

# Homemaker, Personal Care, Adult Day 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.

Please select your eligibility for homemaker, personal care, or adult day services:

- You have cognitive impairment, and you need another person to provide physical guidance or spoken instructions to keep yourself or others safe. ☐ Yes ☐ No  
and/or
- 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

## 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 at/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 at/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 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

## Nutrition Screening Section

### Nutrition Risk Score

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	Refuse to Answer Question	Yes Score
1. Do you have an illness or condition that has made you change the kind and/or amount of food you eat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
2. Do you eat fewer than 2 meals per day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3
3. Do you eat few fruits, vegetables, or milk products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
4. Do you have 3 or more drinks of beer, liquor, or wine almost every day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
5. Do you have tooth or mouth problems that make it hard for you to eat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
6. Are there times you do not have enough money to buy the food you need?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4
7. Do you eat alone most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1
8. Do you take 3 or more different prescribed or over the counter drugs a day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1
9. Without wanting to, have you lost or gained 10 pounds in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
10. Are there times you're physically unable to shop, cook, and/or feed yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2

Total Nutrition Risk Score (Total “Yes” Score): \_\_\_\_\_

Total Nutrition Risk Score Meaning: 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.

## Activities of Daily Living - Must Be Completed for Eligibility

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

Activities of Daily Living	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
1. Bathing or showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Dressing - Putting on and taking off clothing and shoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Using the bathroom - Getting to and on/off the toilet, managing clothing, wiping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Transferring In/Out of Bed/Chair - Getting in and out of sitting or lying positions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Walking/Getting Around the House	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Eating and drinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments on ADLs: \_\_\_\_\_

## Instrumental Activities of Daily Living- Must Be Completed for Eligibility

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

Instrumental Activities of Daily Living	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
1. Meal Preparation - Planning, making, and cleaning up meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Shopping - selecting and paying for food, household supplies, clothing, and other items	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Medication Management - getting prescriptions filled and taking medications as prescribed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Money Management - budgeting, using cards and bank accounts, paying bills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Using a Telephone - making and receiving calls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Light Housework - tidying up, sweeping, vacuuming, mopping, cleaning kitchen and bathroom surfaces, taking out garbage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Heavy Housework - deep cleaning the home, moving light furniture to clean under/behind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Instrumental Activities of Daily Living	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
8. Transportation - driving, walking, or using other forms of available transportation, like buses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments on IADLs: \_\_\_\_\_

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

If yes, who is assisting you? \_\_\_\_\_

## 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 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: \_\_\_\_\_

