OFFICE USE	Rec'd:	Assessment Date:	Start Date:	Route #_____

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.

Contact & Demographic Information:

Last Name: _____ **First Name:** _____ **M.I.** _____

Date of Birth: _____ **Age:**_____ **Nickname:**_____

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: _____

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

_____

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

Email: _____

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 **Are you a veteran?** ☐ Yes ☐ No

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

If you live alone, is your monthly income: ☐ $1,132 or above ☐ $1,132 or below

If you live with others, is your household size (including you) and monthly income:

2 People in Household: ☐ $1,526 or above ☐ $1,526 or below
3 People in Household: ☐ $1,919 or above ☐ $1,919 or below
4 People in Household: ☐ $2,312 or above ☐ $2,312 or below

Are you visually impaired (can't be corrected with glasses)? ☐ Yes ☐ No
Do you have hearing problems? ☐ Yes ☐ No

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:

Client Mobility and Health Conditions

Do you/does the client use any assistive devices? Select all that apply:

☐ 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

Home Conditions and Pets:

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

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	No	Yes	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.

What do you do for weekend meals?_____

Would you like 1% milk with your meals? ☐ Yes ☐ No

Activities of Daily Living and Instrumental Activities of Daily Living:

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):		

Continue for IADLs on next page…

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? _____

_____

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:

_____

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:** _____

☐ **Check here if information provided by someone other than client.**

Completed by_____Phone_____Relation_____

For Office Use Only –
(If filled out by assessor or via phone, please have assessor check here and sign below ☐)

Filled Out By: _____ **Date:** _____

☐ Frozen/milk	☐ Pets	☐ ADRC	☐ SHIP
☐ Delivery time	☐ No service days	☐ Senior Companion	☐ Handyman
☐ Receiving delivery	☐ Donation	☐ Dietitian	☐ Other
☐ Cancellations	☐ Releases	☐ 211	

☐ **Agreed to give service 30 days before quitting.**

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+