OLHSA
A Community Action Agency

Older Adult Services Application

Participant/Head of Household Information **Date:** _____

Name: _____ Phone_____
(Last) (First) (MI)
Address: _____
(street) (city, state, zip code)
Date of Birth_____ _____Male _____Female

Marital Status: _____ Married ____ Divorced _____ Widow/er _____ Single

Please mark if the following applies:

__ Disabled
__ Medicaid/Medicare
__ No dental insurance
__ No health insurance
__ No vision insurance
__ Dementia
__ Veteran
__ Past-due notice on utility
__ Raising grandchildren
__ Utility shut-off notice
__ Food Stamps $ _____ Amount received monthly
__ On Dialysis

Please check race/ethnic background:

__ White/Caucasian
__ Black/African American
__ Asian
__ American Indian/Alaska Native
__ Native Hawaiian/Other Pacific Islander
__ Hispanic
__ Other Multi-Racial

How did you hear about this OLHSA program?
_____

Email Address _____

Highest Level of Education Completed _____

Household Information

__ Own Home ___ Rent Total number of people in household:_____

Have you had any falls in the bathroom during the last 6 months? If you did how many? ___

Assessment/Baseline Data

Housing: Is your home affordable and safe? _____

Energy: Can you pay your utility bills without struggling? _____

Transportation: Do you have a vehicle? Is it reliable? _____

Food: Does your household have enough food for the month? _____

Clothing: Can you afford clothing? Do you use clothing banks? _____

Medicine: Are your medications affordable? _____

Continued....

	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		**N/A**			
Spouse					
Other Member					
Other Member					

SERVICES REQUESTED

___ Grass Cutting ____ Snow removal _____Length of driveway for snow removal

____ Home Injury Control (enclose OLHSA device available list)

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 Information

Emergency Contact:_____ Relationship to Client: _____

Address _____

Phone (Home): _____ Phone (Work) _____

Hospital of Choice: _____ Phone number_____

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

Participant's Name: _____

Participant's Signature: _____ Date: _____