



**JEFFERSON COUNTY OFFICE FOR THE AGING**  
**EISEP INTAKE SCREENING FORM** (rev 9/2020)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Jefferson Co OFA Staff \_\_\_\_\_

**Service Area Interest:**

**Client:** \_\_\_\_\_

- \_\_\_\_\_ Personal Care
- \_\_\_\_\_ Housekeeping
- \_\_\_\_\_ PERS (Personal Emergency Response System)
- \_\_\_\_\_ Respite
- \_\_\_\_\_ Home Delivered Meals

\_\_\_\_\_ Is the service need an immediate need?  
 \_\_\_\_\_ OFA can provide you with local caregiving agency phone numbers for self contact.

**Eligibility for Medicaid:**

	Yes	No
Does applicant have an active Medicaid case?		
If so what is the Medicaid Number?		
Does applicant have a Medicaid Managed Long-Term Care (MLTC) Plan?		
Has applicant applied for Medicaid and been told a determination is pending?		
Is applicant receiving SSI?		
Is applicant <b>income</b> eligible for Medicaid? \$ 875/month    \$ 15,750 annually for a single person: \$1,284/month    \$ 23,100 annually for a married couple: \$3,216/month    \$128,640 annually for a married couple: (with only one person applying /spousal Medicaid)		
Is applicant receiving Medicaid with a Spend Down?		

IF APPLICANT IS **UNDER 60 YEARS OF AGE, OR HAS MEDICAID OR IS ELIGIBLE FOR MEDICAID,**  
 THEN APPLICANT **IS NOT ELIGIBLE FOR EISEP SERVICES** FROM JEFFERSON COUNTY OFA.

**Income Eligibility for EISEP:**

	Yes	No
Is applicant's income at or below \$1,595/month for a single person (4/1/20 limit)		
Is applicant's income at or below \$2,155/month for a married couple (4/1/20 limit)		
** These are general income guidelines, not necessarily a program disqualifier		

**Applicant Information:**

Name (Last, First, MI)			
911 Address			
Mailing Address			
Telephone			
Cell			
Email			
Veteran	Yes:	No:	
Frail/Disabled	Yes:	No:	
Age & Date of Birth	Age:		DOB:
Sex	Male:	Female:	Other:
Primary Language Interpretation	English: Needs Service:		Other:
Marital Status	Single:	Married:	Other:
Living Arrangements	Alone:	Spouse:	Relatives/Other:
Hearing	Impairment:		Aids:
Vision	Impairment:		Glasses:

**Emergency or Other Contact Person or Caregiver:**

Name (Last, First, MI)			
Address			
Address			
Telephone			
Cell			
Email			

**Reason for Assistance:**


**Preliminary Assessment:**

EISEP programmatic eligibility requires the presence of unmet need in at least:

**One (1)** Activities of Daily Living (ADL)

**OR Two (2)** Instrumental Activities of Daily Living (IADL).

“Unmet need” means an impairment (no matter the severity) in some daily function as listed, and that impairment is not being fully met, for any reason.

<b>Activities of Daily Living (ADL’s) Unmet Need: (need 1)</b>	<b>Yes</b>	<b>No</b>
Bathing		
Mobility		
Transferring		
Dressing		
Personal Hygiene		
Toileting		
Eating		
Other		

<b>Instrumental Activities of Daily Living (ADL’s) Unmet Need: (need 2)</b>	<b>Yes</b>	<b>No</b>
Shopping		
Transportation		
Laundry		
Housework/Cleaning		
Light Meals – Prepare or Reheat		
Ability to Handle Personal Finances		
Ability to Use the Telephone		
Ability to Take Medications as prescribed		
Other		

<b>Does applicant have unmet needs in at least 1 ADL or 2 IALDs?</b>		
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If No, applicant is ineligible for EISEP.

**Income:**

<b>Total Monthly Income/Deposits to Bank Account</b>	<b>Monthly Amount</b>
Salary or Wages	\$
Pension or Retirement Income	\$
IRA Distributions (RMD)	\$
Social Security	\$
Interest Income	\$
Rental Income	\$
Other Income	\$

\*\*\*\*\* For OFA Staff Use Only \*\*\*\*\*

<b>Does applicant appear eligible for EISEP?</b>					
<b>Has Medicaid or Appears Eligible for Medicaid – Referral Made to DSS?</b>					
<b>Referral Made to Other Program/Service/Agency?</b>					
<b>Referral for Other OFA Services?</b>	<b>HDM</b>	<b>HIICAP</b>	<b>HEAP</b>	<b>SNAP</b>	<b>Other</b>