Intake

**Form 2276**

Rev. Sept. 2024

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.

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| **Part I – Recipient Identification** | | | | | | | | | | |
| **\***Date: | | SPURS ID No.: | | | | Primary Language: | | | | |
| **\***Last Name: | **\***First Name: | | | **\***MI: | | \*Date of Birth: | | | | **\***Gender:  Female  Male  Other  Unknown |
| **\***Street Address and Apt. No.: | | **\***City: | | | **\***State: | | \*ZIP Code: | | | **\***County: |
| **\***Area Code and Phone No.:  Cell  Home  Other | | | | | | | | Email Address: | | |
| 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)***:**  Hispanic or Latino  Not Hispanic or Latino  Unknown | | **\*Race** *(Check all that apply)***:**  American Indian or Alaska Native  Asian  Black or African American  Native Hawaiian or Pacific Islander  Non-Minority (White, Non-Hispanic)  White – Hispanic | | | | | | **Marital Status** *(Check One)***:**  Married  Widowed  Divorced  Separated  Never Married  Not Reported | | |
| **\***Person lives alone?  Yes  No  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.  **2024 limits: $1,255 individual; $1,703 couple** | | | | | | | | **\***At or below poverty?  Yes  No  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)] | | |  | | | | | |  | |

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| **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 |

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| **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.: |

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| **Part IV – Referral** *(Completed by AAA or provider staff)* | |
| Referred by: | |
| **\***Name of AAA or Provider Staff Completing Intake: | **\***Date: |

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| **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. |

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