GRAND TRAVERSE COUNTY COMMISSION On AGING
Caring for those who cared for you.

New Client Application

Date: ____________ Completed By: ______________________ Phone: (   ) ____________

Client #1:

Last: ____________________________________ First: ______________________________

Are You A Veteran Or Widow Of A Veteran? ☐ Yes ☐ No

Sex: ☐ M ☐ F Ethnicity: ___________________ Date of Birth: ________________

Are You a Person With a Disability? ☐ Yes ☐ No

Client #2:

Last: ____________________________________ First: ______________________________

Are You A Veteran Or Widow Of A Veteran? ☐ Yes ☐ No

Sex: ☐ M ☐ F Ethnicity: ___________________ Date of Birth: ________________

Are You a Person With a Disability? ☐ Yes ☐ No

Do you rent or own where you reside? ☐ Rent ☐ Own

Where is the home located? Township City Village Of ____________________

Household Information:

Address: ____ Apt.#: ______________

City: ____ Zip Code: ________________

Phone: (   ) ______________________________ Email Address: __________________________

☐ Married ☐ Widowed ☐ Divorced ☐ Single

Does Anyone Under The Age Of 60 Live With You? ☐ Yes ☐ No

If Yes, Do They Receive Social Security (SSI or SSD)? ☐ Yes ☐ No

	CLIENT 1	CLIENT 2
1. **Do you live alone?**	☐YES ☐NO	☐YES ☐NO
Screening Score: (If yes, score 2 points)		
2. **Are you able to leave your home independently?**	☐YES ☐NO	☐YES ☐NO
Screening Score: (If no, score 4 points)		
3. **Have you fallen more than once in the last 6 months?**	☐YES ☐NO	☐YES ☐NO
Screening Score: (If yes, score 4 points)		
4. **Have you recently experienced a significant life event such as a loss or health issue?**	☐YES ☐NO	☐YES ☐NO
Screening Score: (If yes, score 4 points)		
5. **Do you have family or friends living nearby that are in contact with you on a regular basis?**	☐YES ☐NO	☐YES ☐NO
Screening Score: (If no, score 4 points)		
6. **Do you experience any confusion or forgetfulness?**	☐YES ☐NO	☐YES ☐NO
Screening Score: (If yes, score 4 points)		
7. **Have you been in the hospital in the past year?**	☐YES ☐NO	☐YES ☐NO
Screening Score: (If yes, score 2. If currently in hospital, score 4 points)		
8. **Have you been in a nursing home or other care facility in the past year?**	☐YES ☐NO	☐YES ☐NO
Screening Score: (If yes, score 4 points)		
9. **Do you have a medical or mental health condition that makes it difficult to perform daily tasks?**	☒YES ☐NO	☐YES ☐NO
Screening Score: (If yes, score 4 points)		
10. **Do you take six or more over the counter or prescription medications?**	☐YES ☐NO	☐YES ☐NO
Screening Score: (If yes, score 2 points)		
TOTAL SCORES		

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Requested Services:

☐ Home Health Care (Bathing & Personal Care, Vital Checks)

☐ Caregiver Relief (Respite)

☐ House Cleaning

  ☐ Please check here if you need laundry done

☐ Lawn Mowing & Leaf Removal

☐ Snow Removal

☐ Outside Window Washing

☐ In-Home Foot Care

☐ Personal Emergency Response Unit (Please check below if you know the type of unit)

  ☐ Landline (basic) ☐ Cellular Phone (GSM) ☐ Global Positioning System (GPS)

☐ Medication Assistance

☐ Transportation Vouchers

☐ BATA Pass

☐ COAST Bus

Approximate **monthly** income for household $______________

Please check if client chooses not to disclose income*. ☐

*Please note: Clients choosing this option will pay the highest rate on the sliding fee scale.

Please list an emergency contact below:

Name: ____

Relationship: ____

Phone Number: (   ) ____

Do you wish to have this person at the Initial Assessment in your home? ☐ Yes ☐ No

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To qualify for services, a person must be 60 years of age and a resident of Grand Traverse County. There are fees for all Commission on Aging services, which are based on the client's household income.

Please return this application, along with proof of income and residency. We cannot accept applications without all of the required paperwork attached. Applications sent without all attachments will be returned.

See the next page for types of income and residency that we accept.

TURN PAGE OVER

After receipt of your application/documentation, a Commission on Aging employee will contact you regarding the programs you have selected. At that time, we will discuss with you the approximate fees charged for that program, based on what you have provided us for proof of income. We will then place you on the wait list for the program(s) that you have indicated. Please note that some programs may have a long wait list and others possibly not. We will not be able to tell you exactly when your name will come off of a wait list.

What we accept for income:
Social Security statements, Bank statements, Income tax returns, Home heating credit returns, Homestead Property tax credit, Prior year W-2's if you have not filed a recent Income tax return.

Please note that we do allow your supplemental insurance costs to be deducted from your income. Social Security already has that breakdown on your Social Security statement, and it is already included in your Income tax returns for Social Security. If you have a pension or 401K (etc.) that does not include the cost of an additional supplemental insurance, please provide proof of that cost as well.

What we accept as proof of residency (must have the correct address):
Driver's license, State issued ID, Utility bill, Copy of rental agreement, Letter from apartment manager where you are living.

If you have any questions you may call us at: (231) 922-4688.

Please return this Application, along with proof of income and proof of residency to the following address:

Grand Traverse County
Commission on Aging
520 West Front Street, Suite B.
Traverse City, MI 49684