IMPERIAL COUNTY AREA AGENCY ON AGENCY
DIGNITY AT HOME FALL PREVENTION PROGRAM
INTAKE ASSESSMENT / PROGRAM ELIGIBIITY FORM

E-mail Form

Date: _____ Applicant Name: _____ DOB: _____

ELIGIBILITY QUESTIONS

1) What is your current income $_____ Weekly ☐ Monthly ☐ Yearly ☐

3) Are you a person with a Disability? **Y** ☐ **/ N** ☐

4) Do you feel you are at risk for falls? **Y** ☐ **/ N** ☐ If "Yes" explain.

_____
_____

5) Have you fallen in the past year? **Y** ☐ **/ N** ☐

6) Have you been hospitalized or injured due to a fall? **Y** ☐**/ N** ☐

7) Do you worry about falling when you walk? **Y** ☐**/ N** ☐If "Yes" explain.

_____
_____

8) Do you use an ambulation assistive device? **Y** ☐**/ N** ☐If "Yes" which one

☐ Walker ☐ Cane ☐ Other _____

9) Do you have feet issues that have caused or may cause you to fall? **Y** ☐**/ N** ☐If "Yes" explain.

_____
_____

10) Do you have visual impairments that prevent you from seeing potential hazards? **Y** ☐**/ N** ☐If "Yes" explain.

_____

11) Do your medications make you dizzy? **Y** ☐**/ N** ☐

If eligible, collect:

Applicant address: _____

Applicant phone number: _____