Cambridgeshire County Council

SOC311 (revised Mar 07)

SOCIAL CARE ASSESSMENT (LEVEL TWO)

1.0 SERVICE USER DETAILS

Surname:	**Title:**
First Name(s)	**DOB:**
	Gender M ☐ F ☐
Address:	**Religion:**
	Ethnicity:
Postcode:	
Tel No(s):	**SWIFT ID**
	Date of Assessment:

2.0 GP DETAILS

Name:	**Tel No:**
Surgery Address:	

3.0 NEXT OF KIN OR NEAREST RELATIVE UNDER MENTAL HEALTH ACT

NB: Are the services of an IMCA required under the Mental Capacity Act 2005? If so, use SOC 1708 form (Assessment of Capacity)

Title:	**Relationship:**
Name:	
Address:	**Tel No(s):**
Postcode:	

4.0 ACCOMMODATION TYPE

e.g. Privately owned; rented; housing association; other

5.0 OTHER KEY PROFESSIONALS INVOLVED

Give name, position and contact details

6.0 PARENTAL RESPONSIBILITY

6.1 Are there children living in this household? Yes ☐ No ☐

Details (e.g. number, age, gender, relationship to disabled adult)

6.2 How is the child / children affected by the illness or disability?

6.3 Is extra support with parenting responsibilities required?

6.4 Is referral to a Young Carers Project appropriate? Discuss with parent and Young Carer,

Note for Assessor – consider child welfare issues

7.0 OTHER INFORMATION

7.1 Relevant Medical/Surgical/Nursing History and Current Health or Disability Issues (including diagnosis if known)

7.2 Medication currently used

7.3 Does the service user take charge of their own medication?
Yes ☐ No ☐

7.3 Equipment / Adaptations currently provided

7.4 Other relevant background information
Topics may reflect both past and present experiences e.g. occupations; critical life events; interests; hobbies; accomplishments;

8.0 RECORD OF ASSESSMENT (Assessor to use SOC303 checklist as prompt)

Current Situation	Consequent Needs

9.0 ELIGIBILITY CRITERIA MATRIX SCORES (Needs Types A to F)

The score to be recorded against each of the 6 needs types is the highest degree of risk for that type of need.

A ☐ **B** ☐ **C** ☐ **D** ☐ **E** ☐ **F** ☐

10.0 CARE OBJECTIVES AND CARE PLAN

In this section we set out how your care needs are addressed. If you require services resulting from the assessment, and you are in agreement with this outcome, details of the services you will receive and who will provide them will be sent to you separately.

10.1 List the Care Objectives. How will desired/required outcomes be achieved? Relate Care Objectives to the identified areas of need contained in the assessment.

10.2 Service User comments and preferences.

10.3 CARE PLAN. List the services required to meet care objectives and record frequency. Include Direct Payments and I.L.F. where appropriate.

11.0 FURTHER ACTION NEEDED

Please state if any further assessment relating to the service user's needs is required recording the specific agency/professional and the date actioned.

12.0 CARER IDENTIFICATION

	Yes	No
12.1 Does the service user have an identified Carer? (Family or Informal Carers)	☐	☐
If No → Go to Service User Information and Signature 16.0		

If Yes → Complete Carer Basic Details 13.0
Other Notes on Carer Identification and Role

13.0 CARER'S BASIC DETAILS

Surname:	**Forename(s):**
Address:	**Title:**
Postcode:	**DOB:**
Tel No(s):	**Email:**
Relationship to the cared for person:	**Ethnic Category:**
Main language:	**Interpreter required?**

14.0
Is the Carer willing/able to continue in their caring role? Yes ☐ No ☐

If 'No' → ensure Care Plan is adjusted to reflect Carer's wishes

If the Carer provides 'regular and substantial' care, have they been advised of their right to have a Carers Assessment, and encouraged to do so Yes ☐ No ☐
Carers Assessment Agreed Yes ☐ No ☐

15.0
If a Carers Assessment is agreed, confirm a time and method, transfer Carer and Cared –for Basic Details above to one of the following

- **SOC 1629 (Carer's Assessment/Short Assessment form)**
- **SOC 1474 (Carer's Assessment/Re-Assessment form)**
- **SOC 1474 (SA)(Carer's Assessment/Self-Assessment form)**
- **Parent Carer Assessment (for service users aged (16-19)**

Ensure Carers Assessment is recorded on SWIFT, including where Assessment is declined

Note to Care Manager/Assessor: what follows is very important service user information. Please ensure you explain each of the points fully and that you give him/her a copy of leaflet C1 Charging Policy.

16.0 SERVICE USER INFORMATION AND SIGNATURE

There may be a charge for your services in accordance with Social Services Charging Policy (see leaflet C1). If applicable, a separate assessment of your finances will be necessary to determine what you will pay for your services and you will be invoiced for your assessed charge.

Your carer, if applicable, will also be asked if they wish to give their own view of the situation and, if so, whether they or not they wish to do so in private.

You will be given a typed copy of your assessment and have the opportunity to agree to its contents.

If you are offered permanent residential care services you, or your representative, will be asked to sign a separate financial declaration which will be explained to you.

Please read this next section very carefully and only sign if you are completely happy to do so. If there is anything you do not understand, please ask.

As part of the assessment process, I am willing for information relevant to my care needs to be requested from, and shared with, caring agencies and health care professionals involved in providing my care. **YES** ☐ **NO** ☐

I am interested in receiving a Direct Payment or Independent Living Fund, if appropriate, as an option to meeting my care needs. **YES** ☐ **NO** ☐

I have been informed about the Social Services Charging Policy and have been given leaflet C1. I understand that I will be invoiced for my assessed charge where applicable.

YES ☐ **NO** ☐

I have been told about the Social Services Complaints and Representations Procedure.

YES ☐ **NO** ☐

SIGNED ....SERVICE USER)*

Print Name: .... DATE: ....

*** if unable to sign, note and give reason**

SIGNED ....(CARER) (if appropriate)

Print Name: .... DATE: ....

17.0 SERVICE USER AGREEMENT TO CONTENTS OF ASSESSMENT

This section to be sent to service user or their representative when the assessment is completed.

I acknowledge receipt of my assessment of needs YES ☐ NO ☐

I understand and accept the results of my assessment. What has been recorded is an accurate statement of my social care needs. YES ☐ NO ☐

Comments: ....

....

....

Signature .... **Service User / Carer**
(Delete as appropriate)

Print Name ....

Date ....

For Office Use Only:

Care Manager / Assessor :
Signature: .... Date : ....

Print Name: .... Date: ....

Job Title: ....

Team: ....

Manager's Authorisation
Signature: .... Date: ....

Print Name: ....

Job Title: ....

APPENDIX A
This page may contain sensitive or confidential information and should not be sent to any Provider

WELFARE BENEFITS

Service User NI number………………………………………………………

Please record the **WEEKLY AMOUNT** of each benefit received, or enter **' A'** if applied for.

ATTENDANCE ALLOWANCE	£
BEREAVEMENT ALLOWANCE	£
CARERS ALLOWANCE	£
CHILD BENEFIT	£
CHILD TAX CREDIT	£
CONSTANT ATTENDANCE ALLOWANCE (paid with War Disablement Pension or Industrial Disablement Benefit	£
COUNCIL TAX BENEFIT	£
DISABILITY LIVING ALLOWANCE – CARE COMPONENT	£
DISABILITY LIVING ALLOWANCE – MOBILITY COMPONENT	£
GUARDIAN'S ALLOWANCE	£
HOUSING BENEFIT	£
INCAPACITY BENEFIT	£
INCOME SUPPORT	£
INDUSTRIAL DEATH BENEFIT	£
JOB SEEKERS ALLOWANCE	£
MATERNITY ALLOWANCE	£
PENSION CREDIT – GUARANTEE CREDIT	£
PENSION CREDIT – SAVINGS CREDIT	£
RETIREMENT PENSION	£
SEVERE DISABLEMENT ALLOWANCE	£
WAR DISABLEMENT PENSION	£
WAR PENSIONERS MOBILITY SUPPLEMENT	£
WAR WIDOWS PENSION	£
WAR WIDOWS SPECIAL PAYMENT	£
WIDOWED PARENTS ALLOWANCE	£
WIDOWS PENSION	£
WORKING TAX CREDIT	£

Completed by: Name…………………………………………..Team……………………………

Signature…………………………………   Date……………………….