

**City of Plainfield Office of Community Development
Safe Housing and Transportation Program
Client Intake Form**

Name _____ S.S.# _____

Address _____ Telephone # _____

1. With what ethnic or racial group do you identify? _____
2. Do you speak / understand English? Yes _____ No _____
3. Total annual income from all sources: \$ _____
4. Do you live: alone? ____; with spouse? ____; with children? ____; with grandchildren? ____
other (please specify) _____

THE FOLLOWING QUESTIONS ARE BEING ASKED TO DETERMINE VULNERABILITY.

5. How many of your friends and/or relatives live near you? _____
6. How often do you see your friends and/or relatives? _____
7. Are you presently receiving any social services? (i.e. transportation, meals, home health care)
_____ If yes, which services? _____
8. Do you have someone who would take care of you if you were sick or disabled (i.e. friend or family member)? Yes _____ No _____
9. Do you need help to do the following? If you need help, are you currently receiving it?

	Help Needed: <u>Y</u> es / <u>N</u> o	Help Received: <u>Y</u> es / <u>N</u> o	<u>R</u> egularly / <u>O</u> ccasionally
____ Shopping	_____	_____	_____
____ Using the telephone	_____	_____	_____
____ Filling out forms	_____	_____	_____
____ Getting to the doctor	_____	_____	_____
____ Banking	_____	_____	_____

THE FOLLOWING QUESTIONS ARE BEING ASKED TO DETERMINE FRAILTY.

10. Are you able to leave your home without assistance? Yes _____ No _____
11. Do you need assistance to get around your home? Yes _____ No _____
12. Do you use any of the following ambulatory devices? Walker _____

Wheelchair _____ Cane _____ Crutches _____

Other (Please Specify) _____

13. Please rate each of the following as **Good**, **Fair** or **Poor**.

Vision _____ Hearing _____ Teeth _____ General Health _____

14. Do you need help to do the following? If you need help, are you currently receiving it?

	Help Needed: <u>Y</u> es / <u>N</u> o	Help Received: <u>Y</u> es / <u>N</u> o	<u>R</u> egularly / <u>O</u> ccasionally
___ Getting out of bed & dressed	___	___	___
___ Using the bathroom / bathing	___	___	___
___ Laundry	___	___	___
___ Preparing meals	___	___	___
___ Eating	___	___	___
___ Climbing stairs	___	___	___
___ Housekeeping	___	___	___
___ Remember / taking Medicine	___	___	___

Signature _____

Date _____