selected, please specify:

48. What is the total monthly income of the individual (before any deductions)?

48a. What is the total monthly income of the household (before any deductions) (if different than above)?

49. What are the total financial assets of the individual?

49a. What are the total financial assets of the couple (if married)?

50. Does the individual own their own home?

Yes No

50a. If yes, what is the value of the home?

H. FUNCTIONAL NEEDS

If the individual is a caregiver seeking respite or other supports, SKIP this section and CONTINUE to [Section I: Disability and Medical Status](#).

51. Does the individual require assistance with completing the following activities of daily living (ADLs)?

Activities of daily living	Requires assistance?		
	Yes	Some assistance needed	No
<p>Bathing</p> <p>The ability to take a full-body shower, bath, or sponge bath for the purpose of maintaining adequate hygiene. This includes transfers in and out of the shower or tub and drying oneself. This excludes washing hair and washing the back.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Dressing</p> <p>The ability to dress and undress as necessary. This includes the ability to put on and remove prostheses, braces, anti-embolism hose, or other assistive devices and includes fine motor coordination for buttons and zippers. This includes choosing appropriate clothing for the weather. Difficulties with a zipper or buttons located on the back of a dress or blouse do not constitute a functional deficit.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Eating</p> <p>The ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew, and swallow food.</p> <p>Note: If the individual is fed via tube feedings or intravenously, mark “No” if they can do so independently, or mark “Yes” if they require another person to assist.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Grooming/Personal hygiene</p> <p>The ability to wash and dry the face, wash and dry the hands, brush teeth, shave, apply makeup, hair care (including combing/brushing hair, shampooing, applying conditioner, and drying hair), and nail care (including fingernail and toenail care).</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Moving around the home and community</p> <p>The ability to move between locations in the individual’s living environment inside and outside the home.</p> <p>Note: Assess the individual’s mobility without regard to the use of equipment other than the use of prosthesis.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activities of daily living	Requires assistance?		
	Yes	Some assistance needed	No
<p>Transferring</p> <p>The physical ability to move between surfaces: from bed/chair to wheelchair, walker, or standing position; the ability to get in and out of bed or usual sleeping place; the ability to use assisted devices, including properly functioning prosthetics, for transfers. This excludes transferring to/from the shower, bath, or toilet, and dressing.</p> <p>Note: Assess the individual’s ability to transfer without regard to the use of equipment.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Toileting</p> <p>The ability to use the toilet, commode, bedpan, or urinal. This includes transferring on/off the toilet, cleansing of self, changing of pad, changing of apparel, managing an ostomy or catheter, and adjusting clothing.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I. DISABILITY AND MEDICAL STATUS

52. Does the individual have the following disability or medical statuses? (Select all that apply.)

Disability or medical status	Mark “X” if applicable	(If applicable) Is medical documentation provided? Mark “X” if yes.
Developmental disability	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual disability	<input type="checkbox"/>	<input type="checkbox"/>
Physical disability	<input type="checkbox"/> If selected, note if a wheelchair, walker, or other assistive device is used: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/>
Military service-connected disability	<input type="checkbox"/>	<input type="checkbox"/>

Disability or medical status	Mark "X" if applicable	(If applicable) Is medical documentation provided? Mark "X" if yes.
Mental, behavioral, or emotional health	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease and related dementias	<input type="checkbox"/>	<input type="checkbox"/>
Substance use disorder	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic brain injury	<input type="checkbox"/>	<input type="checkbox"/>
Spinal cord injury	<input type="checkbox"/>	<input type="checkbox"/>
Blind or visually impaired	<input type="checkbox"/>	<input type="checkbox"/>
Deaf or hard of hearing	<input type="checkbox"/>	<input type="checkbox"/>
Other chronic disabilities or chronic health issues	<input type="checkbox"/> If selected, specify below: <input type="text"/>	<input type="checkbox"/>
Other major medical conditions	<input type="checkbox"/> If selected, specify below: <input type="text"/>	<input type="checkbox"/>

53. Does the individual meet any of the following levels of care? (Select all that apply.)

Level of care	Mark "X" if applicable
Meets hospital level of care	<input type="checkbox"/>
Meets nursing facility level of care	<input type="checkbox"/>
Meets psychiatric facility level of care	<input type="checkbox"/>
Meets Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care	<input type="checkbox"/>

54. Does the individual receive hospice services?

Yes No

55. Does the individual report any health intervention needs? (Select all that apply.)

Health intervention	Mark "X" if applicable
Assistive technology or home modifications or other products that increase, maintain, or improve functional capabilities such as medical devices, speech recognition software, hearing aids, etc.	<input type="checkbox"/> If selected, specify below <input type="text"/>
Other	<input type="checkbox"/> If selected, specify below: <input type="text"/>

J. INFORMAL SUPPORTS AND CAREGIVERS

56. Does the care recipient have any informal supports or caregivers (i.e., people who provide routine and/or incidental assistance without receiving payment)?
If the individual seeking services is a caregiver, mark "Yes."

Yes

If yes: COMPLETE the remaining questions.

No

If no: SKIP the remaining questions.

57. Is the care recipient a Veteran, or is the care recipient currently serving in the military?

58. What is the caregiver's relationship to the care recipient?

59. Is the caregiver paid/compensated for any caregiving activities provided to the care recipient?

Yes No

59a. If yes, please describe:

REFERENCES

1. [Bridging Resources Needs Questionnaire](#)
2. [MnCHOICES Assessment Content](#)
3. [Colorado LTC Level of Care Eligibility Assessment](#)
4. [Maine Medical Eligibility Determination \(MED\) Background Information](#)
5. [California Pre-Pilot Testing of a Universal Assessment for California’s Home- and Community-Based Services](#)
6. [West Virginia BOSS SAEF](#)
7. [Patient Health Questionnaire \(PHQ-9\)](#)
8. [Centers for Medicare & Medicaid Services \(CMS\) Accountable Health Communities Health-Related Social Needs Screening Tool](#)
9. [Three-Item UCLA Loneliness Scale](#)
10. [Virginia Uniform Assessment Instrument](#)