



HOME ALONE ASSESSMENT

Date: _____

Client Name: _____ DOB: _____

Caregiver Name: _____ Assessor: _____

	Yes	No	Comments
Member demonstrates ability to identify an emergency contact name and phone number (other than CG)? Contact Name: _____ Phone Number: _____			
Member demonstrates knowledge of whom and how to call for assistance if needed?			
Member demonstrates ability to convey name, address, phone number and nature of an emergency to others or have life line or enhanced 911?			
Member demonstrates knowledge of when to call for assistance?			
A Phone is available for member to use during unsupervised @me?			
Member demonstrates awareness of fire alarms/ Carbon Monoxide detectors.			
Member demonstrates ability to safely and independently evacuate the home.			
Member demonstrates knowledge of safe response if stranger comes to the door?			
Member demonstrates knowledge of safe response if someone tries to break into the house?			
Member feels safe being unsupervised?			
Based upon the information provided by the member or their representative, I believe that: <input type="checkbox"/> • This person qualifies for up to three hours of alone time in the AFC setting <input type="checkbox"/> • This person does NOT qualify for home alone time and can never be left unattended in AFC setting			

AFC RN Name: _____ Signature: _____

AFC CM Name: _____ Signature: _____

Caregiver Name: _____ Signature: _____