Material Aid/Durable Medical Equipment Health Assessment Form

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.

Registration and Eligibility Section – Must Be Completed Prior to Service

First Name: _____Middle Name (if applicable): _____

Last Name: _____Nickname (if applicable): _____

Date of Birth: _____ Age: _____

Only individuals aged 60 and older are eligible.

Contact Information Section

Home Phone: _____Cell Phone: _____

Email: _____

Home Address Line 1: _____

Home Address Line 2 (Apt/Unit/Floor):_____

County: _____

City: _____ State: _____Zip: _____

Mailing address is the same as home address ☐

Mailing Address Line 1: _____

Mailing Address Line 2 (Apt/Unit/Floor): _____

City: _____ State: _____ Zip: _____

Demographics Section – Used for Anonymous Reporting to Our Funders

- Gender (select all that apply): ☐Male ☐Female ☐Non-binary/Third gender ☐Transgender ☐Another gender not listed: _____ ☐Refuse to answer question
- Ethnicity: ☐Hispanic or Latino/a/e ☐Not Hispanic or Latino/a/e ☐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
- Is your income above or below the amount listed for your household size in the table:
  ☐Above ☐At/below ☐Refuse to answer question

Income Levels Table

Household Size	Monthly Income	Annual Income
1	$1,304	$15,650
2	$1,763	$21,150

Use the table to determine if your income is above or below the monthly or annual income listed for your household size. For each additional person, add $5,500 to annual income.

Communication Section

What is your primary language: _____

Service Access and Support Section

- Health Insurance (select all that apply):
  ☐Medicare ☐Medicare Advantage ☐Medicaid ☐Medicaid Waiver(s) ☐VA ☐Private
  ☐None ☐Other insurance: _____ ☐Refuse to answer question
- Can you access this service through another benefit or program? For example, through Medicaid or Medicare 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
- 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 freely
  - 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

Emergency Contact Section

Name: _____Phone: _____

Relationship: _____ ☐Refuse to provide contact

Disclosures and Waivers

I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that to receive the services requested, it may be necessary to share information with other departments or service providers, and I give my consent to do so.

Signature: _____

Date: _____

If it is filled out by someone other than the client, please check here ☐ and sign below

Filled out by: _____ Date: _____