Appendix B

Client Eligibility Documentation Form

Older Adults Home Modification Program
Client Eligibility Documentation Form[1]

Study ID:	
Site ID	Client ID

Today's Date (mm/dd/yyyy)	Form Completed By:	
	Name	Job Title
		(dropdown menu: administrative staff, program staff, project manager, program manager, other [Specify])

OMB Control No. 2528-XXXX, expiration date XX/XX/2024. This form is designed to provide HUD with information about how effective its Older Adults Home Modification Grant Program is. Your participation in the Evaluation as a grantee is mandatory as a condition of the grant. The Public reporting burden for your collection of information is estimated to be 5 minutes per response. HUD may not collect this information, and you are not required to complete this form, unless it displays a currently valid OMB control number.

Guidance for Grantees: Please complete one form for each home you consider for inclusion in the OAHM program, even if none of the residents are found to be eligible. Enter information for one person per home, i.e., the person most likely to be the client (called "potential client" in this form). Although items are numbered, you can complete this form in the order that makes the most sense for your program. Please provide an answer for each item.

1. Homeownership Questions:

   1.a. Did the potential client submit proof they own the home they would like to enroll in the program? ☐ yes ☐ no

   1.b. Did the potential client submit proof they live in the home they would like to enroll in the program? ☐ yes ☐ no

2. Including the potential client, how many people live in this home? _____ (*Answer must be at least 1)*

3. Household Income Questions:

   3.a. Is the potential client's household annual income above [80% AMI VALUE]?

   ☐ yes *(Go to 4)* ☐ no *Go to 3.b*

   (REDCap: Insert appropriate 80% AMI income level according to the grantee's location and the number of people living in the home based on Q2.)

   3.b. Is the potential client's household annual income above [50% AMI VALUE]?

   ☐ yes *(Go to 4)* ☐ no *Go to 3.c* ☐ information not available *(Go to 4)*

[1] Code for this document: Black font=Question for grantee to answer; *Blue italics* = Instruction for the grantee; *yellow highlighted italics*: Instruction for REDCap programmer.

(REDCap: Insert appropriate 50% AMI income level according to the grantee's location and the number of people living in the home based on Q2.)

3.c. Is the potential client's household annual income above [30% AMI VALUE]?

☐ yes ☐ no ☐ information not available

(REDCap: Insert appropriate 30% AMI income level according to the grantee's location and the number of people living in the home based on Q2.)

4. Does the physical condition of the potential client's home meet the grantee's eligibility criteria?
☐ yes ☐ no ☐ not applicable, home's physical condition is not an eligibility criterion

5. Is the potential client most comfortable speaking in English, Spanish, or another language?

☐ English

☐ Spanish

☐ Another language not mentioned. Specify:_____

6. Age Questions:

6.a. What is the potential client's age (in years)? _____

6.b. What is the potential client's birthdate (mm/dd/yyyy)?____

7. Is the potential client ineligible due to organization-specific eligibility criteria not mentioned above? ☐ Yes (Specify) _____

☐ No ☐ NA, there were no other organization-specific criteria

8. Is the potential client eligible for the program? ☐ yes *Go to 9* ☐ no *(Go to the Lost-to-Project Form)*

9. *Complete the information below **only** after an individual has been found to be eligible for the program, **AND** the licensed occupational therapist (OT)/licensed OT Assistant or Certified Aging-in-Place Specialist (CAPS) whose work is overseen by a licensed OT has determined this individual should be the beneficiary of OAHM services. If the OT/OTA/CAPS-identified client is different from the individual whose data was entered in questions 5 and 6, revise to answer questions for the identified client.*

9.a. Name of Client: _____

9.b. Primary Residence Address:
Street Number and Name: _____

Unit Number: _____

City: _____ State: _____ Zip Code: _____

9.c. Phone Information.

9.c.i Check this box if the client does not have a phone: ☐ *(Do not allow the phone number questions to be filled in, skip to 9d)*

9.c.ii Check this box if the client needs to use TTY or TDD services: ☐

Teletype (TTY) or Telecommunications Device for the Deaf (TDD) number:
_____

9.c.iii Phone number to reach client during the day: _____

Preferred contact method? ☐ yes ☐ no

Does client prefer to receive calls or texts on this phone? (Check "Calls" if the phone is not a cell phone) ☐ Calls ☐ Texts ☐ No preference

9.c.iv Phone number to reach client in the early evening: _____

Preferred contact method: ☐ yes ☐ no

Does client prefer to receive calls or texts on this phone? (Check "Calls" if the phone is not a cell phone) ☐ Calls ☐ Texts ☐ No preference

9.d. Email information: check this box if client does not have an email address: ☐ *(Do not allow the email address questions to be filled in)*

Email address: _____

Preferred contact method: ☐ yes ☐ no

Contact Notes (e.g., list any hearing, vision, or speech issues field staff may need to consider when contacting or visiting the client):