Florida Healthy Homes Program
Home Assessment Tool

Date ____________

Education: Healthy Homes education booklet has been provided? ❑ Yes (❑ Eng ❑ Sp) ❑ No If No, reason why? ______________

Initial Consent: May I ask you some questions about your home? ❑ Yes ❑ No If No, reason why? (optional) ___________________

Client Demographic Information:

Language spoken (check all that apply)
- ❑ English
- ❑ Spanish
- ❑ Haitian-Creole
- ❑ Other __________________
- ❑ Translator will be needed

Housing situation
- ❑ Own home
- ❑ Rent home
- ❑ Section 8
- ❑ Live with other family or friends
- ❑ Other ____________

Race
- ❑ Black
- ❑ White
- ❑ Asian/Pacific Islander
- ❑ American Indian/ Alaskan Native
- ❑ Other

Ethnicity
- ❑ Hispanic
- ❑ Non-Hispanic
- ❑ Haitian

 # living in home by age
- ______ 0 – 3 years
- ______ 4 – 6 years
- ______ 7 – 18 years

Zip Code ____________

Health Risk	Home Assessment: Client-Reported and/or Self-Observed Issues (NOTE: The shaded boxes below in the "Yes" and "No" columns indicate a health risk.)	Yes	No	Reviewed Education Booklet (optional)
Lead Exposure	1. Home built before 1978? **(check "Yes" if do not know)**	❑	❑	❑
	2. Adult in the home whose job or hobby involves lead? **(see page 2 for examples)**	❑	❑	❑
	3. Child eats dirt or mouths on painted surfaces, jewelry, toys or mini-blinds? **(see page 2 for examples)**	❑	❑	❑
	4. Child plays in loose soil near a busy road or factory site? **(see page 2 for examples)**	❑	❑	❑
	5. Child has contact with imported products or home remedies? **(see page 2 for examples)**	❑	❑	❑
	6. Child visited or lived in another country?	❑	❑	❑
	7. Child between 6 mo. and 6 yrs. has had a blood lead test? **(check "No" if do not know)**	❑	❑	❑
Asthma and Allergies	8. Child displays signs and symptoms of asthma (shortness of breath, wheezing, coughing) or allergies (stuffy or runny nose, itching, rash)?	❑	❑	❑
	9. If child has been diagnosed with asthma, does the child have an asthma management plan or support in controlling child's asthma symptoms? ❑ **Not Applicable**	❑	❑	❑
	10. Tobacco smoking inside the home?	❑	❑	❑
	11. Pets inside or outside the home?	❑	❑	❑
	12. Visible house dust present?	❑	❑	❑
	13. Any leaks, flooding, water damage, mold, or damp or musty smell in the home?	❑	❑	❑
	14. Lack of or poor ventilation systems?	❑	❑	❑
	15. Pests like cockroaches, or rodents like mice or rats?	❑	❑	❑
Poisoning	16. Fuel-burning appliances that use natural gas/liquid propane gas, oil, wood or coal?	❑	❑	❑
	17. Carbon monoxide (CO) alarm(s) less than 5 years old?	❑	❑	❑
	18. Safe storage and/or safe disposal of pesticides or hazardous household products?	❑	❑	❑
	19. Poison Control Center number (1-800-222-1222) by phones and saved in cell phones?	❑	❑	❑
Home Safety/ Injury Prevention	20. Smoke alarm(s) less than 10 years old?	❑	❑	❑
	21. Safety risks present around water like pools and bathtubs?	❑	❑	❑
	22. Food safety concerns (proper food temperatures and handling)?	❑	❑	❑
	23. Other home safety hazards/concerns? (list here) ______________________________	❑	❑	❑
	24. Drinking water comes from private water supply like a well?	❑	❑	❑
Radon Exposure	25. Home has been tested for radon? **(check "No" if do not know)**	❑	❑	❑

Release for Referral: I understand that the service associated with this form is solely informational in nature and that no sampling, destructive testing, or hazard qualification has been performed. I am giving written permission for release of the confidential information on this form for referral for program services from the County Health Department and for the quality improvement of services.

Signature ____ **Date** ______________________

If not signed, reason why (optional) ____

Client Contact Information: Name ________________________ Address ________________________

City ________________ State ______________ Zip Code __________ County ________________

Phone _________________ Cell __________________

Directions to home/Rural route directions ____

Referral Made By: Name ________________________ Date __________ Phone ________________

Comments (or you may attach additional information): ____________________________________

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Send ALL Home Assessment Tools to the CHD Healthy Homes Coach

Healthy Start Client ID Number ______________

Healthy Homes Client ID Number ______________

(to be filled out by County Health Department)

Revised 9/24/09