The Cleveland Clergy Alliance in partnership with the Cuyahoga County Division of Senior and Adult Services, are working collaboratively to Connect Seniors to Services, a coordinated programming initiative funded through the Health and Human Services Levy.

Connecting Seniors to Services

Information and Assistance for the Aging and Disabled, provides assistance in applying for Benefits Checkup, Home Energy Assistance Program (HEAP), Buderer Drug Repository Program and Emergency Assistance Program. The Cleveland Clergy Alliance (CCA) is in partnership with the Division of Senior and Adult Services (DSAS). DSAS, in addition, has a partnership with the Aging & Disability Resource Network (ADRN), all entities provide resources and linkages to an array of public benefits to seniors, caregivers and persons with disabilities. The Information Services Unit (ISU) team provides person-centered intensive case management to seniors and disabled adults who are without basic supports and services. The Cleveland Clergy Alliance Community Navigators are available to guide seniors and their families through what can be a difficult and complicated decision-making process and provide short term Case Management Services.

Your Contact Information

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
</tr>
<tr>
<td>City</td>
</tr>
<tr>
<td>Zip</td>
</tr>
<tr>
<td>Phone Number(s)</td>
</tr>
<tr>
<td>Date of Birth</td>
</tr>
<tr>
<td>Alternate Contact</td>
</tr>
<tr>
<td>Alternate Contact Number</td>
</tr>
</tbody>
</table>

Return Completed questionnaire to
Division of Senior and Adult Services
Centralized Intake, 3rd Floor
13815 Kinsman Road
Cleveland, OH 44120

If there are any further questions, please contact:
Division of Senior and Adult Services – Centralized Intake (216) 420-6700
Cleveland Clergy Alliance  
Cuyahoga County  
Division of Senior and Adult Services  
Connecting Seniors to Services

Information and Assistance  
Please select the program(s) that may be of interest to you.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Support for Health Conditions</td>
<td>Adult Protective Services</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>Alzheimer’s Information</td>
</tr>
<tr>
<td>Dental Services</td>
<td>Homeowner’s Insurance</td>
</tr>
<tr>
<td>Vision Services</td>
<td>Volunteer Programs</td>
</tr>
<tr>
<td>Hearing Services</td>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>Transportation</td>
<td>Senior Housing</td>
</tr>
<tr>
<td>Employment</td>
<td>Home Modification</td>
</tr>
<tr>
<td>Home Repair</td>
<td>Other ________________</td>
</tr>
<tr>
<td>Food Assistance</td>
<td></td>
</tr>
<tr>
<td>Education Programs</td>
<td></td>
</tr>
</tbody>
</table>

Long Term Options Counseling  
Please select the program(s) that may be of interest to you.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Assisted Living</td>
<td>PACE (all inclusive medical, rehabilitative, social and personal care needs of older adults)</td>
</tr>
<tr>
<td>In-home Care</td>
<td>Other __________________</td>
</tr>
<tr>
<td>Respite Care</td>
<td>______________________</td>
</tr>
<tr>
<td>Adult Day Program</td>
<td></td>
</tr>
<tr>
<td>Long Term Care Facility</td>
<td></td>
</tr>
<tr>
<td>Caregiver Information</td>
<td></td>
</tr>
<tr>
<td>Nursing Home Discharge</td>
<td></td>
</tr>
</tbody>
</table>

Programs for Homeowners  
Please select the program(s) that may be of interest to you.

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Bug Removal</td>
</tr>
<tr>
<td>Hazardous Tree Branch Removal</td>
</tr>
<tr>
<td>Smoke Detector Installation</td>
</tr>
</tbody>
</table>
Basics

1. Who are you completing this for? [Check only one]
   ______ Self
   ______ Spouse
   ______ Mother
   ______ Father
   ______ Sister
   ______ Brother
   ______ Client
   ______ Test Case
   ______ Other

If you selected “Other” above, please specify (for instance, “Uncle”): ______________

2. Is the person for whom you’re completing this questionnaire: ________ Male ________ Female?

3. Please enter the 5-digit zip code for the area in which you would like to screen for Programs. ______________________________

Demographic

4. What is your U.S. citizenship/immigration status? [Check only one]
   ______ Citizen
   ______ Legal Resident
   ______ Other Qualified Alien
   ______ Other

5. If you are not a citizen and you entered the United States on or after 8/22/96, have you lived in the United States for at least 5 consecutive years? ________ Yes ________ No

6. What is your marital status? [Check only one]
   ______ Single
   ______ Married
   ______ Married Living Separately
   ______ Divorced
   ______ Widowed
Race/Ethnicity

7. Are you Hispanic?  
   [Check only one]
   ______ American Indian or Alaska Native  ______ Asian  
   ______ Black or African American  ______ Native Hawaiian or other Pacific Islander  
   ______ White  ______ Other ______________________

8. Please enter date of birth  
   _______ / _______ / _______

Benefits and Public Programs

9. Are you currently receiving benefits from or participating in any of the following public Programs? Answer this question only for the person for whom you are completing the questionnaire. Do not answer this question for other household members.  
   [Check all that apply]
   ______ Medicare (currently enrolled or expect to be within the next 3 months)  ______ Supplemental Security Income (SSI)
   ______ Medicare Prescription Drug Plan (Part D)  ______ Veteran’s Health Care Benefits  
   ______ Extra Help/LIS through Medicare Low Income Home Energy
   ______ Prescription Drug Coverage  ______ Assistance Program (LIHEAP)
   ______ Medicaid  ______ Public Housing
   Medicare Savings Program (QMB) Housing Choice Vouchers  
   ______ SLMB, or QI-1)  ______ (Section 8)
   ______ Food Assistance Program Senior Community Service Employment  
   ______ Ohio’s Best Rx (State Pharmacy) Program (SCSEP)
   ______ Discount Card

Veteran Status

10. Are you a U.S. veteran?  
    ______ Yes  ______ No

11. If you are a veteran, please let us know if you:
    ______ Have a disability connected with military service
    ______ Were honorably discharged
    ______ Served during a time of war
12. Is your spouse (or former spouse) a U.S. Veteran? ________ Yes ________ No

13. If your spouse or (former spouse) is a veteran, please let us know if they:
   ________ Have a disability connected with military service
   ________ Were honorably discharged
   ________ Served during a time of war

14. Are you or your spouse (or former spouse) a U.S. military retiree (including retired guards and reservists) who has served 20 or more years AND able to get Medicare? ________ Yes ________ No

Health

15. Have you been told by your doctor or health care provider that you have any of the following chronic conditions: arthritis, asthma, emphysema, bronchitis, cancer, depression, anxiety, diabetes, heart disease, high blood pressure, stroke, osteoporosis, or HIV/AIDS?

   [Check only one]

   _____ No Chronic Conditions _____ One Chronic Condition _____ Two or More Chronic Conditions

16. Have you had an eye exam by a Medical Eye Doctor (Ophthalmologist) ________ Yes ________ No in the last three years?

Ability

17. Do you or your spouse (if married) have a condition that seriously limits your ability to work or take care of yourself? ________ Yes ________ No

18. Are you legally blind? ________ Yes ________ No

19. Are you dependent on family members or others for care? ________ Yes ________ No

Housing

20. What type of housing do you live in?
   ________ Own Home
   ________ Rental
   ________ Own Mobile Home
   ________ Boarding Home
   ________ Live with Others
   ________ Nursing Facility
   ________ Assisted Living
   ________ Low-Income Housing
   ________ Homeless or Live in a Shelter
21. Please provide the following information about your household. Include yourself and your spouse (if married) in each total. Enter the total number of people who are:

- Living in your household
- Dependent for at least one-half of their financial support
- 60 years old or older
- Disabled

22. Do you pay property taxes on your place of residence? ________ Yes ________ No

23. Do you or your spouse (if married) pay your own gas and/or electric bill, either directly or include with the rent? ________ Yes ________ No

If you are a grandparent (or know a grandparent) who is helping to raise a grandchild, you are not alone. 7.5 million children in the United States (about 10%), live with a grandparent. Additionally, millions of children age 18 or under do not have health insurance and are unaware they may be able to get help paying their health coverage.

24. We are also making sure that every child has access to basic health insurance. Do you know of any children 18 years or younger, who do not have health insurance coverage? ________ Yes ________ No

Financial

25. Please tell us how much your household spends, on a monthly basis, for the items listed below. If you do not have exact numbers or your expenses change each month, please provide an estimate.

- Rent $ ___________
- Mortgage $ ___________
- Electricity $ ___________
- Gas $ ___________
- Water (quarterly) $ ___________
- Telephone $ ___________
- Other Utilities $ ___________

Dependent Care $ ___________

26. How much money do you spend, on a monthly basis, for medical expenses that are not covered by health insurance? $ ___________

27. What is your monthly income from the Senior Community Service Employment Program? $ ___________
28. Please enter your current gross monthly income in the “Self” column below. If married, enter your spouse’s income in the “Spouse” column. If you have income in both your and your spouse’s name, enter it in the “Joint” column. Enter the income of any other people living in your household in the “Household” column.

<table>
<thead>
<tr>
<th>Self</th>
<th>Spouse</th>
<th>Joint</th>
<th>Household</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pension/Retirement Benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dividends/Interest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Security Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Security Disability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Security</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Retirement/Survivor Benefits</td>
<td></td>
<td></td>
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<tr>
<td>Railroad Retirement Benefits</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Veteran’s Benefits</td>
<td></td>
<td></td>
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<tr>
<td>Unemployment Insurance</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Worker’s Compensation</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>TANF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Non-Work Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work Income</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

29. Please enter the value of your assets in the “Self” column below. If married, enter your spouse’s assets in the “Spouse” column. There are assets that your spouse owns separately from your assets. If your assets are owned in both you and your spouse’s name, enter them in the “Joint” column. Enter assets of any other people living in your household in the “Household” column.

<table>
<thead>
<tr>
<th>Self</th>
<th>Spouse</th>
<th>Joint</th>
<th>Household</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash/Cash Equivalent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Automobile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Automobile: Vehicle 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value of Home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retirement Accounts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment Accounts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Insurance: Cash Value</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Insurance: Face Value</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burial Accounts: Revocable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burial Accounts: Irrevocable</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Economic Security Project

The Economic Security Project helps seniors improve their financial stability. We work with you to help you set financial goals and reach those goals.


Would you like to be contacted by an Economic Security Project Caseworker?

[ ] Yes  [ ] No

If you would like to complete an Economic Check-up, please answer the following questions:

How hard is it for you to provide for your basic needs each month?

[ ] It is not hard for me.
[ ] Sometimes it is hard for me.
[ ] I get by, but it is hard each month.
[ ] I cannot get by on my own, I need help each month.
[ ] I cannot meet my basic needs each month, even with help.

If you are looking for a job, what kind of help do you need? [Check all that apply]

[ ] I need help with the job search.
[ ] I need help with my job skills and would like to take an online class.
[ ] I need help matching my skills with jobs that I can apply for.
[ ] I need help learning how to use technology, such as computers and smart phones.

Please enter your current monthly household expenses below. If you do not have exact numbers or if the amount you get is different each month, please give an estimate.

<table>
<thead>
<tr>
<th>Housing</th>
<th>Health</th>
<th>Food</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transportation</th>
<th>Debt Payments</th>
<th>Other Monthly Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>
If you are having trouble paying your monthly expenses, which of the items below describes your situation? [Check all that apply].

☐ I can only make the minimum (smallest amount allowed) payments on my credit cards.
☐ I am near or at the limit of my lines of credit.
☐ I am thinking about filing for bankruptcy.
☐ I am getting calls from creditors about overdue bills.

How would you rate your health?

☐ Excellent.
☐ Very Good.
☐ Good.
☐ Fair.
☐ Poor.

Over the past few months, how often have you felt down or depressed?

☐ I have not felt down, depressed, or hopeless.
☐ I have felt down, depressed or hopeless on a few days over the past month.
☐ I have felt down, depressed or hopeless on more than half the days of the past month.
☐ I have felt down, depressed or hopeless on most days over the past month.

Please choose any of the following that you may like more information about. [Check all that apply].

☐ Money management resources, including budgeting tools, calculators to cut expenses, and coupons.
☐ Financial programs and services, including information on identifying trusted financial institutions and life insurance.
☐ Retirement planning including guides and calculators, information on Social Security benefits, and assistance with pensions.
☐ Legal concerns, including information on power of attorney, writing a will, and bankruptcy.
☐ Information on senior tax deductions or getting free tax filing assistance.
☐ Unclaimed property, which are any assets that have been lost and forgotten by its owner for a long period of time.
I, __________________________________________________________________________________________

[Please Print Your Name]

Acknowledge that the Cleveland Clergy Alliance, may find it necessary to share information that I provide such as my name, address, income sources, service I receive and general health status with other service providers. I give my permission for the Cleveland Clergy Alliance to share this information for the purpose of helping me receive the service(s) I may need.

I also understand that the demographic information collected about me will be entered into a confidential client database(s) as required by one or more of the following agencies: the Cleveland Department of Aging, Western Reserve Area Agency on Aging and the Ohio Department of Aging.

______________________________________________________________________________ (Signature) __________________________________________________________________________________________

(Address)

______________________________________________________________________________ (CCA Community Navigator Signature) __________________________________________________________________________________________

For staff use only (to be completed when not face to face with a client).

The above was read to __________________________________________________________________________________________ on

(Client’s name) __________________________________________________________________________________________

(Date)

Client gave verbal consent to release information ______ Yes ______ No

I certify that I have received the above verbal authorization:

______________________________________________________________________________ Division of Senior and Adult Services Representative Signature __________________________________________________________________________________________

(Date)