**In-Home Services Assessment Form**

Welcome! Please tell us a bit about yourself so we can offer services that best meet your needs. We ask for demographic information to meet requirements from our funders. All your personal information is confidential. Please see the attached FAQs for more information and guidance on filling out this form.

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| **Contact & Demographic Information:** | | | | | | | | | | | | | | | | | | | | | | |
| **Last Name:** | | | |  | | | | | | | | **First Name:** | |  | | | | | | **M.I.** | |  |
| **Date of Birth:** | | | | |  | | | | | | **Age:** | |  | | |
| **Gender:**  Male  Female  Other gender not listed: | | | | | | | | | | | | | | | | |  | | | | | |
| **Home Address** Line 1: | | | | | | |  | | | | | | | | | | | | | | |
| Line 2 (Apt/Unit/Floor #): | | | | | | |  | | | | | | City: | | |  | | | | |
| Zip: |  | | | County: | | | |  | | | | | | | | | State: | |  | |
| **Mailing Address** Line 1: | | | | | | |  | | | | | | | | | | | | | | | |
| Line 2 (Apt/Unit/Floor #): | | | | | | |  | | | | | | City: | | |  | | | | |
| Zip: |  | | | County: | | | |  | | | | | | | | | State: | |  | |

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| **Location Comments** (additional directions for home or mailing address): |
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| **Home Phone:** | |  | **Cell Phone:** |  |
| **Email:** |  | | | |

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| **Primary language:**  English  Spanish  Other: | |  | | |
| **Ethnicity:**  Hispanic or Latino  Not Hispanic or Latino | | | | | |
| **Race, select all that apply:** | | | | | |
| American Indian/Alaska Native | | Native Hawaiian or Pacific Islander | | | |
| Asian or Asian American | | White | | | |
| Black or African American | | Other not listed: | |  | |
| **Do you live:**  Alone  With Others | | | | | | |
| **Number of people in your household** (including you): | | | | | |  |

**Is your income above or below the amount listed for your household size:**

Above  At/Below

|  |  |  |
| --- | --- | --- |
| Household Size | Monthly Income | Annual Income |
| 1 | $1,073 | $12,880 |
| 2 | $1,452 | $17,420 |
| 3 | $1,830 | $21,960 |
| 4 | $2,208 | $26,500 |
| For each additional person, add $4,540 to annual income | | |

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| **Emergency Contacts:** |

**Primary Emergency Contact:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | | |
| Phone: |  | Relationship: |  |

**Secondary Emergency Contact or Caregiver** (if applicable)**:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | | |
| Phone: |  | Relationship: |  |

**Power of Attorney** (if applicable)**:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: |  | | | |
| Phone: |  | | Relationship: |  |
| Type of Power of Attorney: | |  | | |

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| **Nutrition Screening:** |

Determine your nutritional health. If the statement is true for you, check the box in the “Yes” column and add the points in the “Yes Score” column to your total score.

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| --- | --- | --- | --- |
| **Nutrition Risk Score Questions** | **Yes** | **No** | **Yes Score** |
| Do you have an illness or condition that has made you change the kind and/or amount of food you eat? |  |  | 2 |
| Do you eat fewer than 2 meals per day? |  |  | 3 |
| Do you eat few fruits, vegetables, or milk products? |  |  | 2 |
| Do you have 3 or more drinks of beer, liquor, or wine almost every day? |  |  | 2 |
| Do you have tooth or mouth problems that make it hard for you to eat? |  |  | 2 |
| Are there times you do not have enough money to buy the food you need? |  |  | 4 |
| Do you eat alone most of the time? |  |  | 1 |
| Do you take 3 or more different prescribed or over the counter drugs a day? |  |  | 1 |
| Without wanting to, have you lost or gained 10 pounds in the last 6 months? |  |  | 2 |
| Are there times you’re physically unable to shop, cook, and/or feed yourself? |  |  | 2 |
| **Total Nutrition Risk Score** *Total “Yes” Score:* | | | |

Total Nutrition Risk Score: 0-2 = No Risk, 3-5 = Moderate Risk, 6 or more = High Risk

If you are at high nutrition risk – take action! Speak with a qualified health or social service professional about your nutritional health. Providers – if the client is at high nutrition risk, please make a case note and appropriate referral.

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| **Activities of Daily Living and Instrumental Activities of Daily Living:** |

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| --- | --- | --- |
| **Activities of Daily Living (ADLs)** | **Yes** | **No** |
| I can bathe myself without help. |  |  |
| I can dress myself without help. |  |  |
| I can get around inside my home without help. |  |  |
| I can use the toilet without help. |  |  |
| I can eat without help. |  |  |
| I can get in and out of bed/chairs without help. |  |  |
| **ADL Count** (total “No” score): |  | |

|  |  |  |
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| **Instrumental Activities of Daily Living (IADLs)** | **Yes** | **No** |
| I can manage money without help. |  |  |
| I can take care of shopping without help. |  |  |
| I can take my medication without help. |  |  |
| I can prepare meals without help. |  |  |
| I can do ordinary housework without help. |  |  |
| I can use the telephone without help. |  |  |
| I can use transportation without help. |  |  |
| **IADL Count** (total “No” score): |  | |

|  |  |
| --- | --- |
| **Comments on ADLs/IADLs:** |  |
| **Are you receiving assistance with ADLs or IADLs from anyone?**  Yes  No | |
| **If yes, who is assisting you:** |  |

|  |
| --- |
| **Interest in Other Services:** |

**Health Insurance** (select all that apply): Medicaid  Medicare  Other  None

**Are you interested in receiving nutrition counseling?**  Yes  No

**Would you like to hear about other services?** Yes  No

**If yes, how can we contact you?**  Email  Mail  Phone

|  |  |
| --- | --- |
| **What services are you interested in?** |  |
|  | |

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| **Other Eligibility Criteria:** |

**Client requires Home Health Aide based on physician’s orders?**  Yes  No

**Can the client perform chore activities without help?**  Yes  No

**Comment on the client's inability to perform chore services:**

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| --- |
|  |

**Does the client have cognitive impairment**  None  Mild  Moderate  Severe

**Disclosures and Waivers**

*I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service provider and I herewith give my consent to do so.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** |  | **Date:** |  |

***For Office Use Only –***

*(If filled out by assessor or via phone, please have assessor check here and sign below* )

|  |  |  |  |
| --- | --- | --- | --- |
| **Filled Out By:** |  | **Date:** |  |

Home Delivered Meal Eligibility

Individual Aged 60+

Self-Declared Spouse of eligible individual

Individual with disabilities living with eligible individual

HDM Volunteer

In-Home Services Eligibility (Adult Day, Home Health Aide, Homemaker, Personal Care)

2+ ADLs (adult day, home health aide, personal care)

2+ IADLs (homemaker only)

*and/or*  Cognitive impairment (all)

*and*  Physician’s order (home health aide only)

Chore Eligibility:

Unable to perform chores without help

Case Management Services Eligibility:

Individual Aged 60+