EMERGENCY RENTAL ASSISTANCE PROGRAM
HOUSING STABILITY SERVICES — APPLY HERE

ERAP-HSS Client Intake & Evaluation Form

This form may not be altered. Created 07/19/2021

Basic Client Information	**Date of Assessment:** / /	***ERAP Applicant ID:***	
Legal First Name:	Legal Last Name:	Middle Initial:	Preferred Name:
Date of Birth: / /	Age:	Gender Identity: ❒ Male/Man ❒ Female/Woman ❒ Transgender ❒ Other: _____	Biological Sex at Birth: ❒ Male ❒ Female ❒ Intersex ❒ Other: _____

Ethnicity: ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ Other: _____	Race: ❒ White (Caucasian) ❒ American Indian/Alaskan ❒ Asian/Asian American ❒ Black/African American ❒ Other: _____ ❒ Native Hawaiian/Pacific Islander
Residential Address:	❒ *Check if same as Residential Address* Mailing Address:
Residential City, State and Zip Code:	Mailing City, State and Zip Code:
County of Residence:	Email:
Primary Phone Number: ( )	Secondary Phone Number: ( )

Are you disabled? ❒ Yes ❒ No	Primary Language: ❒ English ❒ Spanish ❒ Other: _____	Are you a senior citizen? ❒ Yes ❒ No
Are you a veteran? ❒ Yes ❒ No	Do you live alone? ❒ Yes ❒ No	Do you live in a rural area? ❒ Yes ❒ No

Is your monthly income at or below this amount (Depending on your family size)? ❒ Yes ❒ No

Family size 1 - $1,073 ***Family size 2 - $1,452*** ***Family size 3 - $1,830*** ***Family size 4 - $2,208***

Emergency contact name:	*Relationship:*	*Phone number:* ( )

Use of Information: The information you provide on the ERAP-HSS Client Intake Form will be disclosed to the Wyoming Department of Health (WDH), Aging Division, Community Living Section. The WDH will only use or disclose the information as permitted by the Health Insurance Portability and Accountability Act (HIPAA). For more detailed information on how the WDH may use or disclose your health information, please see the WDH Notice of Privacy Practices found online at https://health.wyo.gov/admin/privacy/ or you may request a copy from the WDH Aging Division by calling 1 (800) 442-2766. If you feel you have been treated inappropriately, received services that have not been of the quality expected, or you have not been provided services as stated in the service plan, contact the Department of Family Services at (800)-457-3659 or the WDH Aging Division, Community Living Section at (800) 442-2766.

Declaration: I hereby certify that all of the information provided in this questionnaire is true and correct to the best of my knowledge and belief. By answering "Yes" you agree that the information provided in this questionnaire is true and correct to the best of your knowledge and belief. A "Yes" answer will be considered a signature of your acceptance of this form and the information within it.

❒ Yes ❒ No

Client Signature: _____ **Date:** _____

*This page is for ERAP-HSS, all clients receiving one or more services under the ERAP-HSS program.

Wyoming Department of Health

Intake Assessment of a Client's Ability to Perform Activities of Daily Living (All Participants)

Score	ADLs (Activities of Daily Living)	Score	IADLs (Instrumental Activities of Daily Living)
	Rate client's ability to perform BATHING.		**Rate client's ability to PREPARE MEALS.**
0	Independent	**0**	Independent/ prepares simple or partial meals
2	Intermittent supervision/ minimal assistance	**1**	Prepares with verbal cueing or reminding
4	Partial assistance	**2**	Prepares with minimal help
6	Total dependence	**3**	Does not prepare any meals
	Rate client's ability to EAT.		**Rate client's ability to perform SHOPPING.**
0	Independent	**0**	Independent
2	Intermittent supervision/ minimal assistance	**2**	Does with supervision/reminding
4	Extensive help	**4**	Shops with hands-on help/ assistive devices
6	Total dependence	**6**	Done by others or shops by phone
	Rate client's mobility IN HOME.		**Rate client's ability to MANAGE MEDICATIONS.**
0	Independent		Independent/ does not occur
1	Limited physical assistance	**0**	Done with help some of the time
2	Extensive assistance	**2**	Done with help all of the time
3	Total dependence	**4**	
	Rate client's ability to perform TRANSFER.		**Rate client's ability to MANAGE MONEY.**
0	Independent	**0**	Completely independent
1	Limited physical assistance	**2**	Needs assistance sometimes
2	Extensive assistance	**4**	Needs assistance most of the time
3	Total dependence	**6**	Completely dependent
	Rate client's ability to perform TOILETING.		**Rate the client's ability to perform LIGHT HOUSEWORK.**
0	Independent	**0**	Independent
2	Reminding, cueing or monitoring	**1**	Needs assistance sometimes
4	Limited physical assistance	**2**	Needs assistance most of the time
6	Extensive assistance	**3**	Unable to perform tasks
8	Total dependence		
	Rate client's ability to perform DRESSING.		**Rate the client's ability to perform HEAVY HOUSEWORK.**
0	Independent	**0**	Independent
1	Limited physical assistance	**1**	Needs assistance sometimes
2	Reminding, cueing or monitoring	**2**	Does with maximum help
3	Extensive assistance	**3**	Unable to perform tasks
4	Total dependence		
CC Signature: _____			**Rate client's ability to USE THE TELEPHONE.**
Date: _____		**0**	Independent
Quarter Period: _____		**1**	Can perform with some help
		2	Cannot perform function at all without help
ADL Total Number: _____			**Rate the client's ability to access TRANSPORTATION.**
ADL Total Score: _____		**0**	Independent
		1	Done with help some of the time
IADL Total Number: _____		**2**	Done by others
IADL Total Score: _____		**3**	Requires ambulance
Client Initials: _____			

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Home Modifications, Repairs & Hoarding - Initial Evaluation & Project Planning	**YES**	**NO**	**IF NO, PLAN OF ACTION IS:**
General Home Access: Does the client have safe access to all necessary areas of their home? ☐ Is the client's home free of clutter? ☐ Is the home safe for someone with Alzheimer's disease, dementia or other cognitive impairments? ☐			
Entryways, Steps, Ramps and Hallways: Are the steps and walkways outside the client's home in good condition? ☐ Are transitions easy between sections inside the home? ☐ Are ramps sturdy and effective? ☐ Are hallways wide enough? ☐			
Adequate Lighting: Are all areas of the house, outside living space and the garage serviced with adequate light? ☐ Are switches easy to reach? ☐			
Doors: Are doors wide enough for wheelchair access? ☐ Are handles, levers and latches easy to use? ☐ Is the client able to unlock doors and/or windows? ☐			
Environment: Is the client's home free of insects/rodents? ☐ Is the client's home free from odors? ☐ Is the home temperate? ☐ Is the client's home electrical hazard free? ☐			
Kitchen & Laundry: Do appliances work properly? ☐ Are they easy to use? ☐ Is there adequate/proper food storage and waste removal? ☐ Can all cupboards, counters and appliances be safely reached? ☐ Is the flooring adequate for their needs? ☐			
Bathroom: Is the bathroom adequate to meet the client's needs? ☐ Can all cupboards, counters and utilities be safely reached? ☐ Can the client shower/bath safely? ☐ Are sinks wheelchair accessible? ☐ Is there a non-skid bathmat in the bathtub? ☐			
Emergency Exits: In the case of an emergency, would the client be able to get out of his/her home safely on their own? ☐ Are smoke and carbon monoxide detectors present and in working order? ☐ Is the client's home free from fire hazards (i.e. frayed cords, items next to heater, etc.)? ☐			
Stairs: Do stairs have sturdy rails on both sides that are securely fastened? ☐ Are the stair treads sturdy, not deteriorating or broken? ☐ Are top and bottom steps highlighted? ☐ Are stairs and landings well lit, light switches top and bottom? ☐			
All Rooms: Are beds and couches easy to get in/out of? ☐ Are closets easy to enter, use, with items spaced correctly? ☐ Are cords and wires safely hidden away? ☐			
General Home Condition: Is the home sturdy, weather proofed and insulated for heat and have adequate cooling? ☐ Are windows easy to use and accessible? ☐ Is A/C medically necessary for this person? ☐ Is the roof in good condition? ☐			
Project Planning & Other Notes:			

Client Signature: _____ **Date:** _____

CC Signature: _____ **Date:** _____ ☐ HM ☐ T/MHR ☐ HS

*This page is only for those ERAP-HSS clients receiving: Home Modifications, Trailer/Mobile Home Repairs or Hoarding Services

Home Modifications, Repairs & Hoarding - Final Evaluation	**YES**	**NO**	**IF NO, PLAN OF ACTION IS:**
General Home Access: Does the client have safe access to all necessary areas of their home? ☐ Is the client's home free of clutter? ☐ Is the home safe for someone with Alzheimer's disease, dementia or other cognitive impairments? ☐			
Entryways, Steps, Ramps and Hallways: Are the steps and walkways outside the client's home in good condition? ☐ Are transitions easy between sections inside the home? ☐ Are ramps sturdy and effective? ☐ Are hallways wide enough? ☐			
Adequate Lighting: Are all areas of the house, outside living space and the garage serviced with adequate light? ☐ Are switches easy to reach? ☐			
Doors: Are doors wide enough for wheelchair access? ☐ Are handles, levers and latches easy to use? ☐ Is the client able to unlock doors and/or windows? ☐			
Environment: Is the client's home free of insects/rodents? ☐ Is the client's home free from odors? ☐ Is the home temperate? ☐ Is the client's home electrical hazard free? ☐			
Kitchen & Laundry: Do appliances work properly? ☐ Are they easy to use? ☐ Is there adequate/proper food storage and waste removal? ☐ Can all cupboards, counters and appliances be safely reached? ☐ Is the flooring adequate for their needs? ☐			
Bathroom: Is the bathroom adequate to meet the client's needs? ☐ Can all cupboards, counters and utilities be safely reached? ☐ Can the client shower/bath safely? ☐ Are sinks wheelchair accessible? ☐ Is there a non-skid bathmat in the bathtub? ☐			
Emergency Exits: In the case of an emergency, would the client be able to get out of his/her home safely on their own? ☐ Are smoke and carbon monoxide detectors present and in working order? ☐ Is the client's home free from fire hazards (i.e. frayed cords, items next to heater, etc.)? ☐			
Stairs: Do stairs have sturdy rails on both sides that are securely fastened? ☐ Are the stair treads sturdy, not deteriorating or broken? ☐ Are top and bottom steps highlighted? ☐ Are stairs and landings well lit, light switches top and bottom? ☐			
All Rooms: Are beds and couches easy to get in/out of? ☐ Are closets easy to enter, use, with items spaced correctly? ☐ Are cords and wires safely hidden away? ☐			
General Home Condition: Is the home sturdy, weather proofed and insulated for heat and have adequate cooling? ☐ Are windows easy to use and accessible? ☐ Is A/C medically necessary for this person? ☐ Is the roof in good condition? ☐			

Project Planning & Other Notes:

Client Signature: _____ **Date:** _____

CC Signature: _____ **Date:** _____ ☐ HM ☐ T/MHR ☐ HS

*This page is only for those ERAP-HSS clients receiving: Home Modifications, Trailer/Mobile Home Repairs or Hoarding Services

90th Day Client Quarterly Evaluation

Score	ADLs (Activities of Daily Living)	Score	IADLs (Instrumental Activities of Daily Living)
	Rate client's ability to perform BATHING.		**Rate client's ability to PREPARE MEALS.**
0	Independent	0	Independent/ prepares simple or partial meals
2	Intermittent supervision/ minimal assistance	1	Prepares with verbal cueing or reminding
4	Partial assistance	2	Prepares with minimal help
6	Total dependence	3	Does not prepare any meals
	Rate client's ability to EAT.		**Rate client's ability to perform SHOPPING.**
0	Independent	0	Independent
2	Intermittent supervision/ minimal assistance	2	Does with supervision/reminding
4	Extensive help	4	Shops with hands-on help/ assistive devices
6	Total dependence	6	Done by others or shops by phone
	Rate client's mobility IN HOME.		**Rate client's ability to MANAGE MEDICATIONS.**
0	Independent		Independent/ does not occur
1	Limited physical assistance	0	Done with help some of the time
2	Extensive assistance	2	Done with help all of the time
3	Total dependence	4	
	Rate client's ability to perform TRANSFER.		**Rate client's ability to MANAGE MONEY.**
0	Independent	0	Completely independent
1	Limited physical assistance	2	Needs assistance sometimes
2	Extensive assistance	4	Needs assistance most of the time
3	Total dependence	6	Completely dependent
	Rate client's ability to perform TOILETING.		**Rate the client's ability to perform LIGHT HOUSEWORK.**
0	Independent	0	Independent
2	Reminding, cueing or monitoring	1	Needs assistance sometimes
4	Limited physical assistance	2	Needs assistance most of the time
6	Extensive assistance	3	Unable to perform tasks
8	Total dependence		
	Rate client's ability to perform DRESSING.		**Rate the client's ability to perform HEAVY HOUSEWORK.**
0	Independent	0	Independent
1	Limited physical assistance	1	Needs assistance sometimes
2	Reminding, cueing or monitoring	2	Does with maximum help
3	Extensive assistance	3	Unable to perform tasks
4	Total dependence		
CC Signature: _____			**Rate client's ability to USE THE TELEPHONE.**
Date: _____		0	Independent
Quarter Period: _____		1	Can perform with some help
ERAP Applicant ID: _____		2	Cannot perform function at all without help
ADL Total Number: _____			**Rate the client's ability to access TRANSPORTATION.**
ADL Total Score: _____		0	Independent
		1	Done with help some of the time
IADL Total Number: _____		2	Done by others
IADL Total Score: _____		3	Requires ambulance
Client Initials: _____			

*This page is for those ERAP-HSS clients receiving: Homemaking Services, Personal Care – Skilled Nursing Services, Non-Medical Transportation, Personal Emergency Response System (PERS), Information Technology Hardware or Independent Living Skills