**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?** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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? [x]  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/DayClick 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.