Activities of Daily Living
for a Homeless Applicant

Living Arrangements

- How long have you been homeless? _____
- Where do you stay now? _____
- How long have you stayed there? _____
- Describe what you do during the day: _____

_____

Sleep

- Do you get enough sleep? Yes _____ No _____
- Do you feel you sleep too much? Yes _____ No _____
- Where do you sleep at night? _____
- How many hours do you sleep at a time? _____
- Do you take medicine to help you sleep? Yes _____ No _____
- If yes, what do you take? _____
- Do you sleep during the day? Yes _____ No _____
- If yes, where do you sleep during the day? _____

Personal Care

- Do you ever need help with your personal care, such as bathing? Yes _____ No _____
- Do you need to be reminded? Yes _____ No _____
- Does someone help you with your personal care? Yes _____ No _____
- Why do you need the help? _____
- Who helps you? _____
- Where do you take showers, wash clothes, etc.? _____

Meals / Eating Habits

- How many meals do you eat each day? _____
- Where do you eat your meals? _____
- Do you sometimes prepare your own food? Yes _____ No _____
- If you had access to a kitchen, would you be able to cook? Yes _____ No _____
- How have your eating habits changed since becoming homeless? _____

_____

_____.

- Please indicate your current: Weight: _____ Height. _____
- Has your weight changed since you became homeless? Yes _____ No _____
- If yes, amount of weight gained: _____ amount of weight lost: _____

Shopping

- Where do you get your clothes? _____
- Where do you get your grooming products, such as soap? _____
- Do you have difficulty handling your own money or food stamps? Yes _____ No _____
- When you had enough money, were you able to shop? Yes _____ No _____

Name and Social Security Number

Social Contacts

- Do you spend time with others? Yes _____ No _____
- If not, why not? _____
- Do you spend time with friends or relatives? Yes _____ No _____
- If not, why not? _____
- Do you prefer to be with others or by yourself? _____
- Do you find you get along with others? Yes _____ No _____
- If not, why not? _____
- Are you able to take public transportation? Yes _____ No _____
- If not, why not? _____
- Are you able to follow the rules of the shelter? Yes _____ No _____

Concentration / Memory

- Do you have any problems remembering things? Yes _____ No _____
- Do you have any problems following written instructions? Yes _____ No _____
- Do you have any problems following verbal instructions? Yes _____ No _____
- Do you finish what you start out to do? Yes _____ No _____
- If not, please give an example. _____
- For how long can you pay attention? _____
- Describe any difficulty you have with concentration or memory: _____
  _____
- Have you ever been hit in the head? Yes _____ No _____
- How many times have you lost consciousness? _____

Treatment

- Has medication been prescribed? Yes _____ No _____
- If yes, are you taking it as prescribed? Yes _____ No _____
- If not, why not? _____
- If not, do you think medication would help you? Yes _____ No _____
- If you take medications, what are they? _____
- Who prescribes the medication for you? _____
- Does someone help you remember to take the medication? Yes _____ No _____
- Are you now, or have you ever been, in counseling? Yes _____ No _____
- If yes, did you find it helpful? Yes _____ No _____
- Have you had any new treatment for physical or mental problems since you first applied for Social Security disability? Yes _____ No _____
- If anyone assisted you in completing this form, please indicate:
  Name _____
  Address _____
  Telephone _____
  Sign _____ Date _____

_____
Signature and Date