#

# AREA AGENCY ON AGING OF NORTH CENTRAL TEXAS

# CARE COORDINATION INTAKE/REFERRAL FORM

(Items in **BOLD** must be completed)

**Client Rights & Responsibilities and Release of Information have been clearly explained to the client. ( )**

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| --- | --- |
| **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** | **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** |
| **PRIMARY LANGUAGE:** ( ) English ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **DOES CLIENT LIVE ALONE?** **( ) Y ( ) N****Total Number of Family Members in Household Including Client: \_\_\_\_\_\_\_\_** | **IS CLIENT RECEIVING MEDICAID? ( ) Y ( ) N** |
| **MARITAL STATUS:**( ) Married ( ) Widowed  ( ) Divorced ( ) Separated ( ) Never Married ( ) Not Reported  | **TOTAL MONTHLY HOUSEHOLD INCOME (2021):**   ( ) **Poverty**(Single person family unit < =$1,073/mo) (Two person family unit <=$1,452/mo) ( ) **Low (150% FPL)** (Single person family unit <=$1,610/mo) (Two person family unit <= $2,178/mo) ( ) **Moderate**  (Single person family unit >$1,610, but <=$3,945/mo) (Two person family unit >$2,178, but <=$4,818/mo) ( ) **High** (Single person family unit > $3,945/mo) (Two person unit > $4,818/mo) ( ) **Consumer declined to provide** |
| **EMERGENCY CONTACT INFORMATION:**Name: Phone/s: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to client: Primary Caregiver: ( ) Y ( ) N |
| **SERVICES REQUESTED:** ( ) Emergency Response System  ( ) Health Maintenance Supplies/Nutritional Supplements ( ) Home-Delivered Meals ( ) Homemaker (Housekeeping) ( ) Medication Management ( ) Personal Care  ( ) Prescription Assistance ( ) Residential Repair  ( ) Utility Assistance ( ) Benefits Counseling  ( ) Transportation ( ) Other:***If client requests in-home services other than home-delivered meals, fax form to 940-222-4741.***  | **REFERRAL SOURCE:***Name:**Phone number: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship to Caregiver/Recipient:*  |
| **DIAGNOSIS/HEALTH STATUS:** |
| **WAS A REFERRAL MADE TO HHS? Yes ( ) No ( )****COMMENTS:** |
| **To****ToTo be completed by AAA/provider staff:****PrPrint name of AAA/provider staff completing Intake: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **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.
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