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:

First Name: _____ **Middle Name:** _____

Last Name: _____ **Nickname:** _____

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

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: _____

Gender: ☐ Male ☐ Female ☐ Non-Binary/Third Gender

Identify as: ☐ Transgender ☐ Cisgender (identify with your gender from birth)

☐ Gender not listed: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race, select all that apply:

☐ American Indian or Alaska Native ☐ Middle Eastern or North African

☐ Asian or Asian American ☐ Native Hawaiian or Pacific Islander

☐ Black or African American ☐ White

☐ Race 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	$1,215.00	$14,580.00
2	$1,643.00	$19,720.00
3	$2,072.00	$24,860.00
4	$2,500.00	$30,000.00
For each additional person, add $4,720 to annual income		

Communication & Service Needs:

Health Insurance (select all that apply):

☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Medicaid Waiver

☐ None ☐ Other: _____

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? _____

_____

Emergency Contact:

Name: _____

Phone: _____ **Relationship:** _____

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.

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

Activities of Daily Living and Instrumental Activities of Daily Living:

For each activity, please mark the level of help you (or the client) needs.
Independent: no help needed
Verbal assistance: needs direction, intermittent monitoring or reminder to complete activity
Some human help: needs some assistance, constant supervision not required
Lots of human help: needs assistance and supervision to complete most parts of activity
Dependent: totally dependent on help for completing activity, needs constant supervision

Activities of Daily Living (ADLs)	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent
Bathing	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐
Using the Bathroom	☐	☐	☐	☐	☐
Transferring In/Out of Bed/Chair	☐	☐	☐	☐	☐
Walking/Getting Around the House	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐

Comments on ADLs: _____

Instrumental Activities of Daily Living (IADLs)	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent
Meal Preparation	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐
Medication Management	☐	☐	☐	☐	☐
Money Management	☐	☐	☐	☐	☐
Using a Telephone	☐	☐	☐	☐	☐
Light Housework	☐	☐	☐	☐	☐
Heavy Housework	☐	☐	☐	☐	☐
Transportation	☐	☐	☐	☐	☐

Comments on IADLs: _____

Are you receiving assistance with ADLs or IADLs from anyone? ☐ 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:

_____

Client requires Home Health Aide based on physician's orders? ☐ Yes ☐ No

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:** _____

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 NSIP Eligibility

☐ Individual Aged 60+

☐ Self-Declared Spouse of individual aged 60+

☐ Volunteer for the meal programs

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

☐ Tribal Age Specification

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

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 that 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. 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 and that we are serving only people age 60 and older. 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

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 St, 10th Floor
Denver CO 80203
303-866-2800

Can I donate?
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 your 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, in-home safety-related repairs, meals on wheels, 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