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. Please see the attached FAQs for more information and guidance on filling out this form.

Contact & Demographic Information:

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

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

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

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

Is your income above or below the amount listed for your household size:

☐ Above ☐ At/Below

Household Size	Monthly Income	Annual Income
1	$1,133	$13,590
2	$1,526	$18,310
3	$1,919	$23,030
4	$2,313	$27,750
For each additional person, add $4,720 to annual income		

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: _____

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 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.

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):		

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

Marital Status:
☐ Married ☐ Domestic Partner ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Are you a veteran? ☐ Yes ☐ No

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

Do you wear contacts or glasses? ☐ Yes ☐ No

Do you have hearing problems? ☐ Yes ☐ No

How did you hear about our services?

☐ AAA Brochure ☐ AAA Newsletter ☐ Channel 9 Senior Source
☐ Congregate Meal Site ☐ From a Current Client ☐ From a Friend/Relative
☐ Senior Fair ☐ Walk-In ☐ Web Site
☐ Other: _____

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
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: _____

Home Conditions and Pets:

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:

_____

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:** _____

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

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+

Client Information and FAQs Sheet

We are so glad you found us! Please keep this information for your records.

Provider and Area Agency on Aging Information:

Your local Area Agency on Aging: *Upper Arkansas Area Agency on Aging*

What is an Area Agency on Aging?

We're glad you asked! The Area Agency on Aging (AAA) is a regional agency that is designated by the state to administer federal, state, and local funding to meet the needs of older adults in their community. The AAA provides programs and services to older adults and caregivers directly and through contracts with community provider agencies. AAAs also serve as advocates for older adults.

Service Information:

The service you are requesting is funded through the Older Americans Act (OAA) and/or Older Coloradans Act (OCA) funding. This federal and state funding helps older adults, 60+, remain in their homes and communities of choice. Requests for services are processed as funds allow. We can provide you with referrals to other resources in your area, but we will not reach out to them without your permission.

What is the purpose of this form?

We ask you to fill-in this form for several reasons:

- To help us learn about you so we can offer services that best meet your needs
- To help us understand the needs of older adults in our community
- To help us show the need for funding our programs
- To help us meet reporting requirements from our funders

Taxpayer money funds these programs. We must prove that the funding only serves eligible clients and targets older adults and caregivers most in need of services. This paperwork helps us meet that level of accountability.

Income information is not used to determine your eligibility for services. Income and other demographic information (e.g. gender, race, ethnicity) are collected for anonymous demographic reporting purposes. None of your personal information, such as your name or date of birth is disclosed in reporting. You have the right to refuse to provide any of the information requested on the form.

What happens with my information?

We enter your information into a secure state database. As you receive services, we record the services you received in the database. This helps us prove how we spent the funding. The database is secured to the standards outlined in Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH). This means your data remains safe and confidential.

Will you sell my information?

No. We will never sell your information.

How do I provide feedback?

We love hearing how we can improve. Contact your service provider or your local Area Agency on Aging at **719-539-3341** or **tom.mcconaghy@uaacog.com.** Because we value your input, we may at times send you a survey to ask for your feedback.

How do I file a complaint, grievance, or appeal?

Complaint/Grievance/Appeal Procedure:

You have the right to file a complaint or grievance with the organization asking you to fill out this form. If you are not satisfied with the organization's decision, you can appeal the decision to your local Area Agency on Aging (AAA), and/or the State Unit on Aging (SUA). The complete Complaint/Grievance/Appeal Procedures are available upon request by contacting your local AAA and/or the SUA as follows:

Upper Arkansas Area Agency on Aging **139 E 3rd St** **Salida, CO 81201** **719-539-3341** **Tom.mcconaghy@uaacog.com**	**Colorado Department of Human Services, State Unit on Aging** 1575 Sherman Street, 10th Floor Denver, CO 80203 303.866.2800

Can I make a donation?

We accept donations and gifts to contribute towards the cost of services and to support our efforts. Every dollar we receive goes back into the programs and services. Donations are voluntary and are not required to receive services.

You can send to donations to **UAACOG, 139 E 3rd St, Salida, CO 81201**

What other resources are available?

Feel free to reach out to your Area Agency on Aging to get more information about the services available in your region. We love to help!

Services available in our region include: ***Financial aid for dental and vision procedures, in home safety related repairs, meals on wheel, congregate meals, in home assistance, respite services, and legal services.***

You can also call the statewide Aging and Disability Resources for Colorado (ADRC) for information about resources in your area: 1-844-COL-ADRC / 1-844-265-2372

How can I help?

We couldn't meet the needs of older adults in our communities without the amazing help from volunteers and members of our Regional Advisory Councils. Reach out to either your provider or your AAA to see how you can help make a difference in the lives of older adults in our community.