

Caregiver Intake

**Form 2270**

January 2024

Area Agency on Aging of North Central Texas

The information on this form is needed to provide services. All information is confidential and will be guarded against unofficial use and shared only to get services started or changed.

**\**Release of Information and Client Rights and Responsibilities* explained.**

**Note**: All items marked with an asterisk (**\***) are required.

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| **Part I – Caregiver Identification** | | | | | | | | |
| \*Date: | | SPURS ID No.: | | | | Primary Language: | | |
| \*Last Name: | \*First Name: | | \*MI: | | \*Date of Birth: | | \*Gender:  Female  Male  Other  Unknown | |
| \*Street Address and Apt. No. or P.O. Box: | | \*City: | \*State: | | \*ZIP Code: | | \*County: | |
| \*Area Code and Phone No.:  Cell  Home  Other | | | | | Email Address: | | | |
| Check if Mailing Address is different from Home Address and enter Mailing Address below: | | | | | | | | |
| \*Street Address and Apt. No.: | | \*City: | | \*State: | | \*ZIP Code: | | \*County: |
| \***Ethnicity** *(Check One)***:**  Hispanic or Latino  Not Hispanic or Latino  Unknown | | \***Race** *(Check all that apply)***:**  American Indian or Alaska Native  Asian  Black or African American  Native Hawaiian or Pacific Islander  Non-Minority (White, Non-Hispanic)  White – Hispanic | | | | **Marital Status** *(Check One)***:**  Married  Widowed  Divorced  Separated  Never Married  Not Reported | | |
| **\***Person lives alone?  Yes  No  Don't Know | | Total No. of People in Household: | | | | Monthly Household Income: | | |
| Use current Department of Health and Human Services Federal Poverty Guidelines for size of household to decide if person is at or below poverty.  **2024 limits: $1,255 individual; $1,703 couple** | | | | | | **\***At or below poverty?  Yes  No  Don't Know | | |

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| **Part II – Service(s) Requested** *(Completed by AAA or provider staff)* |
| List of Requested Services:  Benefits Counseling  Caregiver Education  Emergency Response Sys.  Health Maintenance Supplies  Home-Delivered Meals  Medication Management  Nutritional Supplements  Personal Care  Prescription Assistance  Residential Repair  Respite  Transportation  Utility Assistance  Other |

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| **Part III – Emergency Contact Information** | | |
| Contact Name: | Relationship: | Area Code and Phone No.: |
| Primary Care Physician: | | Area Code and Phone No.: |

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| **Part IV – Relationship to Care Recipients(s)** | | |
| **\***Choose which of the following best fits the caregiver’s relationship to the care recipient: | | |
| 1. **Relationship to care recipients(s) who is 60 or older or any age if diagnosed with Alzheimer’s disease or a brain disorder.**   Caregiver must be 18 or older. | | |
| Husband  Daughter or Daughter-in-Law  Domestic Partner including Civil Union | Wife  Other Relative  Sister | Son or Son-in-Law  Non-Relative  Brother |
| 1. **Relationship to care recipient(s) who is 18 or younger.**   Caregiver must be 55 or older, live with the care recipient(s) and meet the relationship requirement.  Grandparents  Other Relative  Does the caregiver live with the care recipient? Yes No | | |
| 1. **Relationship to care recipient(s) with disability who is 19 or more, but not older than 59.**   Caregiver must be 55 or older, live with the care recipient and meet the relationship requirement.  Parents  Grandparents  Other Relative  Non-Relative  Does the caregiver live with the care recipient? Yes No | | |

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| **Part V – Care Recipient Identification** | | | | | | |
| Does the care recipient need an interpretation?  Yes  No If yes, who helps in the interpretation?  **\***If the **care recipient is 60 or older**, please complete the following: | | | | | | |
| **\***Date: | | SPURS ID No.: | | | Primary Language: | |
| **\***Last Name: | **\***First Name: | | **\***MI: | **\***Date of Birth: | | \*Gender:  Female  Male  Other  Unknown |
| **\***Street Address and Apt. No. or P.O. Box: | | **\***City: | **\***State: | **\***ZIP Code: | | **\***County: |
| **\***Area Code and Phone No.:  Cell  Home  Other | | | | Email Address: | | |
| **\*Ethnicity** *(Check One)***:**  Hispanic or Latino  Not Hispanic or Latino  Unknown | | **\*Race** *(Check all that apply)***:**  American Indian or Alaska Native  Asian  Black or African American  Native Hawaiian or Pacific Islander  Non-Minority (White, Non-Hispanic)  White – Hispanic | | | **Marital Status** *(Check One)***:**  Married  Widowed  Divorced  Separated  Never Married  Not Reported | |

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| **\*If care recipient is 18 or younger, or has a disability and is 18 or more but not older than 59, complete the following:** | | | |
| **Name** | **Date of Birth** | **Gender** | **Relationship to Caregiver** |
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| **\*Name of AAA or Provider Staff Completing Caregiver Intake \*Date** | | | |

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| **Diagnosis of Care Recipient Referral made to HHS? Name/Phone # of Person making Referral** | | |
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