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

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

Please answer the following questions to help us determine your level of need. Check either yes or no to the following questions.

1. Do you live alone?

Client 1: ☐ YES ☐ NO **Client 2:** ☐ YES ☐ NO

2. Are you able to leave your home independently?

Client 1: ☐ YES ☐ NO **Client 2:** ☐ YES ☐ NO

3. Do you have friends or family nearby that you are in regular contact with?

Client 1: ☐ YES ☐ NO **Client 2:** ☐ YES ☐ NO

4. Have you fallen more than once in the six months?

Client 1: ☐ YES ☐ NO **Client 2:** ☐ YES ☐ NO

5. Do you experience any confusion or forgetfulness?

Client 1: ☐ YES ☐ NO **Client 2:** ☐ YES ☐ NO

6. Have you recently experienced a significant life event such as a loss or health issue?

Client 1: ☐ YES ☐ NO **Client 2:** ☐ YES ☐ NO

7. Do you have a medical or mental health condition that makes it difficult to perform daily tasks?

Client 1: ☐ YES ☐ NO **Client 2:** ☐ YES ☐ NO

8. Have you been in a nursing home or other care facility in the past year?

Client 1: ☐ YES ☐ NO **Client 2:** ☐ YES ☐ NO

9. Does someone else set up or administer your medications for you?

Client 1: ☐ YES ☐ NO **Client 2:** ☐ YES ☐ NO

10. Do you or anyone living with you smoke in your house?

Client 1: ☐ YES ☐ NO **Client 2:** ☐ YES ☐ NO

11. Do you have any sensitivities to perfume or smoke?

Client 1: ☐ YES ☐ NO **Client 2:** ☐ YES ☐ NO

Any additional information you would like to share with us: (Add an additional page if required.)

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Requested Services:

- ☐ Home Health Care (Bathing & Personal Care, Vital Checks)
- ☐ Caregiver Relief (Respite)
- ☐ House Cleaning
  - ☐ Check here if you need laundry done
- ☐ Lawn Mowing & Leaf Removal
- ☐ Snow Removal
- ☐ Outside Window Washing
- ☐ In-Home Foot Care
- ☐ Personal Emergency Response Unit
- ☐ Med Minder
- ☐ Transportation Vouchers
- ☐ BATA Pass
- ☐ COAST Bus

Approximate **monthly** income for household $_____

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. If you have any questions regarding the types of documentation we allow for income and residency, please contact us. Clients choosing not to disclose income are charged at the highest rate.

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.

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

Website Copy