

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 – Recipient Identification

*Date:		SPURS ID No.:		Primary Language:	
*Last Name:		*First Name:		*MI:	*Date of Birth:
					*Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
*Street Address and Apt. No.:		*City:		*State:	*ZIP Code:
					*County:
*Area Code and Phone No.:					Email Address:
<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Other					
<input type="checkbox"/> Check if Mailing Address is different from Home Address and enter Mailing Address below:					
*Street Address and Apt. No. or P.O. Box:		*City:		*State:	*ZIP Code:
					*County:
*Ethnicity (Check One):		*Race (Check all that apply):		Marital Status (Check One):	
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White -- Non-Hispanic <input type="checkbox"/> White – Hispanic		<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	
*Person lives alone?		Total No. of People in Household:		Monthly Household Income:	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know					
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"/> Don't Know	
Monthly Income from:		Participant		Spouse	
Job					
Social Security					
Supplemental Security Income					
Veterans Affairs					
Other Sources					
Other Benefits [e.g., Supplemental Nutritional Assistance Program(SNAP)]					

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

Are you enrolled in? ☐ Medicaid ☐ Medicare

Part III – Emergency Contact Information *(Completed by AAA or provider staff)*

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

Part IV – Referral *(Completed by AAA or provider staff)*

Referred by:

*Name of AAA or Provider Staff Completing Intake:

*Date:

Part V – Nutrition Services *(Completed by AAA or provider staff)*

*Additional Eligibility Requirements if eligible person is under 60. Check which of the following applies:

- ☐ Eligible person is under 60 and the spouse of person 60 or older who takes part in the nutrition program.
- ☐ Eligible person is under 60, serves as volunteer at the nutrition site and the provider offers a meal according to AAA procedures.
- ☐ Eligible person is under 60, has a disability and lives in a housing facility occupied primarily by people 60 and over where congregate meals are served.
- ☐ Eligible person is under 60, has a disability, lives with a person eligible for a meal and the provider offers a meal according to AAA procedures.

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