



Next Calendar Day Home Visit Form

PA Name:		Case #:	Home Visit Conducted By:	
Case Size:	DOA:	# of Occupants:	# of Bedrooms:	Date Conducted:
Address:			Temporary (T) or Permanent (P) Housing:	

A. Housing Orientation

Demonstrate How to Use:

- | | |
|---|--|
| <input type="checkbox"/> Stove/Oven
<input type="checkbox"/> Refrigerator/Freezer (appropriate food storage)
<input type="checkbox"/> Shower/Bath
<input type="checkbox"/> Hot/Cold Water
<input type="checkbox"/> Toilet
<input type="checkbox"/> Heating and Air Conditioning (appropriate temperature settings) | <input type="checkbox"/> Lights in Each Room
<input type="checkbox"/> All Door Locks (interior and exterior doors)
<input type="checkbox"/> All Windows, Window Locks, and Screens
<input type="checkbox"/> Doorbell or Intercom System
<input type="checkbox"/> Mailbox (location/key)
<input type="checkbox"/> Home Telephone and/or Cell Phone
<input type="checkbox"/> Any Other Appliances: |
|---|--|

Ask the following (or similar) questions to ensure understanding of housing orientation.

	<i>Did client/s demonstrate understanding?</i>
Can you tell/show me how to make the temperature warmer or colder in your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can you tell/show me how to ensure the stove/oven is turned off when you are done using it?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can you show me how to lock/unlock the door/s to enter your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Note any housing orientation topics which need additional review to ensure understanding:

B. Assessment of Condition of Housing

Ask the following three questions to identify housing issues. Please note any issues in space below.

Have you noticed anything in your home which is not working properly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any questions or concerns about your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel safe in your home and neighborhood?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Inspect home to identify any housing issues and respond to questions below. If checking yes, describe in space below.

Does the home have any visible health or safety hazards (mold, insects, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any missing furniture/household items (see home supply list)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If a member of the case has a physical disability, does the home meet his/her needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Note any repairs or maintenance needed, missing furniture/household supplies, or other concerns/issues:

C. Safety Procedures and Emergency Contacts*Review the following information with client/s.*

- How to safely answer the door/check who is at the door
- Importance of keeping doors to the outside locked
- Safety regarding keeping windows open/closed and locked
- Smoke Detector (explain sound of alarm, low battery, and what to do if it goes off when cooking)
- Fire Extinguisher (if required, show location and how to use)
- Emergency escape routes (from housing)
- When and how to call 911 (provide written copy)
- How to contact case worker/agency staff
- Client address and phone number (provide written copy)
- Safety precautions for client/s with children N/A
 - Appropriate supervision of children
 - Car/child safety seat and seat belt requirements

Ask the following (or similar) questions to ensure understanding of safety procedures and emergency contacts.

	<i>Did client/s demonstrate understanding?</i>
What number would you call if there was an emergency (such as a medical emergency)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What would you do if the smoke detector alarm went off?	<input type="checkbox"/> Yes <input type="checkbox"/> No

*Note any topics and information which need additional review to ensure client understanding:***D. Assessment of Welfare and Basic Immediate Needs***Ask the following questions to determine if basic immediate needs have been met.*

Do you or any of your family members have urgent medical or medication needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a supply of food or money to purchase food?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you know when you will get more food?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have enough food to last until that time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have seasonal clothing for your immediate needs (including footwear)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been provided with pocket money?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you need diapers or baby food (as applicable)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Do you have any other needs or concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Note any concerns or follow up needed regarding provision of basic needs:

Case Worker or Home Visit Provider Name: _____

Case Worker or Home Visit Provider Signature: _____ Date: _____