CABARRUS COUNTY
America Thrives Here

Housing and Home Improvement Program

The Housing and Home Improvement (HHI) program assists Cabarrus County homeowners aged 60 and over. The goal of the program is to assist in maintaining independence and adequate shelter. This is a cost-sharing program and clients are asked to share in the cost; however, service will not be affected if you are unable to contribute.

Typical program services:

- Build wheelchair ramps
- Build handrails/Install grab bars
- Minor plumbing and HVAC repairs
- Minor floor repairs
- Replacement of broken stoves, washers, water heaters, and refrigerators
- Other safety-related items

To apply for the Housing and Home Improvement Program, please complete and sign the program agreement and the attached application. Please only fill out the highlighted sections of the application.

Your name will be placed on our waiting list after we receive your signed application, and someone from our Housing and Home Improvement Program will contact you to schedule an appointment when funds become available. Please be advised that, due to limited funding, accessibility services and life-threatening emergency repairs will be addressed prior to all other service requests.

CABARRUS COUNTY
America Thrives Here

Participant Program Agreement

As a participant of the Housing and Home Improvement Program, you have the responsibility:

- To provide a workspace supporting safe work in the home and on equipment including removal of pets and any items that limit access to the work area (boxes, clutter, etc.)
- To work cooperatively with program staff and contractors to schedule inspections and service times so work can be completed in a timely and efficient manner.
- To provide access to all rooms in your home, Monday – Friday, during the business hours of 8:00 am- 5:00 pm to inspectors, auditors, and contractors.
- To allow program staff and designees to photograph the unit for pre- and post-work documentation.

Applicant's Signature: _____ Date: _____

65 Church Street SE, Concord, NC 28025 • PO Box 707, Concord, NC 28026
Phone 704-920-2000 • Fax 704-920-2820
cabarruscounty.us

CLIENT REGISTRATION FORM • DAAS 101

NC Department of Health and Human Services - Division of Aging and Adult Services

- COMPLETE SECTIONS I, II and VII ONLY for codes **(180)**-Congregate Nutrition, **(181)**-Congregate Nutrition-NSIP, and **(182)**-Congregate Nutrition Supplemental Meals.
- COMPLETE SECTIONS I and VII ONLY for codes **(250)**-Transportation, **(033)**-Transportation (Medical) and (252) Transportation-Pilot Bus Pass Program.
- COMPLETE SECTIONS I, VI, and VII for Family Caregiver Support Program/Project C.A.R.E. **(all FCSP codes in series 820, 830, 840, 850 – EXCEPT codes 821, 822, 831, 841, 851, 861.** For Care Recipient complete SECTIONS III, IV and V**.**
- COMPLETE SECTIONS I, IV, and VII for codes **235, 236, 237, 238**-In-Home Aid Respite, **309**-Group Respite, **210**-Institutional Respite. Enter data for hands-on recipient, not the caregiver. If applicable, complete Sections V and VI.
- COMPLETE SECTIONS I, II, IV, VII for codes **020**-Home Delivered Meals, **021**-Home Delivered Meals-NSIP, **022**-Home Delivered Meals Supplemental, and **610**-Care Management. If applicable, complete Sections V and VI.
- COMPLETE SECTIONS I, IV, and VII for all other HCCBG services. If applicable, complete Sections V and VI.

Service Codes:	**Region Code:**	**Provider Code:**

CLIENT STATUS: Check the Appropriate box(es) and enter the date.

☐ **New Registration**	DATE:
☐ **Activation**	DATE:
☐ **Waiting for Service** *[Complete Section I ONLY]*	DATE: *(enter 3 service codes):*
☐ **Change of Information**	DATE: *(complete Section I when a change is needed for any client information)*

☐ **Inactive** – DATE: _____ *(check box below) (make inactive only if permanently leaving ARMS)*

If client is a caregiver receiving FCSP/Project C.A.R.E. services and the client inactive reason relates more to CR status, check Care Recipient box.

Reason for making client inactive applies to: ☐ Client/Caregiver ☐ Care Recipient

☐ Moved to adult care home/assisted living
☐ Alternative living arrangement
☐ Death
☐ Hospitalization (not expected to return)
☐ Nursing home placement
☐ Moved out of service area
☐ Improved function/Need eliminated
☐ Service not needed/wanted
☐ Illness (not expected to return)
☐ Other (specify):

SECTION I: CLIENT/CAREGIVER INFORMATION (Required for *ALL* Clients/For FCSP the Caregiver is the Client)

Legal Name: Last	First	M.I.
Suffix	**Last 4 Digits SSN:**	**Phone:** ☐ No phone
Address **County:** Cabarrus	**Email**	**DOB:** ☐ *Check if special eligibility*
City:	**State:** North Carolina	**Zip:**

Sex *(check one)*
☐ Female
☐ Male

At/Below Poverty Level? *(check one)*
☐ Yes
☐ No

Marital Status *(check one)*
☐ Single ☐ Divorced
☐ Married ☐ Widowed
☐ Separated ☐ Partnered
☐ Client Refused ☐ Unknown

Household Status *(check one)*
☐ Lives alone ☐ Lives with Other
☐ Unknown ☐ Client Refused
☐ Lives in Long Term Care (LTC) facility [Legal Assistance is the only service to collect "Lives in Long Term Care (LTC) facility"]

Race (Check all that apply)
☐ Black or African American
☐ White
☐ Asian or Asian American
☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaska Native
☐ Refused/Unknown/Not Reported

Ethnicity (Are you of Hispanic or Latino Origin?)
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unreported/Missing/Client Refused

Primary Language Spoken: ☐English ☐Spanish
☐Other _____ *[see languages in Client Registration Form (CRF) manual]*

Name of Emergency Contact: _____ ☐ Refused to provide
Cell#: _____ Home#: _____ Day#: _____

Caregiver's Overall Functional Status: ☐ Well ☐ At risk ☐ High risk

(When the CAREGIVER IS REGISTERED AS THE CLIENT, use this field for the CAREGIVER'S SELF-REPORTED functional status and complete Section IV for Care Recipient.) If SECTION IV is required, SKIP THIS QUESTION. ARMS will automatically calculate the Caregiver's Overall Functional Status when SECTION IV is entered.

SECTION II: Required *ONLY* for clients of HCCBG Congregate Nutrition, Home-Delivered Meals, Congregate Nutrition Supplemental Meals, Home Delivered Meals Supplemental, NSIP (only meals), and Care Management services.

Nutrition Health Score

Assessment Date:	**Response**	**Refuse**
a. Do you have an illness or condition that made you change the kind and/or amount of food you eat?	☐ Yes ☐ No	☐
b. How many meals do you eat per day?	#	☐
c. How many servings of fruit do you eat per day?	#	☐
d. How many servings of vegetables do you eat per day?	#	☐
e. How many servings of milk/dairy products do you consume per day?	#	☐
f. How many drinks of beer, liquor, or wine do you have every day or almost every day?	#	☐
g. Do you have tooth/mouth problems that make it hard for you to eat?	☐ Yes ☐ No	☐
h. Do you always have enough money or food stamps to buy the food you need?	☐ Yes ☐ No	☐
i. How many meals do you eat alone daily?	#	☐
j. How many prescribed drugs do you take per day?	#	☐
k. How many over-the-counter drugs do you take per day?	#	☐
l. Have you lost 10 or more pounds in the past 6 months without trying?	☐ Yes ☐ No	☐
m. Have you gained 10 or pounds in the past 6 months without trying?	☐ Yes ☐ No	☐
n. Are you physically able to shop for yourself?	☐ Yes ☐ No	☐
o. Are you physically able to cook for yourself?	☐ Yes ☐ No	☐
p. Are you physically able to feed yourself?	☐ Yes ☐ No	☐

SECTION III: Care Recipient Data (not caregiver) for Family Caregiver Support Program/ Project C.A.R.E. services.

CARE RECIPIENT #1 (Adult/Child) (For additional Care Recipients, attach an additional DAAS-101, Sections III, IV, and V.)

Name: Last	First	M.I.
Suffix	**Last 4 Digits SSN/zeros:**	**Phone:** ☐ No phone
Address	**DOB:**	**Sex:** ☐ Male ☐ Female ☐ Other
City:	**State:**	**Zip:**

Is Care Recipient a person with (a) severe disability(ies)? ☐Yes ☐ No

Does the Care Recipient live in same household as Caregiver? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Partnered ☐ Refused ☐ Widowed ☐ Unknown

SECTION IV: Client/Care Recipient Data (not caregiver)/ not required for Children Under 18 Receiving Care by FCSP.

Is the client/care recipient's daily life significantly affected due to memory loss or a cognitive impairment? ☐ Yes ☐ No

Has a doctor/healthcare professional diagnosed care recipient with Alzheimer's disease or a related dementia? ☐ Yes ☐ No

IADLS *(Client/CR can do without help; select Yes/No)*

	Yes	No		Yes	No
Food Preparation	☐	☐	Use Telephone	☐	☐
Shopping	☐	☐	Housekeeping	☐	☐
Manage Medications	☐	☐	Laundry	☐	☐
Manage Finances	☐	☐	Use Transportation	☐	☐

TOTAL IADL SCORE:

ADLS *(Client/CR can do without help; select Yes/No)*

	Yes	No		Yes	No
Feeding	☐	☐	Toileting	☐	☐
Dressing	☐	☐	Transferring	☐	☐
Bathing	☐	☐	Continence	☐	☐

TOTAL ADL SCORE:

Unpaid caregivers (include primary caregiver) _____ ***[ONLY ANSWER for Respite, FCSP, and Project CARE services. Otherwise, enter "0" in ARMS and skip to Section VII on the DAAS-101.]***

SECTION V: Complete for HCCBG respite, FCSP, and Project C.A.R.E. if "unpaid caregiver" = 1 or more in previous question.

How many hours of care does Care Recipient need? _____ ☐ Day ☐ Week

How many hours does Caregiver usually spend providing care for the Care Recipient? _____ ☐ Day ☐ Week

Primary Caregiver Relationship to Care Recipient: *(ONLY check one)*

☐ Wife
☐ Husband
☐ Parent
☐ Sister
☐ Brother
☐ Grandparent
☐ Non-Relative
☐ Other Relative
☐ Son/Son-in-Law
☐ Daughter/Daughter-in-Law
☐ Domestic partner, including civil union
☐ Older Non-Relative (FCSP)
☐ Other Older Relative (FCSP)

Is the primary caregiver a long-distance caregiver? ☐ Yes ☐ No **[If YES, please answer the next questions by listing the NC county or State.]**

☐ **Distance Caregiver** (list NC county _____)
☐ **Out of State** (list state _____)

SECTION VI: Complete for *ALL* Caregivers

In general, would you say that the Caregiver's health is:	Excellent (5) ☐	Very Good (4) ☐	Good (3) ☐	Fair (2) ☐	Poor (1) ☐

How stressful for you is caregiving:	Extremely (5) ☐	Very (4) ☐	Moderately (3) ☐	Slightly (2) ☐	Not at all (1) ☐

Primary Caregiver Employment Status:

☐ Full-time ☐ Part-time ☐ Quit due to caregiving ☐ Is/was not working
☐ Retired early due to caregiving ☐ Retired ☐ Lost job/dismissed due to caregiving
☐ Refused ☐ Other (please specify) _____

SECTION VII: Required for *ALL* Clients

I, the client, understand the information contained on this form will be kept confidential unless disclosure is required by court order or for authorized federal, state or local program reporting and monitoring. I understand that any entitlement I may have to Social Security benefits or other federal or state sponsored benefits shall not be affected by the provision of the aforementioned information. My signature authorizes the providing agency to begin the service(s) requested.

DATE: _____ **CLIENT/CAREGIVER SIGNATURE:** _____

DATE: _____ **AGENCY EMPLOYEE SIGNATURE:** _____

Provider Use Only – initial below after re-assessment:

Registration Update: _____ Staff Initials: _____
Registration Update: _____ Staff Initials: _____
Registration Update: _____ Staff Initials: _____

NOTES/COMMENTS: