Clare Housing Adult Foster Care Application Part A. This part of the application must be filled out by applicant case manager, family member or emergency contact.

PLEASE EMAIL COMPLETED Applications to: HousingApplicant@clarehousing.org
OR FAX TO:612 236 9520

Demographics

Date of Application**:** _____ Name of Person completing application: _____ Relationship to Applicant: _____ Contact information: _____
Location of screening: ☐ Applicant residency ☐ Hospital ☐ Nursing Home ☐ Case manager office ☐ Other

Personal Information:

First Name: _____Last Name: _____ Social Security #: _____DOB: _____
MA or PMI: _____

Gender: ☐ Female ☐ Male ☐ Non-binary Country of Birth: _____ Ethnicity: _____

Permanent Street Address: _____City: _____ State____ Zip Code _____
Phone: _____

Temporary Street Address: _____City: _____ State____ Zip Code _____
Phone: _____

County of Financial Responsibility: Marital status: Click or tap here to enter text.
Name of Emergency Contact: _____ Phone: _____

Do you require an apartment with special accommodations for a physical disability?
If yes, what type accommodations do you need?
_____
_____

History of Criminal or Violent Behavior
We understand that applicants to Clare Housing may have a criminal background. Please describe your criminal history including misdemeanor and felony charges. Please include date of charge, location, sentence, incarceration, parole, etc.
_____
_____
_____
Are you currently on parole, probation or community supervision? ☐ Yes ☐ No
If so, list the name of the worker, agency, phone number, and dates of supervision:
_____
_____

Previous Housing Status (please list last 5 residencies)

Address	Dates of residency	Lease Amt?	Rent Amt?	Reason for leaving?

Preferences:
When is residency desired? ☐ ASAP ☐ Within 3 mos. ☐ Undetermined

Homes (check all that applicant is interested in):
☐ Agape Dos, Mpls., Asleep overnight
☐ Damiano, Mpls., Asleep overnight
☐ Grace 2, Mpls., AWAKE overnight

Why is applicant interested in Adult Foster Care services?
☐ Temporary absence or inability of caregiver
☐ Permanent loss of caregiver
☐ Exhausted caregiver
☐ Behavioral of Emotional Problems
☐ Disorientation or Confusion
☐ Change in functional capacity due to illness or injury
☐ Current services are inadequate
☐ Provider request consideration of supportive housing
☐ Other

Comments:
_____
_____

Pets

Does applicant have pets? ☐ Yes ☐ No
What kind? ☐ Dog ☐ Cat

Clare Housing has a case-by-case pet policy which will be discussed at face-to-face meeting.

CADI (Must have a CADI waiver to live in Foster Care Homes)
Do you have a CADI waiver? ☐ Yes ☐ No
Do you have MA-Dx? ☐ Yes ☐ No
Have you completed the SMRT process? ☐ Yes ☐ No ☐ Unsure
IF yes name/email/ phone of CADI case manager _____
Have you have been assessed for a CADI waiver? ☐ Yes ☐ No ☐ Unsure
If yes, where are you in the process? _____

Income Information

Primary source of income (check all that apply):

☐ GA Amt. per month: _____
☐ SSI/SSDI Amt. per month: _____
☐ Employment Amt. per month: _____
☐ Child Support Amt. per month: _____
☐ Pension Amt. per month: _____
☐ Retirement Amt. per month: _____
☐ Other Amt. per month: _____

Employer, if applicable (name, address, phone, length of employment):

_____

_____

Legal:

Health Care POA If yes, Name: _____ Phone # _____

Legal POA If yes, Name: _____ Phone # _____

Legal Guardian If yes, Name: _____ Phone # _____

Does Applicant have a health care Directive (copy should be provided with application)

Applicant must be willing to provide payment to the adult foster care home on or before the 6th day of each month. In the event applicant is unable to make payment, how will fees by paid and by whom:

_____

Applicants Current CODE STATUS (check one):

☐ Do Not resuscitate (DNR)
☐ Do Not Intubate (DNI)
☐ Full Code

☐ Does applicant have pre-arrange burial or cremation plans
IF yes, please provide name and address _____

Health Insurance (check all that apply):

☐ Medicare A
☐ Medicare B
☐ Medicare D
☐ Medicaid Eligibility Status: _____
☐ Private Name of Insurance Carrier: _____
☐ Veteran
☐ Other

Providers:

Primary Physician: Name _____ Clinic _____

Date of Last Clinic visit: _____
Phone: _____Fax: _____

Other Medical Providers:
Name of Provider: _____Clinic: _____
Type of Provider: _____ Date of Last Clinic visit: _____
Phone: _____Fax: _____

Name of Provider: _____Clinic: _____
Type of Provider: _____ Date of Last Clinic visit: _____
Phone: _____Fax: _____

Name of Provider: _____Clinic: _____
Type of Provider: _____ Date of Last Clinic visit: _____
Phone: _____Fax: _____

Name of Provider: _____Clinic: _____
Type of Provider: _____ Date of Last Clinic visit: _____
Phone: _____Fax: _____

Case Managers and Workers:
CADI Case manager
Name _____ Organization _____ Phone/Email: _____

HIV Case manager
Name _____ Organization _____ Phone/Email: _____

County Case manager
Name _____ Organization _____ Phone/Email: _____

Independent Living Services (ILS) worker
Name _____ Organization _____ Phone/Email: _____

Adult Rehabilitative Mental Health Services
Name _____ Organization _____ Phone/Email: _____

Transitional Housing Case Manager

Name _____ Organization _____ Phone/Email: _____

Home Care Agency
Name _____ Organization _____ Phone/Email: _____

Other
Name _____ Organization _____ Phone/Email: _____

Hospital and Long-term Care Information

Hospital and ED visits

Number of ED visits in the 12 months? _____ Past 3 mos.? ___ Last mos.___

Briefly describe reason for visit:

_____

_____

Number of hospitalizations in the 12 months? _____ Past 3 mos.? ___Last mos.___

Briefly describe reason for visit:

_____

_____

Long Term Care Information

Has applicant ever been a resident at one of the following places (mark all that apply) ? □ Nursing Home
☐ Respite ☐ Adult Foster Care ☐ Group Home ☐ Regional Treatment Center ☐ other

If yes, do we have permission to contact them? ☐ Yes ☐ No
If yes, please fill in below:

Name of Residency	**Dates**	**Contact Info**

Home Safety and Accessibility Concerns (check all that apply):

☐ Signs of careless smoking ☐ Fire hazards ☐ unsafe food ☐ unsanitary conditions ☐ unpleasant odor
☐ Insects or pests ☐ lack general cleanliness ☐ excess clutter ☐ signs of excess chemical use
☐Insufficient heating or cooling ☐ Living alone ☐ stairs ☐ doors do not lock ☐ other

Comments:

_____

_____

Adaptive Equipment or Assistive Devices:

Dentures	☐ Owns	☐Needs
Hearing Aid	☐ Owns	☐Needs
Glasses	☐ Owns	☐Needs
Contact Lenses	☐ Owns	☐Needs
Cane	☐ Owns	☐Needs
Walker	☐ Owns	☐Needs
Brace (leg/back)	☐ Owns	☐Needs
Manual wheelchair	☐ Owns	☐Needs

Electric Wheelchair	☐ Owns	☐Needs
Medical Alert (Lifeline)	☐ Owns	☐Needs
Bedside Commode	☐ Owns	☐Needs
Raised toilet seats	☐ Owns	☐Needs
Grab bars	☐ Owns	☐Needs
Bed (safety rails)	☐ Owns	☐Needs
Hoyer Lift	☐ Owns	☐Needs
Adaptive eating equipment	☐ Owns	☐Needs
Hospital Bed	☐ Owns	☐Needs
Lift Chair	☐ Owns	☐Needs
Other	☐ Owns	☐Needs

Activities of Daily Living (ADLs)

Bathing

☐ Independent ☐ Dependent (hands on complete assistance) ☐ Minimal Supervision/Reminder ☐ Assistance with in/out shower ☐ Assistance with washing/drying body

Comments:

Dressing

☐ Independent ☐ Dependent (hands on complete assistance) ☐ Minimal Supervision/Reminder

Comments:

Grooming (comb hair, wash face, brush teeth and shave):

☐ Independent ☐ Dependent (hands on complete assistance) ☐ Minimal Supervision/Reminder

Comments:

Eating

☐ Independent ☐ Dependent (hands on complete assistance) ☐ Minimal Supervision/Reminder

☐ Assistance with (cutting, opening, spreading, pouring) ☐ NG or IV feeding

Comments:

Toileting

☐ Independent ☐ Dependent (hands on complete assistance) ☐ Minimal Supervision/Reminder

Comments:

Incontinence
Urine ☐ Yes ☐ No **Feces** ☐ Yes ☐ No **Wears "Depends"** ☐ Yes ☐ No

Catheter ☐ Yes ☐ No **If yes,** ☐ indwelling urethral (foley) ☐ Suprapubic ☐ Condom Cath

Problems: ☐ frequency with urination ☐ Constipation ☐ Diarrhea
Comments:

Housekeeping and Laundry
☐ Independent ☐ Dependent (hands on complete assistance) ☐ Minimal Supervision/Reminder
Comments:

Meal Preparation
☐ Independent ☐ Dependent (complete assistance) ☐ Minimal Supervision/Reminder
Comments:

Transferring (Chair to chair/ Bed to Chair):
☐ Independent ☐ Minimal Supervision/Reminder (Verbal or Visual Cues)

☐ Dependent (complete assistance)
If Dependent, please ☐ One person transfer ☐ Two-person transfer ☐ Need Transfer Belt

Comments:

Telephone Use
☐ Independent ☐ Dependent (hands on complete assistance) ☐ Minimal Supervision/Reminder
Comments:

Mobility

Walking
☐ Independent ☐ Dependent (Cannot walk) ☐ Minimal Supervision/Support ☐ Uses Assistive device
Comments:

Wheelchair Use
☐ Independent ☐ Dependent (needs to be pushed) ☐ Minimal Supervision/Support (help with doorways, elevators, ramps, unlocking/locking brakes)
Comments:

Turning/Transferring while in bed/chair
☐ Independent ☐ Dependent ☐ Occasional assistance
Comments:

Transportation
☐Independent ☐Dependent (needs rides made for them)

Mode: ☐Car ☐Taxi ☐ Public transport bus/light rail ☐Walk

Does applicant have car ☐ Yes ☐ No
Does applicant have driver's license ☐ Yes ☐ No
Does applicant have car insurance ☐ Yes ☐ No

RESIDENTS OF ADULT FOSTER CARE MUST HAVE A PHYSICIAN'S STATEMENT CONFIRMING THEY CAN SAFELY OPERATE A MOTOR VEHICLE.

Communication

Orientation
☐ to person, place and time ☐ Periodically disoriented ☐ Forgetful ☐ Disoriented
Comments:

Speech
☐ Clear ☐Clear but thought process unclear ☐ Slurred ☐ Gestures ☐ Sign language
☐ Needs interpreter ☐ Written messages
Comments:

Vision
No impairment ☐ R ☐ L ☐Both
Impairment likely to increase ☐ R ☐ L ☐Both
Significant impairment ☐ R ☐ L ☐Both
Blind ☐ R ☐ L ☐Both

Hearing

☐ No impairment ☐ Impairment likely to increase ☐ Significant impairment
☐ Blind
Comments:

Nutrition

How meals do the applicant eat a day? ☐ Three ☐Two ☐ one ☐ Snacks ☐ More than 3
Comments:

Any problems with the following:
☐ Difficulty chewing and/or swallowing ☐Nausea ☐ Poor appetite ☐ Recent Weight Loss
☐ Chronically underweight ☐ Taste and/or texture issues

Comments:

Any food allergies or intolerances:

Who currently prepares applicant meals
□Self □Partner/Spouse □ Friend/relative □ Home health aid □ Restaurant/.Fast food Delivery
□ Congregate Dining □ Home meal program

Comments:

Behavioral Health

Daily Activities
☐No interventions ☐ Needs Cues☐ Sometimes need cues, may show resistance ☐ Needs behavior management, resists redirection ☐ Needs behavioral management, physically resists redirection

Interaction with others
☐ Interacts well with others ☐ Isolates ☐ Difficulty considering others ☐ Difficulty with authority
☐ Difficulty controlling anger ☐ Functional and appropriate support system (friends/family)
☐Dysfunctional support systems

Compliance
☐Willing/Able to follow directions ☐ Willing/Able able to take medications ☐ Willing/Able to keep appointments ☐ Willing/Able to pay rent on time ☐ Willing/Able to leave and return to the house at appropriate time.

Self-Preservation
☐Independent ☐Minor supervision ☐ Mentally unable ☐ Physically unable ☐ Mentally and physically unable

Judgement and decision-making

☐Appropriate/has good judgement ☐Difficulty managing money ☐ Problems with making decisions
☐ Accepts assistance readily ☐ Difficulty with impulse control ☐ Resists or refuses assistance

Mental Health

☐ Never been diagnosed with or treated for any mental health issues
☐ Had mental health issues in the past
☐ Has current mental health issues and is receiving treatment
☐ Has current mental health issue and is NOT receiving treatment

Mental health treatment and/or support is received from:
☐ Infectious Disease Provider ☐Psychiatrist ☐ Counseling ☐ Support Group ☐ Informal network

Has applicant experienced anxiety or depression? ☐ Yes ☐ No
Does applicant have other psychiatric diagnosis? ☐ Yes ☐ No
If so, name the diagnoses: _____

Does the applicant take medication to mange mental health? ☐ Yes ☐ No
If so, name the medications: _____

Has applicant ever been admitted to psychiatric facility? ☐ Yes ☐ No
If yes, please list name and dates_____

Has applicant ever contemplated suicide? ☐ Yes ☐ No
Has applicant ever attempted suicide? ☐ Yes ☐ No
If staff observe symptoms of mental health problems will applicant agree to a psychiatric consultation?
☐ Yes ☐ No

Does application hear or see things that other do not? ☐ Yes ☐ No

Emotional Health

Is applicant satisfied with their life today? ☐ Yes ☐ No
Has applicant been anxious or nervous? ☐ Yes ☐ No
Does applicant have difficulty sleeping? ☐ Yes ☐ No
Has applicant become physically aggressive or threatened anyone? ☒ Yes ☐ No
Has applicant made threats of self-harm? ☐ Yes ☐ No
Has applicant been a victim of abuse? ☐ Yes ☐ No

Please comment below for those questions answered, "Yes"

_____

_____

Memory

Does the applicant frequently misplace items e.g. glasses or money? ☐ Yes ☐ No
Has the applicant failed to recognize family of friends? ☐ Yes ☐ No
Has the applicant ever lost their way home? ☐ Yes ☐ No
Has the applicant had problems with money or bills due to memory impairment? ☐ Yes ☐ No

Please comment below for those questions answered, "Yes"

_____
_____
_____

Recreation and social activities

What activities does the applicant enjoy?

_____
_____

Are there any activities in which applicant would like to but cannot participate in?

Click or tap here to enter text.

What does the applicant look forward to?

_____
_____

Chemical Health

Does applicant CURRENTLY use alcohol or drugs? ☐ Yes ☐ No

If yes, when did you last use:

Drug	Last Use	Mode	Frequency
Alcohol ☐ Beer ☐ Wine ☐ Hard	Date _____	Click or tap here to enter text.	Click or tap here to enter text.
Marijuana	Date _____	Click or tap here to enter text.	Click or tap here to enter text.
Cocaine/Crack	Date _____	☐ Smoke ☐ Injection ☐ Inhalation ☐ Other	Click or tap here to enter text.

Heroin	Date _____	☐ Smoke ☐ Injection ☐ Inhalation ☐ Other	Click or tap here to enter text.
Amphetamines	Date _____	☐ Smoke ☐ Injection ☐ Inhalation ☐ Other	Click or tap here to enter text.
Hallucinogenic ☐ LSD ☐ PCP ☐ Mushrooms ☐ Other	Date _____	☐ Smoke ☐ Injection ☐ Inhalation ☐ Other	Click or tap here to enter text.
"Club" Drugs ☐Ecstasy ☐K	Date _____	☐ Smoke ☐ Injection ☐ Inhalation ☐ Other	Click or tap here to enter text.
Prescription ☐Valium ☐Xanax ☐Oxycodone	Date _____	☐ Smoke ☐ Injection ☐ Inhalation ☐ Other	Click or tap here to enter text.

Has applicant had a problem with alcohol of drugs in the past? ☐ Yes ☐ No
Is applicant received inpatient, outpatient of both in the currently? ☐ Yes ☐ No
In the past? ☐ Yes ☐ No

PROGRAM DATES

_____

_____

_____

_____

1. **Tobacco**

Dose the applicant smoke tobacco?
If yes,

Substance	**Last Use**	**Mode**	**Frequency**

Tobacco	Date _____	☐ Cigars ☐ Cigarettes ☐ pipe ☐ smokeless	Times/Day Click or tap here to enter text. Packs/weekClick or tap here to enter text.

Is applicant bothered by smoke? ☐ Yes ☐ No
Is applicant allergic to smoke? ☐ Yes ☐ No

Additional Information or comments on applicant:

_____
_____
_____
_____
_____
_____

The Minnesota Department of Health and Hennepin County require some personal information be collected and reported periodically to identify the services that people with HIV/AIDS need and use, to identify barriers to those services and verify to funding sources that this service is being provided. You have the right to refuse to share information about yourself; however, in some cases we may be unable to provide some services unless we have that information. Your name and any identifying information are not released to the Minnesota Department of Health or Hennepin County as a condition of funding. Signing this form constitutes consent to receive services from Abbott Northwester Infectious Disease Clinic AIDS Adult Foster Care social worker and I acknowledge receiving the Client's Bill of Rights.

Signed_____
Date_____

Clare Housing operate as an Equal Housing Opportunity.

Client Bill of Rights

As a client you have the right to:

1. Be treated with consideration and respect by staff, volunteers and interns. You have the responsibility to treat staff, volunteers and interns in a similar manner.

2. Receive quality services without discrimination regardless of race, ethnicity, national origin, religion, age, sexual orientation, gender or disability.

3. Confidentiality of information we collect about you. No identifying information about you will be shared outside of Foster Care without a release of information dated and signed by you listing individuals and agencies with whom you have agreed to have us share information by fax, phone, email or meeting and that all releases will be renewed if needed, on an annual basis. Any exceptions are outlined in the data practices guidelines. All records and files pertaining to the services you receive will be kept in locked filing cabinets and/or secure computer files when not in use.

4. Review all private information in your file and obtain a copy of this information. If you request a copy, the request must be in writing and singed by you. We will not give or send a copy of your file to any other person without a singed release from you except if we receive a valid court order.

5. Expect reasonable assistance to overcome language, cultural, physical or communication barriers. This means for example, that upon request we will provide interpreters for the deaf and for those who do not speak English.

6. Prompt and reasonable response to your questions and requests.

7. Participate in developing your service plan including developing service goals that meet your needs.

8. Prompt information on how to make complaints and pursue a grievance if you are having difficulties orare dissatisfied with the services you are receiving.

9. Refuse services or recommended services and to discontinue services at Foster Care.

10. Receive timely notice and explanation of changes in program guidelines including changes in eligibility criteria and funding availability.

11. If you have questions about services or would like to make a suggestion, you may do so with your service provider, the program manager, or the director of programs.

12. Specific programs or services may have additional rights and responsibilities that will be made available to you upon entry into the program.