**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:** | | | | |
| **First Name:** |  | **Middle Name:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Last Name:** |  | **Nickname:** |  |

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| **Date of Birth:** | | | |  | | | | | | **Age:** |  | |
| **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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| **Gender:** | Male | Female | Non-Binary/Third Gender |  |

**Identify as:**  Transgender  Cisgender (identify with your gender from birth)

|  |  |  |  |
| --- | --- | --- | --- |
| Gender not listed: | |  | |
| **Ethnicity:**  Hispanic or Latino  Not Hispanic or Latino | | | | |
| **Race, select all that apply:** | | | | |
| American Indian or Alaska Native | | | | Middle Eastern or North African |
| Asian or Asian American | | | | Native Hawaiian or Pacific Islander |
| Black or African American | | | | White |
| Race not listed: | |  | | |

**Do you live:**  Alone  With Others  **Are you a veteran?** Yes  No

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| --- | --- |
| **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 | $1,215.00 | $14,580.00 |
| 2 | $1,643.00 | $19,720.00 |
| 3 | $2,072.00 | $24,860.00 |
| For each additional person, add $5,140 to annual income | | |

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| **Communication & Service Needs:** |

**Health Insurance (select all that apply):**

Medicare  Medicare Advantage  Medicaid  Medicaid Waiver

|  |  |  |  |
| --- | --- | --- | --- |
| None |  | Other: |  |

**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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| --- | --- | --- | --- |
| **Emergency Contact:** | | | |
| **Name:** |  | | |
| **Phone:** |  | **Relationship:** |  |

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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.

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

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

**For each activity, please mark the level of help you (or the client) needs.**

**Independent:** no help needed

**Verbal assistance:** needs direction, intermittent monitoring or reminder to complete activity

**Some human help:** needs some assistance, constant supervision not required

**Lots of human help:** needs assistance and supervision to complete most parts of activity

**Dependent:** totally dependent on help for completing activity, needs constant supervision

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| --- | --- | --- | --- | --- | --- | --- |
| **Activities of Daily Living (ADLs)** | | Independent | Verbal Assistance | Some Human Help | Lots of Human Help | Dependent |
| Bathing | |  |  |  |  |  |
| Dressing | |  |  |  |  |  |
| Using the Bathroom | |  |  |  |  |  |
| Transferring In/Out of Bed/Chair | |  |  |  |  |  |
| Walking/Getting Around the House | |  |  |  |  |  |
| Eating | |  |  |  |  |  |
| **Comments on ADLs:** |  | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Instrumental Activities of Daily Living (IADLs)** | | Independent | | Verbal Assistance | Some Human Help | Lots of Human Help | Dependent |
| Meal Preparation | |  | |  |  |  |  |
| Shopping | |  | |  |  |  |  |
| Medication Management | |  | |  |  |  |  |
| Money Management | |  | |  |  |  |  |
| Using a Telephone | |  | |  |  |  |  |
| Light Housework | |  | |  |  |  |  |
| Heavy Housework | |  | |  |  |  |  |
| Transportation | |  | |  |  |  |  |
| **Comments on IADLs:** |  | | | | | | |
| **Are you receiving assistance with ADLs or IADLs from anyone?**  Yes No | | | | | | | |
| **If yes, who is assisting you:** | | |  | | | | |

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| **In Home Services Eligibility:** |

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

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

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|  |

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

**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* )

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

Home Delivered Meal NSIP Eligibility

Individual Aged 60+

Self-Declared Spouse of individual aged 60+

Volunteer for the meal programs

Individual with disabilities living with individual aged 60+ and individual 60+ receives home delivered meals

Tribal Age Specification

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+