Client Assessment Form
Central Iowa RSVP
Volunteer Driver Transportation Program

CONFIDENTIAL

CLIENT INFORMATION

Name: _____ **Date of Assessment:** _____

First   Last   MI   Mo   Day   Year

Residential Address: _____ IA _____

Street   City   State   Zip

The following data is requested by our funders and will not be disclosed by name

Check the racial categories that apply to you: ____White ____Asian ____African American/Black
____American Indian/Alaskan Native ___Native Hawaiian/Other Pacific Islander ___Other

Are you Hispanic or Latino? ___Yes ___No   **Are you a veteran?** ___Yes ___No   **Number in Household** ____

For one person, is your annual household income more than $14,580? ___Yes ___No

For 2 people, is your annual household income more than $19,720? ___Yes ___No

PHYSICAL AND MENTAL ABILITIES

Client Mobility (Check or circle all that apply)

Can go up and down steps unassisted (yes/no): _____ **Able to step into a car unassisted (yes/no):** _____

Able to step into a pick-up truck or SUV unassisted or with very little assistance: _____

___Walks unassisted   ___Uses a cane   ___Uses a walker   ___Uses an oxygen tank

Do you have any other health or physical conditions to be considered in providing transportation?   Yes   No

If yes, please explain: _____

Will you need assistance within the medical facility (escort)?

If yes, please explain: _____

Mental and Sensory (Check all that apply):

___Alert and able to follow directions   _____

___Has difficulty hearing   Explain_____

___Has vision problems   Explain_____

Would you like assistance with or information regarding services for any of the following: personal care, money management, meal preparation, medication management, housekeeping, grocery shopping?_____

TRIPS & SERVICE NEEDED

Will anyone accompany you on your trips?   Yes   No   **If yes, who?**

Level of Assistance Needed: ___**Driver/Escort** (Door to Door with facility assistance)

            ___ **Driver Only (Circle):**   Curb-to-Curb   Door-to-Door w/no Facility Assistance

SIGNATURES

I have given RSVP staff approval for this assessment. I understand that this evaluation will be used to determine my eligibility for RSVP transportation services and/or the level of service I will need. I understand that any information provided to the RSVP Outreach Specialist or staff will be kept confidential and will NOT be shared or used by RSVP except for the purpose of providing transportation services.

Client Signature _____ Date_____

Outreach Specialist/RSVP Staff Signature_____ Date_____

INTERVIEWER NOTES: