AREA AGENCY ON AGING OF NORTH CENTRAL TEXAS
CAREGIVER SUPPORT PROGRAM INTAKE/REFERRAL FORM

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

DATE:	**CLIENT ID NUMBER: (For internal use only)**
CAREGIVER INFORMATION:	
NAME: (Last, MI, First)	
STREET ADDRESS/Apt. #: (Number, City, State & ZIP) **COUNTY:** **MAILING ADDRESS** (If different):	
PHONE: (Please indicate if cell, work or home)	
GENDER: ( ) M ( ) F	**DOB:**
ETHNICITY: **( ) Hispanic or Latino** **( ) Not Hispanic or Latino** **( ) Ethnicity Not Reported** **( ) Consumer declined to provide** **DOES CAREGIVER LIVE ALONE?** ( ) Y ( ) N	**RACE:** **( ) White – Non Hispanic** **( ) White - Hispanic** **( ) American Indian/Alaska Native** **( ) Asian** **( ) Black or African American** **( ) Native Hawaiian or Pacific Islander** **( ) Persons Reporting Some Other Race** **( ) Race Not Reported** **( ) Consumer declined to provide**
MARITAL STATUS: ( ) Married ( ) Widowed ( ) Divorced ( ) Separated ( ) Never Married ( ) Not Reported	**TOTAL MONTHLY INCOME:** ( ) **Poverty** (Single person family unit < =$1,011/mo) (Two person family unit <=$1,371/mo) ( ) **Low (150% FPL)** (Single person family unit <=$1,516/mo) (Two person family unit <= $2,057/mo) ( ) **Moderate** (Single person family unit >$1,516, but <=$6,010) (Two person family unit >$2,057, but <=$6,732) ( ) **High** (Single person family unit > $6,010) (Two person unit > $6,732) ( ) **Consumer declined to provide**
RELATIONSHIP TO CARE RECIPIENT: **( ) Husband** **( ) Niece** **( ) Wife** **( ) Nephew** **( ) Son/Son-in-Law** **( ) Non-Relative** **( ) Daughter/Daughter-in-Law** **( ) Other Relative** **( ) Relationship Missing**	**<u>Relationship to care recipient(s) if 18 years of age or less (Caregiver must be 55+ years of age and fall under OAA, Section 372 as defined):</u>** **( ) Grandparents** **( ) Other Elderly Relative** **( ) Other Elderly Non-Relative**
EMERGENCY CONTACT INFORMATION (FOR CAREGIVER): Contact Name: Phone: (____) _____ Relationship:	

CARE RECIPIENT INFORMATION:

**(Must be person at least 60 years of age,
or person with Alzheimer's,
or grandchild under age 18 who is in primary custody of non-parent relative age 55 and over;
or child with severe disabilities who is being cared for by parent at least 55 years of age)**

NAME: (Last, MI, First)

CLIENT ID NUMBER: (For internal use only)

STREET ADDRESS/Apt. #: (Number, City, State & ZIP)

COUNTY:

MAILING ADDRESS (If different):

PHONE: (Please indicate if cell, work or home)

GENDER: ( ) M ( ) F

DOB:

ETHNICITY:

- **( ) Hispanic or Latino**
- **( ) Not Hispanic or Latino**
- **( ) Ethnicity Not Reported**
- **( ) Consumer declined to provide**

PRIMARY LANGUAGE:

- ( ) English
- ( ) Other _____

If other, does the Care Recipient require an interpreter ( ) Y ( ) N
Who helps in the interpretation? _____

RACE:

- **( ) White – Non Hispanic**
- **( ) White – Hispanic**
- **( ) Black or African American**
- **( ) Race Not Reported**
- **( ) Persons Reporting Some Other Race**
- **( ) Native Hawaiian or Pacific Islander**
- **( ) American Indian/Alaska Native**
- **( ) Asian**
- **( ) Consumer declined to provide**

DOES CARE RECIPIENT LIVE ALONE? ( ) Y ( ) N
If no, does care recipient live with caregiver?
( ) Y ( ) N

MARITAL STATUS:

- ( ) Married
- ( ) Single
- ( ) Widowed
- ( ) Divorced
- ( ) Separated
- ( ) Domestic partner
- ( ) Not Reported

TOTAL MONTHLY INCOME:

- ( ) **Poverty**
  (Single person family unit < =$1,011/mo)
  (Two person family unit <=$1,371/mo)
- ( ) **Low (150% FPL)**
  (Single person family unit <=$1,516/mo)
  (Two person family unit <= $2,057/mo)
- ( ) **Moderate**
  (Single person family unit >$1,516, but <=$6,010)
  (Two person family unit >$2,057, but <=$6,732)
- ( ) **High**
  (Single person family unit > $6,010)
  (Two person unit > $6,732)
- ( ) **Consumer declined to provide**

MEDICARE:

- Are you receiving Medicare benefits? **Yes ( ) No ( ) (If no, stop here.)**
- Are you aware that Medicare provides for preventive care, like annual wellness visits? **Yes ( ) No ( )**
- Are your resources at or below:
  - $14,100 year (one person) **Yes ( ) No ( )**
  - $28,150 year (couple) **Yes ( ) No ( )**
- Are you receiving or applying for Social Security Disability or Medicare Disability? (Cannot answer yes if age is =>65) **Yes ( ) No ( )**
- Do you have any questions about Medicare? **Yes ( ) No ( )**
  (If yes, please contact a Benefits Counselor at 1-800-272-3921)

If caregiver is a 55+ grandparent or relative of a child 18 years of age or younger who:

- **lives with the child;**
- **is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child; and has a legal relationship to the child, such as legal custody or guardianship, or is raising the child informally, complete the following:**

Name	Client ID Number	Birth Date	Gender	Relationship

SERVICES REQUESTED:	**REFERRAL SOURCE:**
( ) Home-Delivered Meals/Ensure ( ) Transportation ( ) Homemaker ( ) Benefits Counseling ( ) ERS ( ) Other ( ) Residential Repair ( ) Equipment ( ) Utility Assistance ( ) Medication Assistance	Name: Phone number: Relationship to Caregiver/Recipient:
DIAGNOSIS:	
WAS A REFERRAL MADE TO HHS? Yes ( ) No ( ) **COMMENTS:**	
INITIAL SCREENING BY:	

Print name of AAA/Provider Staff Completing Intake **Date**