TEXAS Health and Human Services

Form 2270
Rev. Jan 2026

Caregiver Intake

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.

Part I – Caregiver Identification

*Date:	SPURS ID No.:		Primary Language:	
*Last Name:	*First Name:	*MI:	*Date of Birth:	*Sex: ☐ Male ☐ Female
*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 ☐ 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. **2026 limits: $1,330 individual; $1,803 couple**		*At or below poverty? ☐ Yes ☐ No ☐ Don't Know

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
- ☐ Nutritional Supplements
- ☐ Personal Care
- ☐ Prescription Assistance
- ☐ Residential Repair
- ☐ Respite
- ☐ Transportation
- ☐ Utility Assistance
- ☐ Other

Part III – Emergency Contact Information

Contact Name:	Relationship:	Area Code and Phone No.:
Primary Care Physician:		Area Code and Phone No.:

Part IV – Relationship to Care Recipients(s)

*Choose which of the following best fits the caregiver's relationship to the care recipient:

A. 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 ☐ Wife ☐ Son or Son-in-Law
☐ Daughter or Daughter-in-Law ☐ Other Relative ☐ Non-Relative
☐ Domestic Partner including Civil Union ☐ Sister ☐ Brother

B. 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 ☐ Non-Relative

Does the caregiver live with the care recipient? ☐ Yes ☐ No

C. 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

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:	*Sex: ☐ Male ☐ Female

*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)*:	***Race** *(Check all that apply)*:	**Marital Status** *(Check One)*:
☐ Hispanic or Latino	☐ American Indian or Alaska Native	☐ Married
☐ Not Hispanic or Latino	☐ Asian	☐ Widowed
☐ Unknown	☐ Black or African American	☐ Divorced
	☐ Native Hawaiian or Pacific Islander	☐ Separated
	☐ White -- Non-Hispanic	☐ Never Married
	☐ White – Hispanic	☐ Not Reported

***If care recipient is 18 or younger, or has a disability and is 19 or more but not older than 59, complete the following:**

Name	Date of Birth	Sex	Relationship to Caregiver

_____ _____

***Name of AAA or Provider Staff Completing Caregiver Intake** ***Date**

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