

**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.

<b>Part I – Caregiver Identification</b>	
*Date:	SPURS ID No.: Primary Language:
*Last Name:	*First Name: *MI: *Date of Birth: *Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Unknown
*Street Address and Apt. No. or P.O. Box:	*City: *State: *ZIP Code: *County:
*Area Code and Phone No.: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Other	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. <b>2024 limits: \$1,255 individual; \$1,703 couple</b>	
*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
- 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.

Husband                                       Wife                                       Son or Son-in-Law  
 Daughter or Daughter-in-Law               Other Relative                       Non-Relative  
 Domestic Partner including Civil Union     Sister                                       Brother

**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.

Grandparents                                       Other Relative  
 Does the caregiver live with the care recipient?     Yes     No

**C. Relationship to care recipient(s) with disability who is 19 or more, but not older than 59.**  
 Caregiver must be 55 or older, live with the care recipient and meet the relationship requirement.

Parents                                       Grandparents                                       Other Relative                                       Non-Relative  
 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?

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

*Date:	SPURS ID No.:	Primary Language:		
*Last Name:	*First Name:	*MI:	*Date of Birth:	*Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Unknown
*Street Address and Apt. No. or P.O. Box:	*City:	*State:	*ZIP Code:	*County:
*Area Code and Phone No.: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Other			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

