NORTH WEST HOUSING PARTNERSHIP
CAPABLE PROJECT

Community **A**ging in **P**lace, **A**dvancing **B**etter **L**iving for **E**lders

Overview: Capable project is a program which aims to help individuals live independently in their home and more fully engage in daily activities. Many adults prefer to age in place by remaining in their home and community. However, physical challenges may impede a person's ability to remain safely in the home. This innovative program coordinates the services of an occupational therapist, a nurse, and handyperson - to assist with a person's self-identified key challenges and make home repairs to assist with these goals.

Who Is Eligible: Age 62+ residing at home in Oak Park and River Forest.

How It Works: The OT, nurse, and handyperson come to the home to deliver services over a four-month period. In most cases, the OT makes 6 visits, and the nurse makes 4 visits. **The OT and nurse services are cost free. There may be a small fee for the Handyperson and materials that are determined by the OT for home safety depending on income.** See reverse for details on screening, goal setting, and action plan.

For information or to make an appointment, call NWHP at 847-969-0561 or email paulabush@nwhp.net

Capable Program Partners:

North West Housing Partnership (nwhp.net), The Harry and Jeanette Weinberg Foundation (hjweinbergfoundation.org), Oak Park Township (oakparktownship.org), River Forest Township (riverforesttownship.org), Village of Oak Park (oak-park.us), and Village of River Forest (vrf.us).

Brought to residents of Oak Park and River Forest with funds from:

NORTH WEST HOUSING PARTNERSHIP

The Harry and Jeanette Weinberg Foundation

OAK PARK TOWNSHIP

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Oak Park

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CAPABLE PROJECT STEPS

1. Initial Screening and Interview with North West Housing Partnership
2. 1st visit with Occupational Therapist - includes assessment and discussion of priority goals
3. 2nd OT visit - includes examination of the home and creation of work order for the Handyperson
4. Handyperson comes to make repairs and if needed accessibility modifications
5. 1st RN visit focused on pain, strength, medication, communication with primary care providers
6. Additional OT visits to address priority goals
7. 2nd RN visit - set goals, review exercises, consider how to improve communication with primary care provider
8. Additional RN visits to review progress and use strategies, complete action plan
9. The 6th OT visit is a wrap-up and helping the participant generalize what they learned so that they can address new challenges. If someone picks only 2 goals, sometimes they have just 5 visits.
10. Once services are completed, a survey and evaluation visit will occur to answer questions and assess impact.

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