



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): Race (Check all that apply): Marital Status (Check One):
(1) Hispanic or Latino (2) Not Hispanic or Latino (3) Ethnicity Not Reported
(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
(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}

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:

- | | |
|---|---|
| <input type="checkbox"/> Texas Department of Family & Protective Services (DFPS) | <input type="checkbox"/> Home & Community Care Organization |
| <input type="checkbox"/> Texas Department of Assistive & Rehabilitative Services (DARS) | <input type="checkbox"/> Family Member |
| <input type="checkbox"/> Texas Department of State Health Services (DSHS) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital <input type="checkbox"/> Assisted Living Facility | |

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. | <input type="checkbox"/> |
| (2) Serves as volunteer at the nutrition site in accordance with OAA standards. | <input type="checkbox"/> |
| (3) Disabled/resides in the housing facility and wants to participate in the congregate meal program provided at the site. | <input type="checkbox"/> |
| (4) Disabled and lives with the person participating in congregate meal program. | <input type="checkbox"/> |