



Serving Detroit, Hamtramck, Harper Woods, Highland Park & the 5 Grosse Pointes

1333 Brewery Park Blvd. Ste. 200 | Detroit MI 48207 | 313-446-4444

www.DetroitSeniorSolution.org

DETROIT AREA AGENCY ON AGING
Information & Assistance - Prescreening Checklist 2021/2022

Referral Agency _____ Date _____

Contact _____ Telephone () _____

Client Name _____ D.O.B. _____ Age _____

Address _____ Telephone () _____
Number Street City ZIP

3rd Party Contact _____ Agency _____

Relationship to Client _____ Telephone () _____

Check all that apply: (In most cases, to qualify all six criteria should have checks.)

1 _____ **Resident of Region 1-A** (Detroit, Hamtramck, Harper Woods, Highland Park, the five Grosse Pointes)

_____ **Seniors age 60 and over**

_____ **Disabled Persons age 18 +**

2 _____ **Requires assistance with ADLs and IADLs** (Two or more of the following should have checks.)

_____ **Transferring:** Difficulty getting in/out of bed, chair, etc.

_____ **Locomotion:** Requires mechanical or human help to walk

_____ **Mobility in Bed:** Difficulty with turning in bed

_____ **Dressing:** Difficulty with dressing

_____ **Eating:** Difficulty with feeding self or meal preparation

_____ **Toileting:** Bladder or bowel incontinence

_____ **Personal Hygiene:** Difficulty with bathing - getting in/out of tub

_____ **Confusion/memory loss**

_____ **Client is homebound**

3 _____ **Inadequate support systems**

_____ No support family/friends

_____ Limited support family/friends

4 _____ **Gross income below \$2,523/monthly (*Subject to Change*)**

5 _____ **Less than \$2,000 (single) or \$3000 (couple)** in liquid assets (e.g., checking, savings)

If client is on Medicaid, assest should be below \$2,000

6 _____ **Medicaid Eligible** **Medicaid ID#** _____

_____ Client receives Medicaid or is Medicaid eligible

_____ Client on Medicaid WITHOUT a Chore (Adult Home Help) provider

_____ This client is a candidate for the DAAA Medicaid Waiver

7 _____ **Nutrition:** - Home delivered meal services _____ Solid _____ Liquid

_____ Congregate meal sites

8 _____ **Transportation:** Non- Emergency Medical Transportation

9 _____ **Healthy Aging Services**

I affirm that the above information is accurate to the best of my knowledge:

Agency Representative Signature _____ Date _____

Note: Referral agencies may call **313-446-4444 ext. 5607** or fax their referrals to the attention of:

I&A Department, Fax: (313) 446-4459, Online @ www.DetroitSeniorSolution.org