**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.

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| **Contact & Demographic Information:** | | | | |
| **First Name:** |  | **Middle Name:** |  |

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| **Last Name:** |  | **Nickname:** |  |

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| **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: |  |

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| |  |  | | --- | --- | | **Mailing Address Same as Home Address:** |  |   **Home Location Comments** (additional directions for home or mailing address): |
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| **Home Phone:** | |  | **Cell Phone:** |  |
| **Email:** |  | | | |

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| **Gender:** | Male | Female | Non-Binary/Third Gender |  |

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

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| Gender, if 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, if not listed: | |  | | |

**Do you live:**  Alone  With Others

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| **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 | $1,255 | $15,060 |
| 2 | $1,703 | $20,440 |
| 3 | $2,152 | $25,820 |
| 4 | $2,600 | $31,200 |
| 5 | $3,048 | $36,580 |
| 6 | $3,497 | $41,960 |
| 7 | $3,945 | $47,340 |
| 8 | $4393 | $52,720 |
| For each additional person, add $5,380 to annual income | | |

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| **Communication & Service Needs:** |

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| --- | --- |
| **Primary Language:**  English  Spanish  Other, if not listed: |  |

**Health Insurance (select all that apply):**

Medicare  Medicare Advantage  Medicaid  Medicaid Waiver

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| Private | None | Other, if not listed: |  |

**Would you like to hear about other services?** Yes  No

**If yes, how can we contact you?**  Email  Mail  Phone

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| **What services are you interested in?** |  |

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| **Emergency Contact:** | | | |
| **Name:** |  | | |
| **Phone:** |  | **Relationship:** |  |

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| **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.

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| **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 in SUDS and make the appropriate referral.

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

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| **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

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| **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:** |  | | | | | |

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| **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:** | | |  | | | | |

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| **In Home Services Eligibility:** |

**Can the client perform chore activities without help?**  Yes  No

**Comment on the client's inability to perform chore services:**

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**Does the client have cognitive impairment**  None  Mild  Moderate Severe

**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.

A qr code on a white background

Description automatically generated

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.*

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| **Signature:** |  | **Date:** |  |

***For Office Use Only –***

*(If filled out by assessor or via phone, please have assessor check here and sign below* )

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| **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, Homemaker, Personal Care)

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

2+ IADLs (homemaker only)

*and/or*  Cognitive impairment (all)

Chore Eligibility:

Unable to perform chores without help

Case Management Services Eligibility:

Individual Aged 60+

**DELETE THE FOLLOWING PAGES BEFORE PROVIDING THE FORM TO CLIENTS**

**In-Home Assessment Form Instructions**

**Services that must use the In-Home Assessment form for meeting minimum state and federal client registration and reporting requirements:**

* Adult Day Care/Adult Day Health
* Case Management
* Chore
* Home Delivered Meals
* Homemaker
* Personal Care
* Vouchers for all services that fall into the service categories above
* *Care Recipients (age 18+)* for Title III-E Caregiver Respite and Supplemental Services (the Caregiver needs to fill out the Caregiver Assessment)
* Any other services requiring a lower-level form (e.g. a Basic Intake Form or Congregate Nutrition Assessment) can use the In-Home Assessment Form

**Re-assessments:**

* Services that require the in-home assessment form also require re-assessments to ensure information is up to date for eligibility and/or need for services. The exception is chore services.

**All clients filling in the In-Home Services Assessment Form should also be provided with:**

* Client Information/FAQs sheet
* Disclosures/Waivers sheet

**Demographic Questions:**

The following demographic information is required for federal reporting and the questions are required on all forms. Clients can choose to refuse to answer any of the questions, but they need to be given an informed choice about whether to provide their demographic information. This information must be entered into the SUDS Client record for all clients receiving services that require registration:

* DOB (to calculate age as of the end of the Federal Fiscal Year)
* Gender
* Zip code (to determine non-rural/rural geography)
* Ethnicity
* Race
* Lives With
* Poverty (income above or at/below poverty)

**Nutrition Screening:**

The Nutrition Screening questions are required to determine the client’s Nutrition Risk Score for federal reporting and cannot be changed. They must be included on the In-Home and Congregate Nutrition Assessment forms and entered in SUDS for clients receiving the services that require those assessment forms. You can add a refuse to answer response option and give the client more information about the meaning of the nutrition questions during the assessment.

**ADLs/IADLs:**

The ADL/IADLs are required for federal reporting for all services listed on this form. They must be included on the In-Home Assessment Form and entered in SUDS for clients receiving the services that require the In-Home Assessment form. If the client reports additional ADL or IADL limitations that are not listed, you can add this information to the Comments about ADL/IADLs question on the In-Home Assessment and in SUDS. You can add refuse to answer options and use the Alternative Question Wording options available for these questions.

**Collecting Additional Client Information:**

* You can collect more client information on your region’s assessment forms than the minimum information required by the SUA Standard Assessment Forms.
* Check the Optional Assessment Questions and Alternative Wording documents for ideas on collecting more client information
* For SUDS Data Entry (if applicable), double check where to enter info & train staff/providers on data entry
* You can also add your own local questions that are not listed in the Optional Assessment Questions. If you would like to enter this information into SUDS, get in touch with the SUDS Help Desk for guidance.

**Waitlist and Targeting Considerations:**

* Some services that can use this form may require additional questions based on a region’s waitlist and targeting prioritization criteria.
* Waitlist and targeting prioritization may differ by region and service, and we do not include all possible prioritization questions on the Standard SUA Assessment Form.
* Please follow the directions above on Collecting Additional Client Information for adding Waitlist and Targeting Prioritization questions to your forms