2021 Consumer In-Home Services Assessment Form

Updated June 3, 2021

Basic Client Information:		**Date of Assessment:**
*Last Name:	*First Name:	Middle Initial:
*Gender: ☐ Male ☐ Female ☐ Other	*Date of Birth:	*Age:
Residential Address:		
*Address Line 1:	*Address Line 2(Apt #, Unit #, Floor #):	
*City:	*State:	*Zip:
Phone (Home):	Phone (Mobile):	
Location Comments (Directions):		
Email Address:	Are you receiving Medicaid? ☐ Yes ☐ No	
What is your marital status? ☐ Married/Domestic Partner ☐ Single ☐ Widowed	Are you a veteran? ☐ Yes ☐ No	
*Lives: ☐ Alone ☐ With others	What is your primary language?	
*What is your race?	*Ethnicity? ☐ Hispanic/Latino ☐ Not Hispanic/Latino	
*Are you visually impaired (cannot be corrected with glasses)? ☐ Yes ☐ No		
Do you wear glasses/contacts? ☐ Yes ☐ No	Do you have hearing problems? ☐ Yes ☐ No	
How many people live in your household?	Is your monthly income below $1,073? ☐ Yes ☐ No	
Mailing Address, if different from physical Address:		
Address Line 1:	Address Line 2 (Apt #, Unit #, Floor #):	
City:	State:	Zip:
Are you interested in receiving nutrition counseling? ☐ Yes ☐ No		

Emergency Contacts:	**First and Last Name**	**Phone Number**	**Relationship**
POA (if applicable):			
Primary Contact:			
Secondary Contact:			

Client's Mobility and Health Conditions:	**Client's Home Condition and Pets:**
Does the client use any mobility devices? ☐ 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: _____	Does the client smoke? ☐ Yes ☐ No 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:

Nutrition Checklist:	**Yes**	**No**	**Yes Score**
*I have an illness or condition that made me change the kind and/or amount of food I eat.	☐	☐	2
*I eat fewer than 2 meals per day.	☐	☐	3
*I eat few fruits or vegetables or milk products.	☐	☐	2
*I have 3 or more drinks of beer, liquor, or wine almost every day.	☐	☐	2
*I have tooth or mouth problems that make it hard for me to eat.	☐	☐	2
*I don't always have enough money to buy the food I need.	☐	☐	4
*I eat alone most of the time.	☐	☐	1
*I take 3 or more different prescribed or over the counter drugs a day.	☐	☐	1
*Without wanting to, I have lost or gained 10 pounds in the last 6 months.	☐	☐	2
*I am not always physically able to shop, cook and/or feed myself.	☐	☐	2
What is the consumer's nutritional risk score? (0-2 = No Risk 3-5 = Moderate Risk 6 or more = High Risk)		**Total 'Yes' Score:**	_____

ADLs and IADLs required to determine eligibility for in-home services:					
ADLs (Activities of Daily Living)	**Yes**	**No**	**IADLs (Instrumental Activities of Daily Living)**	**Yes**	**No**
*I can bathe myself without help.	☐	☐	*I can manage money without help.	☐	☐
*I can dress myself without help.	☐	☐	*I can take care of shopping without help.	☐	☐
*I can get around inside my home without help.	☐	☐	*I can take my medication without help.	☐	☐
*I can use the toilet without help.	☐	☐	*I can prepare meals without help.	☐	☐
*I can eat without help.	☐	☐	*I can do ordinary housework without help.	☐	☐
*I can get in and out of bed/chairs without help.	☐	☐	*I can use the telephone without help.	☐	☐
	☐	☐	*I can use transportation without help.	☐	☐
What is the consumer's ADL count? **Total 'No' Score:**			What is the consumer's IADL count? **Total 'No' Score:**		
Are you receiving assistance with ADLs or IADLs from anyone? ☐ Yes ☐ No			From whom are you receiving assistance with ADLs and or IADLs?		

Other Eligibility Criteria:	**Yes**	**No**
*Does the client require Home Health Aide based on orders from a physician?	☐	☐
*Is the client homebound or in a geographically isolated location to justify home delivered meals?	☐	☐
*Can the client perform chore activities without help?	☐	☐
*Comment on the client's inability to perform chore services:		
*Does the client have cognitive impairment? ☐ None ☐ Mild ☐ Moderate ☐ Severe (Requires assistance in routine situations due to lack of cognitive functioning)		

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

Signature _____ Date _____

Office use only

Information filled out by: _____ Date _____

Phone Reassessment by: _____ Date _____

Contact by: ☐ Email ☐ Telephone ☐ In Person ☐ OC Only – Time: _____ ☐ HMK Only ☐ Both

If by in person:

Setting: ☐ Office ☐ Community residence ☐ SNF ☐ Hospital ☐ Other _____