**2020 Consumer In-Home Services Assessment Form** Updated March 10, 2020

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Basic Client Information: Date of Assessment: / / | | | | | | | | | | | | | | | | | | | | |
| \*Last Name: | | | \*First Name: | | | | | | | | Middle Initial: | | | | | | | | | |
| \*Gender: □Male □Female □Other | | | \*Date of Birth: / / | | | | | | | | \*Age: | | | | | | | | | |
| **Residential Address:** | | | | | | | | | | | | | | | | | | | | |
| \*Address Line 1: | | | | | | | \*Address Line 2(Apt #, Unit #, Floor #): | | | | | | | | | | | | | |
| \*City: | | | | | | | \*State: | | | | | | | \*Zip: | | | | | | |
| \*County: | | | | | | | Phone (Home): | | | | | | | | | | | | | |
| Phone (Mobile): | | | | | | | Phone (Work): | | | | | | | | | | | | | |
| Location Comments (Directions): | | | | | | | | | | | | | | | | | | | | |
| Email Address: | | | | | | | | Are you receiving Medicaid? □Yes □No | | | | | | | | | | | | |
| What is your marital status? □Married/Domestic Partner □Single □ Widowed | | | | | | | | | | | Are you a veteran? □Yes □No | | | | | | | | | |
| \*Lives : □Alone □ With others | | | | | | | What is your primary language? | | | | | | | | | | | | | |
| \*What is your race? | | | | | | | \*Ethnicity? □Hispanic/Latino □ Not Hispanic/Latino | | | | | | | | | | | | | |
| \*Are you visually impaired (cannot be corrected with glasses)? □Yes □No | | | | | | | | | | | | | | | | | | | | |
| Do you wear glasses/contacts? □Yes □No | | | | | | | | Do you have hearing problems? □Yes □No | | | | | | | | | | | | |
| How many people live in your household? | | | | | | | | | | | | | | | | | | | | |
| What is your monthly individual income? | | | | | | | What is your monthly household income? | | | | | | | | | | | | | |
| \*What is your monthly income range? | | □ $1,063 or less  □ $1,064 to $1,327  □ $1,328 to $1,965  □ $1,966 or more | | | | | \*What is you and your spouse’s combined monthly income range? | | | | | | □ $1,437 or less  □ $1,438 to $1,796  □ $1,797 to $2,658  □ $2,659 or more | | | | | | | |
| **Mailing Address, if different from physical Address:** | | | | | | | | | | | | | | | | | | | | |
| Address Line 1: | | | | | | | | Address Line 2 (Apt #, Unit #, Floor #): | | | | | | | | | | | | |
| City: | | | | State: | | | | | | | | Zip: | | | | | | | | |
| Are you interested in receiving nutrition counseling? □Yes □No | | | | | | | | | | | | | | | | | | | | |
| How did you hear about our services?  □AAA Brochure □AAA Newsletter □Channel 9 Senior Source (TV) □Congregate Meal Site □From a Current Client □From a Friend/Relative □Senior Fair □Walk-In □Web Site □Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | |
| **Emergency Contacts:** | **First and Last Name** | | | | | | | | | **Phone Number** | | | **Relationship** | | | | | | | |
| POA (if applicable): |  | | | | | | | | |  | | |  | | | | | | | |
| Type of Power of Attorney: | | | | | | | | | | | | | | | | | | | | |
| Primary Contact: |  | | | | | | | | |  | | |  | | | | | | | |
| Secondary Contact: |  | | | | | | | | |  | | |  | | | | | | | |
| Primary care physician: |  | | | | | | | | |  | | |  | | | | | | | |
| Caregiver (if applicable): |  | | | | | | | | |  | | |  | | | | | | | |
| **Client’s Mobility and Health Conditions:** | | | | | | | | | **Client’s Home Condition and Pets:** | | | | | | | | | | | |
| Does the client use any mobility devices?  □None □Ambulatory □Cane □Crutches □Electric Scooter □Walker □ Wheelchair □Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is the client memory impaired? □Yes □No  Has the client been diagnosed as being diabetic? □Yes □No  Does the client use oxygen? □Yes □No  Does the client use incontinence supplies? □Yes □No  Does the client need supervision? □Yes □No  Does the client have any of the following disabilities?  □Autism □Epilepsy/Seizure disorder □Intellectual disability  □Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | Does the client smoke? □Yes □No  Is the home in need of repair? □Yes □No  If so, list what kind (especially if safety concern): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are there any pets in the household? □Yes □No  If so, what pets does the client have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Any vicious pets (threat to in-home help)? □Yes □No  Other helpful information regarding home condition or pets :  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| **Nutrition Checklist:** (0-2 = No Risk 3-5 = Moderate Risk 6 or more = High Risk) | | | | | | | | | | | | | | | **Yes** | **No** | | | Yes Score | |
| \*I have an illness or condition that made me change the kind and/or amount of food I eat. | | | | | | | | | | | | | | |  |  | | | 2 | |
| \*I eat fewer than 2 meals per day. | | | | | | | | | | | | | | |  |  | | | 3 | |
| \*I eat few fruits or vegetables or milk products. | | | | | | | | | | | | | | |  |  | | | 2 | |
| \*I have 3 or more drinks of beer, liquor, or wine almost every day. | | | | | | | | | | | | | | |  |  | | | 2 | |
| \*I have tooth or mouth problems that make it hard for me to eat. | | | | | | | | | | | | | | |  |  | | | 2 | |
| \*I don’t always have enough money to buy the food I need. | | | | | | | | | | | | | | |  |  | | | 4 | |
| \*I eat alone most of the time. | | | | | | | | | | | | | | |  |  | | | 1 | |
| \*I take 3 or more different prescribed or over the counter drugs a day. | | | | | | | | | | | | | | |  |  | | | 1 | |
| \*Without wanting to, I have lost or gained 10 pounds in the last 6 months. | | | | | | | | | | | | | | |  |  | | | 2 | |
| \*I am not always physically able to shop, cook and/or feed myself. | | | | | | | | | | | | | | |  |  | | | 2 | |
| What is the consumer's nutritional risk score? **Total ‘Yes’ Score: \_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | |
| **ADLs and IADLs required to determine eligibility for in-home services:** | | | | | | | | | | | | | | | | | | | | |
| **ADLs (Activities of Daily Living)** | | | | | **Yes** | **No** | **IADLs (Instrumental Activities of Daily Living)** | | | | | | | | | | | **Yes** | | **No** |
| \*I can bathe myself without help. | | | | |  |  | \*I can manage money without help. | | | | | | | | | | |  | |  |
| \*I can dress myself without help. | | | | |  |  | \*I can take care of shopping without help. | | | | | | | | | | |  | |  |
| \*I can get around inside my home without help. | | | | |  |  | \*I can take my medication without help. | | | | | | | | | | |  | |  |
| \*I can use the toilet without help. | | | | |  |  | \*I can prepare meals without help. | | | | | | | | | | |  | |  |
| \*I can eat without help. | | | | |  |  | \*I can do ordinary housework without help. | | | | | | | | | | |  | |  |
| \*I can get in and out of bed/chairs without help. | | | | |  |  | \*I can use the telephone without help. | | | | | | | | | | |  | |  |
|  | | | | |  |  | \*I can use transportation without help. | | | | | | | | | | |  | |  |
| What is the consumer's ADL count? **Total ‘No’ Score: \_\_\_\_\_** | | | | | | | What is the consumer's IADL count? **Total ‘No’ Score: \_\_\_\_\_** | | | | | | | | | | | | | |
| Are you receiving assistance with ADLs or IADLs from anyone? □Yes □No | | | | | | | From whom are you receiving assistance with ADLs and or IADLs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| **Other Eligibility Criteria:** | | | | | | | | | | | | | | | | | **Yes** | | | **No** |
| \*Does the client require Home Health Aide based on orders from a physician? | | | | | | | | | | | | | | | | |  | | |  |
| \*Is the client homebound or in a geographically isolated location to justify home delivered meals? | | | | | | | | | | | | | | | | |  | | |  |
| \*Can the client perform chore activities without help? | | | | | | | | | | | | | | | | |  | | |  |
| \*Comment on the client's inability to perform chore services: | | | | | | | | | | | | | | | | | | | | |
| \*Does the client have cognitive impairment?  □None □Mild □Moderate □Severe (Requires assistance in routine situations due to lack of cognitive functioning) | | | | | | | | | | | | | | | | | | | | |

*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.*

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

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office use only:** Information filled out by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_