

Caregiver 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 – Caregiver Identification

*Date:	SPURS ID No.:		Primary Language: Choose an item.	
*Last Name:	*First Name:	*MI:	*Date of Birth:	*Gender: Choose an item.
*Street Address and Apt. No. or P.O. Box:	*City:	*State:	*ZIP Code:	*County:
*Area Code and Phone No.: Choose an item.	Email Address:			
<input type="checkbox"/> Check if Mailing Address is different from Home Address and enter Mailing Address below:				
*Street Address and Apt. No.:	*City:	*State:	*ZIP Code:	*County:
*Ethnicity (Check One): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	*Race (Check all that apply): <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"/> Non-Minority (White, Non-Hispanic) <input type="checkbox"/> White – Hispanic		*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	
*Person lives alone? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	Total No. of People in Household:		Monthly Household Income:	
Use current Department of Health and Human Services Federal Poverty Guidelines for size of household to decide if person is at or below poverty. 2021 limits: \$1,073 individual; \$1,451 couple			*At or below poverty? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	

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
- Medication Management
- Nutritional Supplements
- Personal Care
- Prescription Assistance
- Residential Repair
- Respite
- Transportation
- Utility Assistance
- Other

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.
Choose an item.

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.
Choose an item.
Does the caregiver live with the care recipient? Yes No

C. Relationship to care recipient(s) with disability who is 18 or more, but not older than 59.
Caregiver must be 55 or older, live with the care recipient and meet the relationship requirement.
Choose an item.
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? [Click or tap here to enter text.](#)

*If the care recipient is 60 or older, please complete the following:

*Date:	SPURS ID No.:	Primary Language: Choose an item.		
*Last Name:	*First Name:	*MI:	*Date of Birth:	*Gender: Choose an item.
*Street Address and Apt. No. or P.O. Box:	*City:	*State:	*ZIP Code:	*County:
*Area Code and Phone No.: Choose an item.	Email Address:			
*Ethnicity (Check One): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	*Race (Check all that apply): <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"/> Non-Minority (White, Non-Hispanic) <input type="checkbox"/> White – Hispanic		*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 18 or more but not older than 59, complete the following:

Name	Date of Birth	Gender	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