In-Home Services Assessment Form

Date: _____

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

Contact & Demographic Information:

First Name: _____ **Middle Name:** _____

Last Name: _____ **Nickname:** _____

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: _____

Location Comments (additional directions for home or mailing address):

_____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Gender (select all that apply): ☐Male ☐Female ☐Non-binary/Third gender

☐Transgender ☐Another gender not listed: _____

☐Refuse to answer question

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Refuse to answer question

Racial Identity (select all that apply):

☐American Indian or Alaska Native ☐Asian or Asian American ☐Black or African American

☐Middle Eastern or North African ☐Native Hawaiian or Pacific Islander ☐White

☐Another identity not listed: _____ ☐Refuse to answer question

Do you live alone or with others? ☐Alone ☐With others ☐Refuse to answer question

Number of people in your household (including you): ____

Household Monthly Income: _____

Marital Status: ☐ Single (never married) ☐ Domestic Partner/Committed Relationship/Common Law ☐ Married ☐Divorced ☐ Widowed ☐ Not Collected

Veteran: ☐ Yes ☐ No

Client has a disability: ☐ Yes ☐ No
Client is a caregiver: ☐ Yes ☐ No

Communication & Service Needs:

What is your primary language? _____
Health Insurance (select all that apply):
☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Medicaid Waiver ☐ VA
☐ None ☐ Other: _____

Can you access this service through another benefit or program? For example, through Medicaid HCBS or Medicare Advantage benefits? ☐Yes ☐No ☐Refuse to answer question ☐I don't know

Do you have reliable outside support from family, friends, or a caregiver? ☐Yes ☐No ☐Refuse to answer question

Do you have reliable outside support for food access and/or meal preparation (for example, from family, friends, or a caregiver)? ☐Yes ☐No ☐Refuse to answer question

Are you homebound? Select "Yes" if any of the following statements are true for you:

- You need the help of another person to leave your home, or
- You have a health condition or disability that makes it difficult to leave your home on a regular basis, or
- You are only able to leave your home infrequently and for short periods of time

☐Yes ☐No ☐Refuse to answer question

Are you isolated from community resources? Examples of community resources include stores, banks, health services, and senior center activities. Select "Yes" if any of the following statements are true for you:

- You live in a remote area, or
- You have a health condition or disability that makes it difficult for you to access community resources, or
- You have financial or technology challenges that make it difficult for you to access community resources, or
- You cannot drive or use public transportation, or

- You do not feel welcome in your community due to cultural or language barriers

☐Yes ☐No ☐Refuse to answer question

Emergency Contact Section

Name: _____Phone: _____

Relationship: _____

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.

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 only eat a 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 – speak with a qualified health or social service professional.

Home Delivered Meal's:

If you are under age 60, please select your eligibility for home delivered meals:

▫Self-declared spouse of participating individual age 60+

60+ Spouse's Full Name: _____

The following individuals are only eligible when there is no waitlist for home delivered meals:

▫Volunteer for the meal programs

▫Individual with disabilities who lives with an active participant age 60+

60+ Participant's Full Name: _____

Nutrition Counseling:

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

If you are under age 60, please select your eligibility for nutrition counseling

☐Current participant in congregate or home delivered meal program

☐Caregiver of an individual aged 60+

Instrumental Activities of Daily Living

For each activity, please mark the level of help you need.

Activities of Daily Living (ADLs)	Independent I don't need any help with this activity	Some help: I need some help or reminders from another person, but I can do parts of this activity on my own	Dependent: I always need help from another person to do this activity
Bathing or showering	☐	☐	☐
Dressing	☐	☐	☐
Using the Bathroom	☐	☐	☐
Transferring In/Out of Bed/Chair	☐	☐	☐
Walking/Getting Around the House	☐	☐	☐
Eating and drinking	☐	☐	☐

Comments on ADLs:

Instrumental Activities of Daily Living (IADLs)	Independent I don't need any help with this activity	Some help: I need some help or reminders from another person, but I can do parts of this activity on my own	Dependent: I always need help from another person to do this activity
Meal Preparation	☐	☐	☐
Shopping	☐	☐	☐
Medication Management	☐	☐	☐
Money Management	☐	☐	☐
Using a Telephone	☐	☐	☐
Light Housework	☐	☐	☐
Heavy Housework	☐	☐	☐
Transportation	☐	☐	☐

Comments on IADLs:

- Does anyone help you with ADL or IADL activities? ☐Yes ☐No ☐Refuse to answer question

If yes, who is assisting you? _____

Chore:

Chore Service(s) you are requesting_____
Do you need help performing this chore? ☐ Yes ☐ No
Please share the reason(s) you need help with this chore:
_____

Is the home: ☐ Owned ☐ Rented

Are there any pets in the household? ☐ Yes ☐ No
If yes, please list: _____

Are any of your pets uncomfortable with visitors to the home? ☐ Yes ☐ No
If yes, please describe: _____

Homemaker; Personal Care, Adult Day:

Please select eligibility for the service:

- **You have cognitive impairment, and you need another person to provide physical guidance or spoken instructions to keep yourself or others safe.**

☐ Yes ☐ No

- **Homemaker: You have 2 or more Instrumental Activity of Daily Living (IADL) limitations** ☐ Yes ☐ No ☐ Not applicable
- **Personal Care and Adult Day: You have 2 or more Activity of Daily Living (ADL) limitations** ☐ Yes ☐ No ☐ Not applicable

Health and Home Conditions:

Do you/does client have any of the following conditions? Check all that apply:

- ☐ Dementia or Alzheimer's
- ☐ DD / ID
- ☐ Autism
- ☐ Diabetes
- ☐ Epilepsy / Seizure Disorder
- ☐ Intellectual Disability
- ☐ Mental Illness
- ☐ Memory Problems
- ☐ Other: (Write in) _____

- ☐ Mobility Impairment
- ☐ Hearing Impairment
- ☐ Visual Impairment (can't be corrected w/glasses)
- ☐ Physical Disability
- ☐ Traumatic Brain Injury
- ☐ Not Applicable
- ☐ Client Didn't Answer
- ☐ Not Collected

Does the client need supervision? ☐ Yes ☐ No

Client requires Home Health Aide based on physician's orders? ☐ Yes ☐ No

Does the client have cognitive impairment? ☐ None ☐ Mild ☐ Moderate ☐ Severe

Is the client medically dependent on any of the following:

☐ N/A ☐ Insulin ☐ Oxygen ☐ Dialysis

Dentures:	☐ Uses	☐ Needs or needs update	☐ N/A
Hearing Aids:	☐ Uses	☐ Needs or needs update	☐ N/A
Glasses and Contacts:	☐ Uses	☐ Needs or needs update	☐ N/A

Mobility Devices:

Does the client use or need (but does not currently have) any mobility devices?

☐ Yes ☐ No

If Yes:

Cane	☐ Uses	☐ Needs
Walker	☐ Uses	☐ Needs
Wheelchair	☐ Uses	☐ Needs
Electric Scooter	☐ Uses	☐ Needs
Other mobility devices	☐ Uses	☐ Needs

What is it? _____

Special Equipment:

Does the client use or need (but does not currently have) any special equipment or assistive devices?

□ Yes □ No

If Yes:	Medical Phone Alert	□ Uses	□ Needs
	Incontinence Supplies	□ Uses	□ Needs
	Bathing Equipment	□ Uses	□ Needs
	Transfer Equipment	□ Uses	□ Needs
	Adaptive Eating Equipment	□ Uses	□ Needs
	Other Special Equipment/ Assistive Device	□ Uses	□ Needs

What is it? _____

Care Plan Case Managers will create a Care Plan with the client.

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 providers and I give my consent to do so.

Signature: _____

Date: _____

If filled out by someone other than the client (for example a caregiver or assessor, please check here ☐ and sign below)

Filled out by: _____

Date: _____