TEXAS Health and Human Services

Form 2276
Rev. Jan. 2025

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 useand 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: ☐ Male ☐ Female
*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 ☐ 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. **2025 limits: $1,304 individual; $1,763 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)]		

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