



OLDER ADULT SERVICES APPLICATION

Name: _____ Phone _____
(Last) (First) (MI)

Address: _____
(Street) (City, state, zip code)

Email Address: _____

Date of Birth _____ Male Female

Marital Status: Married Divorced Widowed Single

Please mark all that apply:

- No dental insurance
- No health insurance
- No vision insurance
- Dementia
- Raising grandchildren
- Past-due notice on utility
- Utility shut-off notice
- Food Stamps \$ _____ (Amount received monthly)
- On Dialysis

Please answer the following:

- Disabling Condition: Yes No
- U.S. Military Status: None Active Duty Veteran
- Health Insurance: None Direct Purchase Employment Based Medicaid Medicare
- Housing: Own Rent Affordable Safe
- Energy Bills: Pay easily Struggle to pay
- Transportation: Own, reliable vehicle No or unsafe vehicle
- Food: Have enough food for the month Do NOT have enough food for the month
- Clothing: Can afford clothes Cannot afford clothes Use clothing banks
- Medicine: Can afford Cannot afford

Please check race/ethnic background:

- White/Caucasian
- Black/African American
- Asian
- American Indian/Alaska Native
- Native Hawaiian/Other Pacific Islander
- Bi-racial/Multi-Racial
- Hispanic
- Refuse to answer

How did you hear about this OLHSA program? _____

Highest Level of Education Completed: _____

Total number of people in household: ____

	Name	Relationship to Head of Household	Date of Birth	Age	Gross Monthly Income and source of income (Please list each type separately)
Head of Household					
Spouse					
Other Member					
Other Member					

SERVICES REQUESTED

____ Grass Cutting ____ Acreage ____ Snow removal ____ Length of driveway for snow removal

____ Home Injury Control (enclose Home Injury Control Devices form)

Please see our website www.olhsa.org or call 248-209-2600 to find out about other services available.

Please mark all activities that you are unable to perform without personal assistance, stand-by assistance, supervision or cues.

Activities of Daily Living:	
<input type="checkbox"/> Eating/feeding	<input type="checkbox"/> Toileting (Grooming)
<input type="checkbox"/> Dressing	<input type="checkbox"/> Bladder function
<input type="checkbox"/> Bathing	<input type="checkbox"/> Bowel function
<input type="checkbox"/> Walking	<input type="checkbox"/> Wheeling
<input type="checkbox"/> Stair climbing	<input type="checkbox"/> Transferring
<input type="checkbox"/> Bed mobility	<input type="checkbox"/> Mobility level

Instrumental Activities of Daily Living:	
<input type="checkbox"/> Shopping	<input type="checkbox"/> Cooking meals
<input type="checkbox"/> Handling finances	<input type="checkbox"/> Reheating meals
<input type="checkbox"/> Heavy cleaning	<input type="checkbox"/> Taking medication
<input type="checkbox"/> Light cleaning	<input type="checkbox"/> Using phone
<input type="checkbox"/> Using public transportation	<input type="checkbox"/> Doing laundry
<input type="checkbox"/> Using private transportation	<input type="checkbox"/> Keeping appointments
	<input type="checkbox"/> Heating home

Emergency Contact: _____ **Relationship to Client:** _____

Phone (Home): _____ **Phone (Mobile):** _____

Hospital of Choice: _____ **Hospital City:** _____

I certify that the statements and information contained in this document are true, accurate and complete.

Print Name: _____

Participant/Proxy Signature: _____ Date: _____



A Community Action Agency

Home Injury Control Devices

Client Name _____ Address _____

Phone Number _____ Emergency Contact name and number _____

Date of Application _____ Worker who took application _____

Amount of Donation: _____ Is client currently at home? _____

Have you had any falls in the bathroom during the last 6 months? If yes, how many? _____

If you would like a shower chair or transfer bench, please estimate your weight: _____

I want these items

- _____ **installed grab bars (max 2 bars only)**
- _____ shower chair with back
- _____ shower chair without back
- _____ transfer bench
- _____ hand-held showerhead
- _____ tub mat
- _____ smoke alarm
- _____ CO detector
- _____ raised toilet seat with bars
- _____ bedside commode

I received these items

- installed grab bars**_____
- shower chair with back_____
- shower chair without back_____
- transfer bench_____
- hand-held showerhead _____
- tub mat_____
- smoke alarm_____
- CO detector_____
- raised toilet seat with bars_____
- bedside commode_____
- Safety Manual _____

I certify that I have received the above devices that are marked on the right side of the page.

Client Signature Date

Worker/Contractor Signature Date

MHR:

_____ stairway/hallway wall bars stairway/hallway wall bars _____



Release of Information for OLHSA's Older Adults Services Program

I _____ declare to the best of my knowledge, I am the only member of my household designated above who has applied for assistance in this program. I certify that my household meets the income guidelines of this program. I authorize OLHSA to verify information I have provided regarding income by waiving my rights to privacy concerning such records. Further, I certify that all information on the application is true and correct realizing misrepresentation is illegal and violations will be pursued. I hereby release any information on the application to agencies to which I may be referred.

I also declare that I am a person 60 years or older, handicapped, or low income. As a recipient of OLHSA older adult services programs funded by the Area Agency on Aging 1-B (AAA1-B) funds. I give my consent to release information about myself, which may be necessary to secure services, follow-up assistance, and that emergency information can be shared and /or emergency contacts notified in the event of an emergency. I give my consent to have my demographic data to be reported in the National Aging Program Information System (NAPIS) if applicable. I understand that this information will only be released to an appropriate management person, applicable funding source representative, or emergency contact while I am a client of an OLHSA program. I understand that my name, address and phone number will be supplied to the contractors or volunteers by email in order for them to provide services to me. I hereby fully indemnify and hold harmless the OLHSA Board, Staff, Administration, AAA1-B, and assigns from any and all expenses and liability of any kind which may arise out of or in connection with the performance of OLHSA'S Older Adult Services Program.

Participant's Printed Name

Participant/Proxy Signature Date

Tub Bar Installation Release

In consideration of OLHSA's agreement to install tub grab bars at _____ [insert address], the undersigned, on its own behalf and on behalf of all individuals, family members, guests, and/or invitees, both now and in the future, on said property, does forever waive any and all claims against OLHSA and its employees, agents and representatives, including but not limited to any slip and fall claim at the above said address.

IN WITNESS WHEREOF, the undersigned has executed this Release as his or her free act and deed this ____ day of _____ [insert date]. _____ [insert name]

WITNESS:



From: Pauline Kenner, Older Adult Supervisor

OLHSA, A Community Action Agency, has been installing safety devices such as grab bars for over a decade in the homes and apartments of eligible senior citizens at their request. OLHSA is a private, non-profit agency using funding for this program from the Area Agency on Aging 1-B.

OLHSA uses standard 16" steel bars. This installation is done by an experienced contractor or volunteer of OLHSA, using anchors appropriate to the wall type.

If you need further information, please contact me at (248)209-2722.

In order to proceed with the requested installation, it will be necessary for the apartment management to return a signed copy of this letter to me authorizing OLHSA to do this work.

Authorization to Install Safety Grab Bars

As an authorizing official of the _____ Apartments, I hereby grant permission for OLHSA to install a standard grab bar(s) in the apartment:

(Resident's Name)

Apt #

I understand OLHSA is fully bonded and insured and there will be no charge to the resident or the apartment complex for this service.

Signature: _____

Date: _____

Printed Name: _____

Title _____



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I also declare that I am a person 60 years or older, handicapped, or low income. As a recipient of OLHSA older adult services programs funded by the Area Agency on Aging 1-B (AAA1-B) funds. I give my consent to release information about myself, which may be necessary to secure services, follow-up assistance, and that emergency information can be shared and /or emergency contacts notified in the event of an emergency. I give my consent to have my demographic data to be reported in the National Aging Program Information System (NAPIS) if applicable. I understand that this information will only be released to an appropriate management person, applicable funding source representative, or emergency contact while I am a client of an OLHSA program. I understand that my name, address and phone number will be supplied to the contractors or volunteers by email in order for them to provide services to me. I hereby fully indemnify and hold harmless the OLHSA Board, Staff, Administration, AAA1-B, and assigns from any and all expenses and liability of any kind which may arise out of or in connection with the performance of OLHSA'S Older Adult Services Program.

Participant's Printed Name

Participant/Proxy Signature

Date

Other Referrals Made:

I give my verbal release of info for these follow up referrals. Worker list referral, initial and date.

MMAPI\SHIP talk _____

Other _____