**Clare Housing Adult Foster Care Application Part A.** This part of the application must be filled out by applicant case manager, family member or emergency contact.

**PLEASE EMAIL COMPLETED Applications to: HousingApplicant@clarehousing.org**

**OR FAX TO:612 236 9520**

**Demographics**

Date of Application**:** \_\_\_\_\_\_\_\_\_\_\_\_Name of Person completing application: \_\_\_\_\_\_\_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location of screening:  Applicant residency  Hospital  Nursing Home  Case manager office  
 Other

**Personal Information:**

First Name:\_\_\_\_\_\_\_\_\_\_\_\_Last Name:\_\_\_\_\_\_\_\_\_\_\_Social Security #: \_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

MA or PMI: \_\_\_\_\_\_\_\_\_\_\_\_

Gender:  Female  Male  Non-binary Country of Birth: \_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_

**Permanent** Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_ State\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_

**Temporary** Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_ State\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

County of Financial Responsibility: Marital status: Click or tap here to enter text.

Name of Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you require an apartment with special accommodations for a physical disability?

**If yes,** what type accommodations do you need?

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**History of Criminal or Violent Behavior**

We understand that applicants to Clare Housing may have a criminal background. Please describe your criminal history including misdemeanor and felony charges. Please include date of charge, location, sentence, incarceration, parole, etc.

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Are you currently on parole, probation or community supervision?  Yes  No

If so, list the name of the worker, agency, phone number, and dates of supervision:   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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**Previous Housing Status (please list last 5 residencies)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Address** | **Dates of residency** | **Lease Amt?** | **Rent Amt?** | **Reason for leaving?** |
|  |  |  |  |  |
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|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Preferences:**

When is residency desired?  ASAP  Within 3 mos.  Undetermined

**Homes (check all that applicant is interested in):**

Agape Dos, Mpls., Asleep overnight

Damiano, Mpls., Asleep overnight

Grace 2, Mpls., AWAKE overnight

**Why is applicant interested in Adult Foster Care services?**

Temporary absence or inability of caregiver

Permanent loss of caregiver

Exhausted caregiver

Behavioral of Emotional Problems

Disorientation or Confusion

Change in functional capacity due to illness or injury

Current services are inadequate

Provider request consideration of supportive housing

Other

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Pets**

Does applicant have pets?  Yes  No

What kind?  Dog  Cat

Clare Housing has a case-by-case pet policy which will be discussed at face-to-face meeting.

**CADI (Must have a CADI waiver to live in Foster Care Homes)**

Do you have a CADI waiver?  Yes  No

Do you have MA-Dx?  Yes  No

Have you completed the SMRT process?  Yes  No  Unsure

IF yes name/email/ phone of CADI case manager \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you have been assessed for a CADI waiver?  Yes  No  Unsure

If yes, where are you in the process? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Income Information**

Primary source of income (check all that apply):

GA Amt. per month: \_\_\_\_\_\_

SSI/SSDI Amt. per month: \_\_\_\_\_\_

Employment Amt. per month: \_\_\_\_\_\_

Child Support Amt. per month: \_\_\_\_\_\_

Pension Amt. per month: \_\_\_\_\_\_

Retirement Amt. per month: \_\_\_\_\_\_

Other Amt. per month: \_\_\_\_\_\_

Employer, if applicable (name, address, phone, length of employment):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Legal:**

Health Care POA If yes, Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_

Legal POA If yes, Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_

Legal Guardian If yes, Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_

Does Applicant have a health care Directive (copy should be provided with application)

Applicant must be willing to provide payment to the adult foster care home on or before the 6th day of each month. In the event applicant is unable to make payment, how will fees by paid and by whom:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Applicants Current CODE STATUS (check one):**

Do Not resuscitate (DNR)

Do Not Intubate (DNI)

Full Code

Does applicant have pre-arrange burial or cremation plans

IF yes, please provide name and address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Medicare A

Medicare B

Medicare D

Medicaid Eligibility Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Private Name of Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Veteran

Other

**Providers:**

**Primary Physician:** Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Clinic visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Medical Providers:**

Name of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Clinic visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Clinic visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Clinic visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Clinic visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Managers and Workers:**

*CADI Case manager*

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Organization \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*HIV Case manager*

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Organization \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*County Case manager*

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Organization \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Independent Living Services (ILS) worker*

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Organization \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Adult Rehabilitative Mental Health Services*

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Organization \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Transitional Housing Case Manager*

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Organization \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Home Care Agency*

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Organization \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Other*

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Organization \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospital and Long-term Care Information**

**Hospital and ED visits**

Number of ED visits in the 12 months? \_\_\_\_\_ Past 3 mos.? \_\_\_ Last mos.\_\_\_

Briefly describe reason for visit:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Number of hospitalizations in the 12 months? \_\_\_\_\_ Past 3 mos.? \_\_\_Last mos.\_\_\_

Briefly describe reason for visit:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Long Term Care Information**

Has applicant ever been a resident at one of the following places (mark all that apply) ? □ Nursing Home

Respite  Adult Foster Care  Group Home  Regional Treatment Center  other

If yes, do we have permission to contact them?  Yes  No

If yes, please fill in below:

|  |  |  |
| --- | --- | --- |
| **Name of Residency** | **Dates** | **Contact Info** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Home Safety and Accessibility Concerns (check all that apply):**

Signs of careless smoking  Fire hazards  unsafe food  unsanitary conditions  unpleasant odor

Insects or pests  lack general cleanliness  excess clutter  signs of excess chemical use

Insufficient heating or cooling  Living alone  stairs  doors do not lock  other

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Adaptive Equipment or Assistive Devices:**

Dentures  Owns Needs

Hearing Aid  Owns Needs

Glasses  Owns Needs

Contact Lenses  Owns Needs

Cane  Owns Needs

Walker  Owns Needs

Brace (leg/back)  Owns Needs

Manual wheelchair  Owns Needs

Electric Wheelchair  Owns Needs

Medical Alert (Lifeline)  Owns Needs

Bedside Commode  Owns Needs

Raised toilet seats  Owns Needs

Grab bars  Owns Needs

Bed (safety rails)  Owns Needs

Hoyer Lift  Owns Needs

Adaptive eating equipment  Owns Needs

Hospital Bed  Owns Needs

Lift Chair  Owns Needs

Other  Owns Needs

**Activities of Daily Living (ADLs)**

**Bathing**

Independent  Dependent (hands on complete assistance)  Minimal Supervision/Reminder  Assistance with in/out shower  Assistance with washing/drying body

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Dressing**

Independent  Dependent (hands on complete assistance)  Minimal Supervision/Reminder

Comments:

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**Grooming (comb hair, wash face, brush teeth and shave):**

Independent  Dependent (hands on complete assistance)  Minimal Supervision/Reminder

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Eating**

Independent  Dependent (hands on complete assistance)  Minimal Supervision/Reminder

Assistance with (cutting, opening, spreading, pouring)  NG or IV feeding

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Toileting**

Independent  Dependent (hands on complete assistance)  Minimal Supervision/Reminder

Comments:

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**Incontinence**

**Urine**  Yes  No **Feces**  Yes  No **Wears “Depends”**  Yes  No

**Catheter**  Yes  No **If yes,**  indwelling urethral (foley)  Suprapubic  Condom Cath

**Problems:**  frequency with urination  Constipation  Diarrhea

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Housekeeping and Laundry**

Independent  Dependent (hands on complete assistance)  Minimal Supervision/Reminder

Comments:

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**Meal Preparation**

Independent  Dependent (complete assistance)  Minimal Supervision/Reminder

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Transferring** (Chair to chair/ Bed to Chair):

Independent  Minimal Supervision/Reminder (Verbal or Visual Cues)

Dependent (complete assistance)

If Dependent, please  One person transfer  Two-person transfer  Need Transfer Belt

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Telephone Use**

Independent  Dependent (hands on complete assistance)  Minimal Supervision/Reminder

Comments:

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**Mobility**

**Walking**

Independent  Dependent (Cannot walk)  Minimal Supervision/Support  Uses Assistive device

Comments:

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**Wheelchair Use**

Independent  Dependent (needs to be pushed)  Minimal Supervision/Support (help with doorways, elevators, ramps, unlocking/locking brakes)

Comments:

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**Turning/Transferring while in bed/chair**

Independent  Dependent  Occasional assistance

Comments:

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**Transportation**

Independent Dependent (needs rides made for them)

Mode: Car Taxi  Public transport bus/light rail Walk

Does applicant have car  Yes  No

Does applicant have driver’s license  Yes  No

Does applicant have car insurance  Yes  No

RESIDENTS OF ADULT FOSTER CARE MUST HAVE A PHYSICIAN’S STATEMENT CONFIRMING THEY CAN SAFELY OPERATE A MOTOR VEHICLE.

**Communication**

**Orientation**

to person, place and time  Periodically disoriented  Forgetful  Disoriented

Comments:

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**Speech**

Clear Clear but thought process unclear  Slurred  Gestures  Sign language

Needs interpreter  Written messages

Comments:

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**Vision**

No impairment   R  L Both

Impairment likely to increase  R  L Both   
Significant impairment  R  L Both   
Blind  R  L Both

**Hearing**

No impairment  Impairment likely to increase  Significant impairment

Blind

Comments:

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**Nutrition**

**How meals do the applicant eat a day**?  Three Two  one  Snacks  More than 3

Comments:

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**Any problems with the following:**

Difficulty chewing and/or swallowing Nausea  Poor appetite  Recent Weight Loss

Chronically underweight  Taste and/or texture issues

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Any food allergies or intolerances:**

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**Who currently prepares applicant meals**

□Self □Partner/Spouse □ Friend/relative □ Home health aid □ Restaurant/.Fast food Delivery

□ Congregate Dining □ Home meal program

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Behavioral Health**

**Daily Activities**

No interventions  Needs Cues  Sometimes need cues, may show resistance  Needs behavior management, resists redirection  Needs behavioral management, physically resists redirection

**Interaction with others**

Interacts well with others  Isolates  Difficulty considering others  Difficulty with authority

Difficulty controlling anger  Functional and appropriate support system (friends/family)

Dysfunctional support systems

**Compliance**

Willing/Able to follow directions  Willing/Able able to take medications  Willing/Able to keep appointments  Willing/Able to pay rent on time  Willing/Able to leave and return to the house at appropriate time.

**Self-Preservation**

Independent Minor supervision  Mentally unable  Physically unable  Mentally and physically unable

**Judgement and decision-making**

Appropriate/has good judgement Difficulty managing money  Problems with making decisions

Accepts assistance readily  Difficulty with impulse control  Resists or refuses assistance

**Mental Health**

Never been diagnosed with or treated for any mental health issues

Had mental health issues in the past

Has current mental health issues and is receiving treatment

Has current mental health issue and is NOT receiving treatment

Mental health treatment and/or support is received from:

Infectious Disease Provider Psychiatrist  Counseling  Support Group  Informal network

Has applicant experienced anxiety or depression?  Yes  No

Does applicant have other psychiatric diagnosis?  Yes  No

If so, name the diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the applicant take medication to mange mental health?  Yes  No

If so, name the medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has applicant ever been admitted to psychiatric facility?  Yes  No

If yes, please list name and dates\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has applicant ever contemplated suicide?  Yes  No

Has applicant ever attempted suicide?  Yes  No

If staff observe symptoms of mental health problems will applicant agree to a psychiatric consultation?

Yes  No

Does application hear or see things that other do not?  Yes  No

**Emotional Health**

Is applicant satisfied with their life today?  Yes  No

Has applicant been anxious or nervous?  Yes  No

Does applicant have difficulty sleeping?  Yes  No

Has applicant become physically aggressive or threatened anyone?  Yes  No

Has applicant made threats of self-harm?  Yes  No

Has applicant been a victim of abuse?  Yes  No

Please comment below for those questions answered, “Yes”

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Memory**

Does the applicant frequently misplace items e.g. glasses or money?  Yes  No

Has the applicant failed to recognize family of friends?  Yes  No

Has the applicant ever lost their way home?  Yes  No

Has the applicant had problems with money or bills due to memory impairment?  Yes  No

Please comment below for those questions answered, “Yes” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Recreation and social activities**

What activities does the applicant enjoy?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any activities in which applicant would like to but cannot participate in?

Click or tap here to enter text.

What does the applicant look forward to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chemical Health**

Does applicant CURRENTLY use alcohol or drugs?  Yes  No

If yes, when did you last use:

|  |  |  |  |
| --- | --- | --- | --- |
| **Drug** | **Last Use** | **Mode** | **Frequency** |
| Alcohol  Beer  Wine  Hard | Date \_\_\_\_\_\_\_\_\_ | Click or tap here to enter text. | Click or tap here to enter text. |
| Marijuana | Date \_\_\_\_\_\_\_\_\_ | Click or tap here to enter text. | Click or tap here to enter text. |
| Cocaine/Crack | Date \_\_\_\_\_\_\_\_\_ | Smoke  Injection  Inhalation  Other | Click or tap here to enter text. |
| Heroin | Date \_\_\_\_\_\_\_\_\_ | Smoke  Injection  Inhalation  Other | Click or tap here to enter text. |
| Amphetamines | Date \_\_\_\_\_\_\_\_\_ | Smoke  Injection  Inhalation  Other | Click or tap here to enter text. |
| Hallucinogenic  LSD  PCP  Mushrooms  Other | Date \_\_\_\_\_\_\_\_\_ | Smoke  Injection  Inhalation  Other | Click or tap here to enter text. |
| “Club” Drugs  Ecstasy  K | Date \_\_\_\_\_\_\_\_\_ | Smoke  Injection  Inhalation  Other | Click or tap here to enter text. |
| Prescription  Valium  Xanax  Oxycodone | Date \_\_\_\_\_\_\_\_\_ | Smoke  Injection  Inhalation  Other | Click or tap here to enter text. |

Has applicant had a problem with alcohol of drugs in the past?  Yes  No

Is applicant received inpatient, outpatient of both in the currently?  Yes  No

In the past?  Yes  No

PROGRAM DATES

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Tobacco**

Dose the applicant smoke tobacco?

If yes,

|  |  |  |  |
| --- | --- | --- | --- |
| **Substance** | **Last Use** | **Mode** | **Frequency** |
| Tobacco | Date \_\_\_\_\_\_\_\_\_ | Cigars  Cigarettes  pipe  smokeless | Times/Day  Click or tap here to enter text.  Packs/weekClick or tap here to enter text. |

Is applicant bothered by smoke?  Yes  No

Is applicant allergic to smoke?  Yes  No

**Additional Information or comments on applicant:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Minnesota Department of Health and Hennepin County require some personal information be collected and reported periodically to identify the services that people with HIV/AIDS need and use, to identify barriers to those services and verify to funding sources that this service is being provided. You have the right to refuse to share information about yourself; however, in some cases we may be unable to provide some services unless we have that information. Your name and any identifying information are not released to the Minnesota Department of Health or Hennepin County as a condition of funding. Signing this form constitutes consent to receive services from Abbott Northwester Infectious Disease Clinic AIDS Adult Foster Care social worker and I acknowledge receiving the Client’s Bill of Rights.

**Signed**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clare Housing operate as an Equal Housing Opportunity.

**Client Bill of Rights**

As a client you have the right to:

1. Be treated with consideration and respect by staff, volunteers and interns. You have the responsibility to treat staff, volunteers and interns in a similar manner.
2. Receive quality services without discrimination regardless of race, ethnicity, national origin, religion, age, sexual orientation, gender or disability.
3. Confidentiality of information we collect about you. No identifying information about you will be shared outside of Foster Care without a release of information dated and signed by you listing individuals and agencies with whom you have agreed to have us share information by fax, phone, email or meeting and that all releases will be renewed if needed, on an annual basis. Any exceptions are outlined in the data practices guidelines. All records and files pertaining to the services you receive will be kept in locked filing cabinets and/or secure computer files when not in use.
4. Review all private information in your file and obtain a copy of this information. If you request a copy, the request must be in writing and singed by you. We will not give or send a copy of your file to any other person without a singed release from you except if we receive a valid court order.
5. Expect reasonable assistance to overcome language, cultural, physical or communication barriers. This means for example, that upon request we will provide interpreters for the deaf and for those who do not speak English.
6. Prompt and reasonable response to your questions and requests.
7. Participate in developing your service plan including developing service goals that meet your needs.
8. Prompt information on how to make complaints and pursue a grievance if you are having difficulties orare dissatisfied with the services you are receiving.
9. Refuse services or recommended services and to discontinue services at Foster Care.
10. Receive timely notice and explanation of changes in program guidelines including changes in eligibility criteria and funding availability.
11. If you have questions about services or would like to make a suggestion, you may do so with your service provider, the program manager, or the director of programs.
12. Specific programs or services may have additional rights and responsibilities that will be made available to you upon entry into the program.