

## Craig Handicap Assessment and Reporting Technique Short Form (CHART-SF)

Name: \_\_\_\_\_

\* Record Date: \_\_\_\_\_

Division: \_\_\_\_\_

Care Start Date: \_\_\_\_\_

\* Care Type: \_\_\_\_\_

\* Score Type: \_\_\_\_\_

Score: \_\_\_\_\_

### PHYSICAL INDEPENDENCE

Score: \_\_\_\_\_

**People with disabilities often need assistance. We would like to differentiate between personal care for physical disabilities and supervision for cognitive problems. First, focus on physical "hands on" assistance: This includes help with eating, grooming, bathing, dressing, management of a ventilator or other equipment, transfers, etc. Keeping in mind these daily activities...**

- \* 1. How many hours in a typical 24-hour day do you have someone with you to provide physical assistance for personal care activities such as eating, bathing, dressing, toileting, and mobility?

\* ☐ Hours Paid Assistance

\* ☐ Hours Unpaid (Family, Others)

### COGNITIVE INDEPENDENCE

Score: \_\_\_\_\_

**Now, focus on supervision for cognitive problems instead of physical assistance. This includes remembering, decision-making, judgment, etc.**

2. How much time is someone with you in your home to assist you with activities that require remembering, decision-making, or judgment?
- ☐ Someone else is always with me to observe or supervise.
  - ☐ Someone else is always around, but they only check on me now and then.
  - ☐ Sometimes I am left alone for an hour or two.
  - ☐ Sometimes I am left alone for most of the day.
  - ☐ I have been left alone all day and all night, but someone checks in on me.
  - ☐ I am left alone without anyone checking on me.
3. How much of the time is someone with you to help you with remembering, decision-making, or judgment when you go away from your home?
- ☐ I am restricted from leaving, even with someone else.
  - ☐ Someone is always with me to help with remembering, decision-making or judgment when I go anywhere.
  - ☐ I go to places on my own as long as they are familiar.
  - ☐ I do not need help going anywhere.

### MOBILITY

Score: \_\_\_\_\_

**Now, I have a series of questions about your typical activities. Are you up and about regularly?**

4. On a typical day, how many hours are you out of bed? ☐ Hours
5. In a typical week, how many days do you get out of your house and go somewhere? ☐ Days
6. In the last year, how many nights have you spent away from your home (excluding hospitalizations)?  
☐ none ☐ 1-2 ☐ 3-4 ☐ 5 or more

### OCCUPATION

Score: \_\_\_\_\_

**How do you spend your time?**

7. How many hours per week do you spend working in a job for which you get paid? ☐ Hours  
What is your occupation? \_\_\_\_\_
8. How many hours per week do you spend in school working toward a degree or in an accredited technical training program? (including hours in class and studying) ☐ Hours
9. How many hours per week do you spend in active homemaking including parenting, housekeeping, and food preparation? ☐ Hours
10. How many hours per week do you spend in home maintenance activities such as gardening, house repairs, or home improvement? ☐ Hours
11. How many hours per week do you spend in recreational activities such as sports, exercise, playing cards, or going to movies? Please do not include time spent watching TV or listening to the radio. ☐ Hours

SOCIAL INTEGRATION			Score:
With whom do you spend time?			
12.	How many people do you live with?	<input type="checkbox"/>	People
13.	Is one of them your spouse or significant other?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable (subject lives alone)	
14.	Of the people you live with how many are relatives?	<input type="checkbox"/>	Relatives
15.	How many business or organizational associates do you visit, phone, or write to at least once a month?	<input type="checkbox"/>	Associates
16.	How many friends (non-relatives contacted outside business or organizational settings) do you visit, phone, or write to at least once a month?	<input type="checkbox"/>	Friends
17.	With how many strangers have you initiated a conversation in the last month (for example, to ask information or place an order)?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 6 or more	
ECONOMIC SELF-SUFFICIENCY			Score:
What financial resources do you have?			
18.	Approximately what was the combined annual income, in the last year, of <b>all family members in your household?</b> (consider all sources including wages and earnings, disability benefits, pensions and retirement income, income from court settlements, investments and trust funds, child support and alimony, contributions from relatives, and any other source.) <input type="checkbox"/> Less than 10,000 <input type="checkbox"/> 10,000 – 14, 999 <input type="checkbox"/> 15,000 – 19,999 <input type="checkbox"/> 20,000 – 24,999 <input type="checkbox"/> 25,000 – 34,999 <input type="checkbox"/> 35,000 – 49,999 <input type="checkbox"/> 50,000 – 74,999 <input type="checkbox"/> 75,000 or more <input type="checkbox"/> Don't know <input type="checkbox"/> Refused		
19.	Approximately, how much did you pay last year for medical care expenses? (Consider any amounts paid by yourself or the family members in your household and not reimbursed by insurance or benefits.) "Would you say your unreimbursed medical expenses are....?" <input type="checkbox"/> Less than 1,000 <input type="checkbox"/> 1,000 – 2,499 <input type="checkbox"/> 2,500 – 4,999 <input type="checkbox"/> 5,000 – 9,999 <input type="checkbox"/> 10,000 or more <input type="checkbox"/> Don't know <input type="checkbox"/> Refused		

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- If any one field within a subscale section is completed, then all the fields within that subscale section are mandatory to save the form.