



AREA AGENCY ON AGING OF NORTH CENTRAL TEXAS CARE COORDINATION INTAKE/REFERRAL FORM

(Items in **BOLD** must be completed)

Client Rights & Responsibilities and Release of Information have been clearly explained to the client. ()

DATE:	CLIENT ID NUMBER: (For internal use only)
CLIENT INFORMATION:	
NAME: (Last, MI, First)	
HOME ADDRESS: STREET/Apt. #: (Number, City, State & ZIP) COUNTY:	
() Check if Mailing Address is Home Address:	
PHONE: (____) _____ Home () Cell () Other () (Check One)	
GENDER: () M () F	DOB:
ETHNICITY (Check One): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Ethnicity Not Reported <input type="checkbox"/> Consumer declined to provide	RACE (Check all that apply): <input type="checkbox"/> White - Non Hispanic <input type="checkbox"/> White - Hispanic <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Persons Reporting Some Other Race <input type="checkbox"/> Race Not Reported <input type="checkbox"/> Consumer declined to provide
PRIMARY LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Other _____	
DOES CLIENT LIVE ALONE? () Y () N Total Number of Family Members in Household Including Client: _____	IS CLIENT RECEIVING MEDICAID? () Y () N
MARITAL STATUS: <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	TOTAL MONTHLY HOUSEHOLD INCOME (2020): <input type="checkbox"/> Poverty (Single person family unit <= \$1,063/mo) (Two person family unit <= \$1,437/mo) <input type="checkbox"/> Low (150% FPL) (Single person family unit <= \$1,595/mo) (Two person family unit <= \$2,155/mo) <input type="checkbox"/> Moderate (Single person family unit > \$1,595, but <= \$9,700/mo) (Two person family unit > \$2,155, but <= \$11,083/mo) <input type="checkbox"/> High (Single person family unit > \$9,700/mo) (Two person unit > \$11,083/mo) <input type="checkbox"/> Consumer declined to provide

CARE COORDINATION INTAKE/REFERRAL FORM

EMERGENCY CONTACT INFORMATION:

Name: _____ Phone/s: (____) _____

Relationship to client: _____ Primary Caregiver: () Y () N

SERVICES REQUESTED:

- () Emergency Response System
- () Health Maintenance Supplies/Nutritional Supplements
- () Home-Delivered Meals
- () Homemaker (Housekeeping)
- () Medication Management
- () Personal Care
- () Prescription Assistance
- () Residential Repair
- () Utility Assistance
- () Benefits Counseling
- () Transportation
- () Other:

If client requests in-home services other than home-delivered meals, fax form to 940-222-4741.

REFERRAL SOURCE:

Name: _____
 Phone number: (____) _____
 Relationship to Caregiver/Recipient: _____

DIAGNOSIS/HEALTH STATUS:

WAS A REFERRAL MADE TO HHS? Yes () No ()

COMMENTS:

To be completed by AAA/provider staff:

Print name of AAA/provider staff completing Intake: _____

Nutrition Services: If participant is "other Older Americans Act (OAA) or Nutrition Service Incentive Program (NSIP) eligible participant under 60 years of age," check which of the following applies:

- (1) Spouse is eligible and participates in congregate or home delivered meal program.
- (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 a 60+ person who is eligible for congregate or home delivered meal program.