**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 □NoHas the client been diagnosed as being diabetic? □Yes □NoDoes the client use oxygen? □Yes □NoDoes the client use incontinence supplies? □Yes □NoDoes 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 □NoIs the home in need of repair? □Yes □NoIf so, list what kind (especially if safety concern): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are there any pets in the household? □Yes □NoIf 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_