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. Updated 11/19/2021 - Version 2

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:* *( )*

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. A signature will be considered acceptance that this form and the information contained therein is true and accurate.

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.

Client Signature: ____ **Date:** ______________

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

Intake Assessment/Renewal 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 Bowel/Bladder CONTINENCE.		**Rate client's ability to MANAGE MEDICATIONS.**
0	Independent	0	Independent/ does not occur
1	Requires assistance sometimes	2	Done with help some of the time
2	Totally dependent	4	Done with help all of the time
	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 LAUNDRY.**
0	Independent	0	No setup or physical help/ Independent
1	Limited physical assistance	1	Supervision/cueing required
2	Reminding, cueing or monitoring	2	Totally dependent
3	Extensive assistance		
4	Total dependence		
	Provider Signature: ______________________		**Rate client's ability to USE THE TELEPHONE.**
	Date: ______________________	0	Independent
	Quarter 1 of 4: ______________________	1	Can perform with some help
	ADL Count of Categories >0: ______________________	2	Cannot perform function at all without help
	ADL Total Score: ______________________		**Rate the client's ability to access TRANSPORTATION.**
	IADL Count of Categories >0: ______________________	0	Independent
	IADL Total Score: ______________________	1	Done with help some of the time
	Client Signature & Initials: ______________________	2	Done by others
		3	Requires ambulance

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**Each intake form should end up with 4 quarterly assessments ADL's and IADL's a year unless. An initial intake is the first quarter assessment.

Home Modifications, Repairs & Hoarding - Initial Evaluation & Project Planning	**YES**	**NO**	**IF NO, THE 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 bath mat 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:** ______________

Provider Signature: ______________________________ **Date:** ______________

(Circle the correct program below)

- HM
- T/MHR
- HS

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

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 bath mat 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:** _____________

Provider Signature: ______________________________________ **Date:** _____________

(Circle the correct program below)
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90th Day Client Quarterly Assessment – Quarter 2 of 4

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 Bowel/Bladder CONTINENCE.		**Rate client's ability to MANAGE MEDICATIONS.**
0	Independent	**0**	Independent/ does not occur
1	Requires assistance sometimes	**2**	Done with help some of the time
2	Totally dependent	**4**	Done with help all of the time
	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		
2	Reminding, cueing or monitoring	**0**	Independent
4	Limited physical assistance	**1**	Needs assistance sometimes
6	Extensive assistance	**2**	Needs assistance most of the time
8	Total dependence	**3**	Unable to perform tasks
	Rate client's ability to perform DRESSING.		**Rate the client's ability to perform LAUNDRY.**
0	Independent	**0**	No setup or physical help/ Independent Supervision/cueing
1	Limited physical assistance	**1**	required
2	Reminding, cueing or monitoring	**2**	Totally dependent
3	Extensive assistance		
4	Total dependence		
	Provider Signature: ______________________________		**Rate client's ability to USE THE TELEPHONE.**
	Date: ____	**0**	Independent
	ADL Count of Categories >0: ____________________	**1**	Can perform with some help
	ADL Total Score: ________________________________	**2**	Cannot perform function at all without help
	IADL Count of Categories >0: ___________________		**Rate the client's ability to access TRANSPORTATION.**
	IADL Total Score: ______________________________	**0**	Independent
	Client Signature & Initials: ___________________	**1**	Done with help some of the time
		2	Done by others
		3	Requires ambulance

*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 - Quarterly (optional), Independent Living Skills or Hoarding Services – Mental Health Counseling

**Each intake form should end up with 4 quarterly assessments ADL's and IADL's a year unless. An initial intake is the first quarter assessment.

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90th Day Client Quarterly Assessment – Quarter 3 of 4

Score	ADLs (Activities of Daily Living)	Score	IADLs (Instrumental Activities of Daily Living)
 0 2 4 6	**Rate client's ability to perform BATHING.** Independent Intermittent supervision/ minimal assistance Partial assistance Total dependence	 0 1 2 3	**Rate client's ability to PREPARE MEALS.** Independent/ prepares simple or partial meals Prepares with verbal cueing or reminding Prepares with minimal help Does not prepare any meals
 0 2 4 6	**Rate client's ability to EAT.** Independent Intermittent supervision/ minimal assistance Extensive help Total dependence	 0 2 4 6	**Rate client's ability to perform SHOPPING.** Independent Does with supervision/reminding Shops with hands-on help/ assistive devices Done by others or shops by phone
 0 1 2	**Rate client's Bowel/Bladder CONTINENCE.** Independent Requires assistance sometimes Totally dependent	 0 2 4	**Rate client's ability to MANAGE MEDICATIONS.** Independent/ does not occur Done with help some of the time Done with help all of the time
 0 1 2 3	**Rate client's ability to perform TRANSFER.** Independent Limited physical assistance Extensive assistance Total dependence	 0 2 4 6	**Rate client's ability to MANAGE MONEY.** Completely independent Needs assistance sometimes Needs assistance most of the time Completely dependent
 0 2 4 6 8	**Rate client's ability to perform TOILETING.** Independent Reminding, cueing or monitoring Limited physical assistance Extensive assistance Total dependence	 0 1 2 3	**Rate the client's ability to perform LIGHT HOUSEWORK.** Independent Needs assistance sometimes Needs assistance most of the time Unable to perform tasks
 0 1 2 3 4	**Rate client's ability to perform DRESSING.** Independent Limited physical assistance Reminding, cueing or monitoring Extensive assistance Total dependence	 0 1 2	**Rate the client's ability to perform LAUNDRY.** No setup or physical help/ Independent Supervision/cueing required Totally dependent
Provider Signature: ______________________________ **Date:** ____		 0 1 2	**Rate client's ability to USE THE TELEPHONE.** Independent Can perform with some help Cannot perform function at all without help
ADL Count of Categories >0: ____________________ **ADL Total Score:** ______________________________ **IADL Count of Categories >0:** ___________________ **IADL Total Score:** _____________________________ **Client Signature & Initials:** ____________________		 0 1 2 3	**Rate the client's ability to access TRANSPORTATION.** Independent Done with help some of the time Done by others Requires ambulance

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90th Day Client Quarterly Assessment – Quarter 4 of 4

Score	ADLs (Activities of Daily Living)	Score	IADLs (Instrumental Activities of Daily Living)
 0 2 4 6	**Rate client's ability to perform BATHING.** Independent Intermittent supervision/ minimal assistance Partial assistance Total dependence	 0 1 2 3	**Rate client's ability to PREPARE MEALS.** Independent/ prepares simple or partial meals Prepares with verbal cueing or reminding Prepares with minimal help Does not prepare any meals
 0 2 4 6	**Rate client's ability to EAT.** Independent Intermittent supervision/ minimal assistance Extensive help Total dependence	 0 2 4 6	**Rate client's ability to perform SHOPPING.** Independent Does with supervision/reminding Shops with hands-on help/ assistive devices Done by others or shops by phone
 0 1 2	**Rate client's Bowel/Bladder CONTINENCE.** Independent Requires assistance sometimes Totally dependent	 0 2 4	**Rate client's ability to MANAGE MEDICATIONS.** Independent/ does not occur Done with help some of the time Done with help all of the time
 0 1 2 3	**Rate client's ability to perform TRANSFER.** Independent Limited physical assistance Extensive assistance Total dependence	 0 2 4 6	**Rate client's ability to MANAGE MONEY.** Completely independent Needs assistance sometimes Needs assistance most of the time Completely dependent
 0 2 4 6 8	**Rate client's ability to perform TOILETING.** Independent Reminding, cueing or monitoring Limited physical assistance Extensive assistance Total dependence	 0 1 2 3	**Rate the client's ability to perform LIGHT HOUSEWORK.** Independent Needs assistance sometimes Needs assistance most of the time Unable to perform tasks
 0 1 2 3 4	**Rate client's ability to perform DRESSING.** Independent Limited physical assistance Reminding, cueing or monitoring Extensive assistance Total dependence	 0 1 2	**Rate the client's ability to perform LAUNDRY.** No setup or physical help/ Independent Supervision/cueing required Totally dependent
Provider Signature: ____________________________ **Date:** ______________________________________ **ADL Count of Categories >0:** ___________________ **ADL Total Score:** ______________________________ **IADL Count of Categories >0:** __________________ **IADL Total Score:** _____________________________ **Client Signature & Initials:** ____________________		 0 1 2	**Rate client's ability to USE THE TELEPHONE.** Independent Can perform with some help Cannot perform function at all without help
		 0 1 2 3	**Rate the client's ability to access TRANSPORTATION.** Independent Done with help some of the time Done by others Requires ambulance

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