Office Use	Rec'd:	Assessed:	Start: Route #
	Milk: Yes No	Frozen: Yes No	SUDS:

In-Home Services Application 2024

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:

First Name: _____ D.O.B: _____ **Middle Name:** _____

Last Name: _____ Age: _____ **Nickname:** _____

Home Address: Unit#

City: Zip:

Mailing Address: Unit#:

City: County: ST: Zip:

Home Phone: **Cell Phone**:

Gender: ☐ Male ☐ Female ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race, select all that apply:

☐ American Indian / Alaska Native
☐ Asian or Asian American
☐ Black or African American
☐ Middle Eastern or North African
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Race, if not listed: _____

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

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

Is your income above or below the following federal poverty guidelines?

☐ Above ☐ At or Below

Household Size	Monthly Income	Annual Income
1	$1,255.00	$15,060.00
2	$1,703.00	$20,440.00
3	$2,152.00	$25,820.00
4	$2,600.00	$31,200.00
For each additional person add $5,380 annual income		

Communication & Service Needs:

Health Insurance (select all that apply):

☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Medicaid Waiver
☐Private ☐None ☐ Other, if not listed: _____

Are you Hearing Impaired? ☐ Yes ☐ No **Are you Sight Impaired?** ☐ Yes ☐ No

Nutrition Screening

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 = <u>No Risk</u>, 3-5 = <u>Moderate Risk</u>, 6 or more = <u>High Risk</u>

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

ADLs (Activities of Daily Living)	Yes	No	IADLs (Instrumental Activities of Daily Living)	Yes	No
I bathe myself without help			I can meal prep. without help		
I dress myself without help			I can shop without help		
I use the toilet without help			I take my medication without help		
I get in/out of bed/chairs without help			I manage my money without help		
I get around inside my home without help			I can us the phone without help		
I can eat without help			I can do light housework		
			I can do heavy housework		
			I can use transportation without help		
Total 'No' Score:			Total 'No' Score		

Comments on ADLs & IADLs:

Are you receiving assistance with your ADLs & IADLs? ☐ Yes ☐ No

If yes, who is assisting you:

In Home Services Eligibility:

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

Home & Health Conditions:

Is the client Homebound or Geographically isolated? ☐ Yes ☐ No
Has the client been diagnosed as diabetic? ☐ Yes ☐ No
Does the client have memory issues? ☐ Yes ☐ No
Does the client use oxygen? ☐ Yes ☐ No

Which of these assistive devices does the client use?
☐None ☐Cane ☐Crutches ☐Walker ☐Wheelchair ☐Electric Scooter ☐Other

Does the client have any pets in the home? ☐ Yes ☐ No
How many and what kind? _____
Are they a threat to visitors? ☐ Yes ☐ No

Primary Emergency Contact:

Name: _____
Phone: _____ **Relationship:** _____

Secondary Emergency Contact:

Name: _____
Phone: _____ **Relationship:** _____

MPOA Contact:

Name: _____
Phone: _____ **Relationship:** _____

Signature: _____ **Date:** _____

(If filled out by assessor or via phone, please have assessor check here and sign below ☐*)*
Filled Out By: _____ **Date:** _____

Are you interested in learning about nutrition and a healthy diet?

If yes, you're invited to enroll in Text2LiveHealthy, a nutrition education program delivered to you via text message. Scan this QR code with your phone's camera to enroll or text the word FRUIT to 97699.

Message & Data Rates May Apply. Text HELP for information. Text STOP to97699 to opt out. No purchase necessary. For Privacy Policy and Terms and Conditions, visit: https://coloradosph.cuanschutz.edu/text2livehealthy

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.

For Office Use Only –

☐ Frozen/milk	☐ Pets
☐ Delivery time	☐ No service days
☐ Receiving delivery	☐ Donation
☐ Cancellations	☐ Releases

☐ Agree to give service 30 days before quitting.

Home Delivered Meal NSIP Eligibility

☐ Individual Aged 60+

☐ Self-Declared Spouse of individual aged 60+

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

In-Home Services Eligibility (Adult Day, Homemaker, Personal Care)

☐ 2+ ADLs (adult day, home health aide, personal care)

☐ 2+ IADLs (homemaker only)

and/or ☐ Cognitive impairment (all)