AREA AGENCY ON AGING OF_____

CLIENT INTAKE AND SERVICE REQUEST FORM

The information on this form is required by your local service provider, the Area Agency on Aging (AAA), and the Texas Department of Aging and Disability Services. All information provided will be kept confidential and guarded against unofficial use. Information gathered through an intake or through an assessment may be shared to effectively plan, arrange and deliver services to meet individual client needs.

Client's Primary Language: _____

Release of information has been clearly explained to the client. ☐

Date: _____ **Client ID Number:** _____

Last Name: _____ **MI:** _____ **First Name:** _____

Street Address/Apt. #: _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____

Phone: (_____) _____ **Gender: Male** ☐ **Female** ☐ **Birth Date:** _____

Ethnicity (Check One):

- **(1) Hispanic or Latino** ☐
- **(2) Not Hispanic or Latino** ☐
- **(3) Ethnicity Not Reported** ☐

Race (Check all that apply):

- **(1) White – Non Hispanic** ☐
- **(2) White – Hispanic** ☐
- **(3) American Indian/Alaska Native** ☐
- **(4) Asian** ☐
- **(5) Black or African American** ☐
- **(6) Native Hawaiian or Pacific Islander** ☐
- **(7) Persons Reporting Some Other Race** ☐
- **(8) Race Not Reported** ☐

Marital Status (Check One):

- (1) Married ☐
- (2) Widowed ☐
- (3) Divorced ☐
- (4) Separated ☐
- (5) Never Married ☐
- (6) Not Reported ☐

Does client live alone? **Yes** ☐ **No** ☐

Total Number of Family Members in Household Including Client: _____

Monthly Household Income: $_____ **Low Income** ☐ **Moderate Income** ☐ **High Income** ☐

{Low Income Levels for: Single person family unit – $ 10,830; Two person family unit – $14,570}

Funded by the Texas Department of Aging and Disability Services

Monthly Income from:	Individual	Spouse
Job		
Social Security		
SSI		
VA		
Other Sources		
Other Benefits (e.g., Food Stamps)		

Emergency Contact Information

Contact Name: _____ **Phone:** (_____) _____

Relationship: _____

Primary Care Physician: _____ **Phone:** (_____) _____

Service(s) Requested: _____

Are you enrolled in? ☐ Medicare - Medicare # _____ ☐ Medicaid- Medicaid # _____

Referred By:

☐ Texas Department of Family & Protective Services (DFPS)

☐ Texas Department of Assistive & Rehabilitative Services (DARS)

☐ Texas Department of State Health Services (DSHS)

☐ Doctor ☐ Hospital ☐ Assisted Living Facility

☐ Home & Community Care Organization

☐ Family Member

☐ Other

_____ _____

Signature of AAA/Provider Staff Completing Intake **Date**

To be completed by AAA/provider staff

Nutrition Services: If participant is "other Older Americans Act or NSIP eligible participant under 60 year of age", check which of the following applies:

(1) Spouse is eligible and participates at the nutrition site. ☐

(2) Serves as volunteer at the nutrition site in accordance with OAA standards. ☐

(3) Disabled/resides in the housing facility and wants to participate in the congregate meal program provided at the site. ☐

(4) Disabled and lives with the person participating in congregate meal program. ☐