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

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

PRIMARY LANGUAGE:
- ( ) English
- ( ) Other _____

RACE (Check all that apply):
- **( ) 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**

DOES CLIENT LIVE ALONE? ( ) Y ( ) N

Total Number of Family Members in Household Including Client: _____

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**

CARE COORDINATION PROGRAM INTAKE/REFERRAL FORM

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)**

EMERGENCY CONTACT INFORMATION:

Name: Phone/s: (____) _____

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

Services Requested:

( ) Home-Delivered Meals/Ensure
( ) Homemaker
( ) ERS
( ) Residential Repair
( ) Equipment
( ) Utility Assistance
( ) Medication Assistance
( ) Benefits Counseling
( ) Transportation
( ) Other:

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:

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. ☐

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