Appendix B Client Eligibility Documentation Form

Older Adults Home Modification Program Client Eligibility Documentation Form¹

| Study ID: | | dv ID: | Today's Date | Form Completed By: | | |
|---|--------------------------|---|---|--|---|--|
| Site I | | Client ID | (mm/dd/yyyy) | Name | Job Title | |
| | | | | | (dropdown menu: | |
| | | | | | administrative staff. | |
| | | | | | program staff, project | |
| | | | | | manager, program manager, other | |
| | | | | | [Specify]] | |
| Older A The Pub | dults H blic rep | Iome Modification G orting burden for yo | rant Program is. Your part ur collection of informatio | icipation in the Evaluation a n is estimated to be 5 minu | ride HUD with information about how effective its as a grantee is mandatory as a condition of the grant ites per response. HUD may not collect this tly valid OMB control number. | |
| Guida | ince f | or Grantees: Ple | ase complete one fo | rm for each home yo | u consider for inclusion in the OAHM | |
| | | | | • | r 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. | | | | | | |
| provid | ae an | answer for each | i item. | | | |
| 4 11 | | 1: 0 / | | | | |
| | Homeownership Questions: | | | | | |
| 1. | | id the potential cogram? \Box ye | • | hey own the home th | ey would like to enroll in the | |
| 1. | | rid the potential rogram? □ yes | - | hey live in the home | they would like to enroll in the | |
| | cludi ast 1) | | client, how many pe | ople live in this home | e? (<mark>Answer must be at</mark> | |
| 3. H | ouseh | old Income Que | estions: | | | |
| 3. | a. Is | the potential cl | ient's household ann | ual income above [80 |)% AMI VALUE]? | |
| | | \square yes (Go to | 4) □ no Go to 3.b | | | |
| | | • | | AMI income level acc he home based on Q2 | cording to the grantee's location 2.) | |
| 3.1 | b. Is | the potential cl | ient's household ann | ual income above [50 |)% AMI VALUE]? | |
| | | \square yes (Go to 4) | !) □ no Go to 3.c | \square information not av | ailable <mark>(Go to 4)</mark> | |

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]? \square yes \square no \square 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? \square yes \square no \square 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) \square No \square NA, there were no other organization-specific criteria 8. Is the potential client eligible for the program? \square yes Go to 9 \square 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 Agingin-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: \Box (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: \Box Teletype (TTY) or Telecommunications Device for the Deaf (TDD) number:

| | 9.c.iii Phone number to reach client during the day: | | | |
|------|--|--|--|--|
| | Preferred contact method? \square yes \square no | | | |
| | Does client prefer to receive calls or texts on this phone? (Check "Calls" if the phone is not a cell phone) \square Calls \square Texts \square No preference | | | |
| | 9.c.iv Phone number to reach client in the early evening: | | | |
| | Preferred contact method: \square yes \square no | | | |
| | Does client prefer to receive calls or texts on this phone? (Check "Calls" if the phone is not a cell phone) \square Calls \square Texts \square No preference | | | |
| 9.d. | Email information: check this box if client does not have an email address: □ <i>(Do not allow the email address questions to be filled in)</i> Email address: | | | |
| | Preferred contact method: \square yes \square no | | | |
| | tact Notes (e.g., list any hearing, vision, or speech issues field staff may need to consider when acting or visiting the client): | | | |