OLHSA
A Community Action Agency

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:

__ Eating/feeding
__ Dressing
__ Bathing
__ Walking
__ Stair climbing
__ Bed mobility
__ Toileting (Grooming)
__ Bladder function
__ Bowel function
__ Wheeling
__ Transferring
__ Mobility level

Instrumental Activities of Daily Living:

__ Shopping
__ Handling finances
__ Heavy cleaning
__ Light cleaning
__ Using public transportation
__ Using private transportation
__ Cooking meals
__ Reheating meals
__Taking medication
__ Using phone
__ Doing laundry
__ Keeping appointments
__ 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: _____

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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	I received these items
___ bedside commode	bedside commode _____
___ CO detector	CO detector _____
___ hand-held showerhead	hand-held showerhead _____
___ installed grab bars (maximum 2 bars only)	installed grab bars _____
___ raised toilet seat with bars	raised toilet seat with bars _____
___ shower chair with back	shower chair with back _____
___ shower chair without back	shower chair without back _____
___ smoke alarm	smoke alarm_____
___ transfer bench	transfer bench_____
___ tub mat	tub mat _____

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_____

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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:

_____

_____

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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_____

forms\tub bar waiver

Updated 2/25/15

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_____

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.

MMAP\SHIP talk _____

Other _____