



Caregiver Intake

Form 2270

Rev. Feb 27
2026

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:
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*Last Name:	*First Name:	*MI:	*Date of Birth:	*Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
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*Street Address and Apt. No. or P.O. Box:	*City:	*State:	*ZIP Code:	*County:
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*Area Code and Phone No.: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Other	Email Address:
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Check if Mailing Address is different from Home Address and enter Mailing Address below:

*Street Address and Apt. No.:	*City:	*State:	*ZIP Code:	*County:
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*Ethnicity (Check One): <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Missing/Unknown	*Race (Check all that apply): <input type="checkbox"/> American Indian/Native Alaskan (Alone) <input type="checkbox"/> Asian (Alone) <input type="checkbox"/> Black or African American (Alone) <input type="checkbox"/> Native Hawaiian/Other Pacific Islander (Alone) <input type="checkbox"/> White <input type="checkbox"/> Not Available	Marital Status (Check One): <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Never Married <input type="checkbox"/> Not Reported
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not provided	Monthly Household Income:	Total No. of People in Household:
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*Lives with?	<input type="checkbox"/> Lives alone	<input type="checkbox"/> Spouse/Partner	<input type="checkbox"/> Child/Children
	<input type="checkbox"/> Spouse & Child	<input type="checkbox"/> Lives in Long Term Care (LTX) Facility	<input type="checkbox"/> Other

***Veteran Status**
Have you ever served in the United States Armed Forces or Texas Military Forces, regardless of length of service or type of discharge?

Yes No Chooses not to answer

Part II – Service(s) Requested (Completed by AAA or provider staff)

List of Requested Services: <input type="checkbox"/> Benefits Counseling <input type="checkbox"/> Caregiver Education <input type="checkbox"/> Emergency Response Sys. <input type="checkbox"/> Health Maintenance Supplies <input type="checkbox"/> Home-Delivered Meals <input type="checkbox"/> Nutritional Supplements	<input type="checkbox"/> Personal Care <input type="checkbox"/> Prescription Assistance <input type="checkbox"/> Residential Repair <input type="checkbox"/> Respite <input type="checkbox"/> Transportation <input type="checkbox"/> Utility Assistance <input type="checkbox"/> 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.:

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.
***Caregiver relationship to care recipient:** _____

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.
***Caregiver relationship to care recipient:** _____
 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.
***Caregiver relationship to care recipient:** _____
 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:
*Street Address and Apt. No. or P.O. Box:	*City:	*State:
*Area Code and Phone No.: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Other	*Date of Birth:	*ZIP Code:
*Ethnicity (Check One): <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Missing/Unknown	*Race (Check all that apply): <input type="checkbox"/> American Indian/Native Alaskan (Alone) <input type="checkbox"/> Asian (Alone) <input type="checkbox"/> Black or African American (Alone) <input type="checkbox"/> Native Hawaiian/Other Pacific Islander (Alone) <input type="checkbox"/> White <input type="checkbox"/> Not Available	*Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
*County:		*County:
Email Address:		Email Address:
Marital Status (Check One): <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Never Married <input type="checkbox"/> 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