Los Angeles County Area Agency on Aging

Agency Name: Santa Clarita Valley Committee on Aging Client Name: _____ Date: 7/1/18-6/30/19

UNIVERSAL INTAKE FORM

Funding Identifier:

Title IIIB ☐ **Title C1** ☐ **Title C2** ☐ **Title IIIE** ☐ **Title IIIE(G)** ☐ **Linkages** ☐

IDENTIFICATION

1a

Applicant Last Name	First Name	Middle Initial	GetCare ID #

Date of Birth (D.O.B.)	Age	Social Security # (*Optional*)	
Home Address *(Number/Street)*	City	State	Zip Code
Mailing Address *(If different than home address)*	City	State	Zip Code
Home Phone	Work Phone	Cell Phone	
Email Address			

DEMOGRAPHICS

1b

Rural Designation
☐ Rural ☐ Urban ☐ Declined to State

Unincorporated City
☐ Yes ☐ No ☐ Declined to State

Sex at birth
☐ Male ☐ Female ☐ Declined to State

Gender
☐ Male ☐ Female ☐ Transgender Female to Male
☐ Transgender Male to Female ☐ Genderqueer/ Gender
☐ Non-binary ☐ Not Listed ☐ Declined to State

Sexual Orientation
☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same Gender-Loving ☐ Questioning/Unsure
☐ Not Listed ☐ Declined to State

Veteran ☐ Yes ☐ No ☐ Declined to State

Spouse of Veteran ☐ Yes ☐ No ☐ Declined to State

Race
☐ White ☐ American Indian or Alaska Native ☐ Hispanic/Latino ☐ Black or African American
☐ Chinese ☐ Japanese ☐ Filipino ☐ Korean ☐ Vietnamese ☐ Asian Indian ☐ Laotian ☐ Cambodian
☐ Other Asian ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race
☐ Multiple Race ☐ Declined to State

Relationship Status
☐ Single (Never Married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed
☐ Declined to State

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1b Cont.

Type of Residence

☐ House ☐ Apartment ☐ Hotel ☐ Mobile Home

☐ Nursing Home ☐ Residential Care Home

☐ Room and Board ☐ Homeless ☐ Other ☐ Declined to State

Does the individual

☐ Rent ☐ Own ☐ Other

☐ Declined to State

Employment Status

☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Declined to State

Living Arrangement

☐ Lives alone without help ☐ Lives with others without help

☐ Lives alone with help 4 hrs/day or less

☐ Lives with others with help ☐ Declined to State

Federal Poverty Guideline (FPG)

Is your income ☐ At or below 100% FPG

☐ Above 100% FPG

☐ Declined to State

Primary Language

☐ American Sign Language ☐ Arabic ☐ Armenian ☐ Cambodian ☐ Cantonese ☐ Chinese ☐ English

☐ Farsi ☐ French ☐ Korean ☐ Laotian ☐ Mandarin ☐ Japanese ☐ Russian ☐ Spanish ☐ Tagalog

☐ Thai ☐ Vietnamese ☐ Other ☐ Declined to State

Translation needed ☐ Yes ☐ No ☐ Declined to State

EMERGENCY CONTACTS

2	Contact Last Name	First Name		Middle Initial
Address *(Number/Street)*		City	State	Zip Code
Home Phone	Work Phone	Cell Phone	Relationship	
Contact Name (*Last, First, Middle Initial*) – *Optional*				
Address *(Number/Street)*		City	State	Zip Code
Home Phone	Work Phone	Cell Phone	Relationship	
Primary Physician			Office Phone	
Physician's Address		City	State	Zip Code

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BENEFITS

3	Are you currently receiving Social Security Benefits? ☐ Yes ☐ No ☐ Declined to State	Do you currently receive Supplemental Security Income (SSI) Benefits? ☐ Yes ☐ No ☐ Declined to State

Do you participate in CalFresh (Food Stamps, SNAP, EBT)?

☐ Yes ☐ No ☐ Declined to State

Do you have Health Insurance? ☐ Yes ☐ No ☐ Declined to State	Health Insurer's Name	Policy Number: *(Optional)*
Do you receive Medi-Cal? ☐ Yes ☐ No ☐ Declined to State	Medi-Cal # *(Optional)* Issue date:	Do you receive Medicare? ☐ Yes ☐ No ☐ Declined to State

Do you receive In-Home Supportive Services *(IHSS)?* ☐ Yes ☐ No ☐ Declined to State

Do you receive any additional benefits? (i.e., Veterans Benefits, CAPI, etc.)

REFERRAL INFORMATION

4 Referral Source

Last Name	First Name	Phone	
Address	City	State	Zip Code

Presenting Problems/Services Requested/Comments/Follow-up:

NUTRITIONAL RISK FACTORS

5 **NUTRITIONAL RISK FACTORS**

(Add the numbers from each checked box to determine Nutrition Risk Score)

I have an illness or condition that made me change the kind and/or amount of food I eat.	2 ☐ Yes	☐ No	☐ Declined to State
I eat fewer than 2 meals per day.	3 ☐ Yes	☐ No	☐ Declined to State
I eat few fruits or vegetables or milk products.	2 ☐ Yes	☐ No	☐ Declined to State
I have 3 or more drinks of beer, liquor or wine almost every day.	2 ☐ Yes	☐ No	☐ Declined to State
I have tooth or mouth problems that make it hard for me to eat.	2 ☐ Yes	☐ No	☐ Declined to State
I don't always have enough money to buy the food I need.	4 ☐ Yes	☐ No	☐ Declined to State
I eat alone most of the time.	1 ☐ Yes	☐ No	☐ Declined to State
I take 3 or more different prescribed or over-the-counter drugs a day.	1 ☐ Yes	☐ No	☐ Declined to State
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2 ☐ Yes	☐ No	☐ Declined to State
I am not always physically able to shop, cook and/or feed myself.	2 ☐ Yes	☐ No	☐ Declined to State
Total Nutritional Risk Score		(If total is 6 or more, participant is at **High** Nutritional Risk)	

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ADL/IADL RISK FACTORS & DISABILITY FACTORS

6 ACTIVITIES OF DAILY LIVING (ADL)/INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) RISK FACTORS & DISABILITY FACTORS *(Excluding Title IIIE Caregiver Program)*

Activities of Daily Living *(ADL)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Eating	☐	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐	☐
Transferring	☐	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐

Instrumental Activities of Daily Living *(IADL)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Meal Preparation	☐	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐	☐
Med. Mgmt.	☐	☐	☐	☐	☐	☐
Money Mgmt.	☐	☐	☐	☐	☐	☐
Using Phone	☐	☐	☐	☐	☐	☐
Hvy. Housework	☐	☐	☐	☐	☐	☐
Lt. Housework	☐	☐	☐	☐	☐	☐
Transportation	☐	☐	☐	☐	☐	☐

Disability Factors

☐ Visually Impaired ☐ Hearing Impaired ☐ Speech Impaired

☐ Physically Impaired ☐ Walking Aid ☐ Wheelchair

☐ Bedbound ☐ Memory Impaired ☐ Depression

☐ Cognitively Impaired ☐ None ☐ Declined to State

Recent Hospital Discharge ☐ Yes ☐ No

☐ Declined to State

Date of Discharge

Date To Stop Service

Hospital

Diabetic

☐ Yes ☐ No

☐ Declined to State

Have you been diagnosed with Alzheimer's or a related neurological disorder?

☐ Yes ☐ No ☐ Declined to State

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TITLE IIIE CARE RECEIVER DEMOGRAPHICS

7 TITLE IIIE CARE RECEIVER DEMOGRAPHICS

Please make additional copies of Section 7 & 8 if more than one Care Receiver

Caregiver Relationship: ☐ Spouse ☐ Domestic Partner ☐ Sibling ☐ Son/Son-in-Law ☐ Daughter/Daughter-in-Law ☐ Grandparent ☐ Other Relative ☐ Non-Relative ☐ Other ☐ Declined to State

Care Receiver Last Name	First Name	Middle Initial	Care Receiver GetCare ID #

Address (Number & Street)	City	State	Zip Code

Rural Designation
☐ Rural ☐ Urban ☐ Declined to State

Unincorporated City
☐ Yes ☐ No ☐ Declined to State

Home Phone	Work Phone	Cell Phone	Emergency Contact Phone

Date of Birth (D.O.B.) | Age | Gender ☐ Male ☐ Female ☐ Declined to State

Social Security # (Optional) | Email Address

Veteran
☐ Yes ☐ No ☐ Declined to State

Spouse of Veteran
☐ Yes ☐ No ☐ Declined to State

Race
☐ White ☐ American Indian or Alaska Native ☐ Hispanic/Latino ☐ Black or African American
☐ Chinese ☐ Japanese ☐ Filipino ☐ Korean ☐ Vietnamese ☐ Asian Indian ☐ Laotian ☐ Cambodian
☐ Other Asian ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race
☐ Multiple Race ☐ Declined to State

Relationship Status
☐ Single *(Never Married)* ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed
☐ Declined to State

Type of Residence
☐ House ☐ Apartment ☐ Hotel ☐ Room and Board
☐ Nursing Home ☐ Residential Care Home ☐ Mobil Home
☐ Homeless ☐ Other ☐ Declined to State

Does the individual
☐ Rent ☐ Own
☐ Other
☐ Declined to State

Living Arrangement
☐ Alone
☐ Not Alone
☐ Declined to State

Receive In-Home Supportive Services *(IHSS)?*
☐ Yes ☐ No
☐ Declined to State

Federal Poverty Guideline (FPG)
Is your Care Receiver income
☐ At or below 100% FPG
☐ Above 100% FPG ☐ Declined to State

Have Health Insurance?	Receive Medicare?	Receive Social Security?	Receive Medi-Cal?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Declined to State	☐ Declined to State	☐ Declined to State	☐ Declined to State

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TITLE IIIE CARE RECEIVER ADL/IADL RISK FACTORS & DISABILITY FACTORS

8 TITLE IIIE CARE RECEIVER ACTIVITIES OF DAILY LIVING (ADL)/ INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) RISK FACTORS & DISABILITY FACTORS

Activities of Daily Living *(ADL) (Grandchildren exempt)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Eating	☐	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐	☐
Transferring	☐	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐

Instrumental Activities of Daily Living *(IADL) (Grandchildren exempt)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Meal Preparation	☐	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐	☐
Med. Mgmt.	☐	☐	☐	☐	☐	☐
Money Mgmt.	☐	☐	☐	☐	☐	☐
Using Phone	☐	☐	☐	☐	☐	☐
Hvy. Housework	☐	☐	☐	☐	☐	☐
Lt. Housework	☐	☐	☐	☐	☐	☐
Transportation	☐	☐	☐	☐	☐	☐

Disability Factors

☐ Visually Impaired ☐ Hearing Impaired ☐ Speech Impaired ☐ Physically Impaired ☐ Walking Aid

☐ Wheelchair ☐ Bedbound ☐ Memory Impaired ☐ Depression ☐ Cognitively Impaired ☐ None

☐ Declined to State

Diabetic

☐Yes ☐ No

☐ Declined to State

Has Care Receiver been diagnosed with Alzheimer's or a related neurological disorder?

☐Yes ☐No ☐ Declined to State

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CERTIFICATION

9

CERTIFICATION

(To be completed by Interviewer and signed by Client)

I certify that the information on this form, provided to me by the client, is accurate and true to the best of my abilities. I also certify that I have informed the Client that this information may be shared with other providers for the purpose of providing services. Client signature establishes agreement to services.

Completed by (Print Name)	*Phone*
Signature	*Date*
Client Name (Print)	
Client Signature	*Date*

DISENROLLMENT

10 **REASON FOR DISENROLLMENT** *Date of disenrollment:*

☐ Deceased ☐ Moved Out of Service Area ☐ No Longer Desires Services ☐ No Longer SNF Certifiable

☐ No Longer Medi-Cal Eligible ☐ Institutionalization ☐ High Cost of Services ☐ Won't Follow Care Plan

☐ On Hold ☐ Service No Longer Needed ☐ Past Active ☐ On Waiting List ☐ Other Reason

NOTES:

Thank you for completing the Universal Intake Form (UIF). As the aging population grows and funding remains limited, it is vital to capture this critical information to reinforce and substantiate the increased demand for older adult services. This information will assist the Los Angeles County Area Agency on Aging (AAA) in identifying unmet needs, effectively developing plans, and better coordinate services to meet your needs.

EMERGENCY INFORMATION

CLIENT

Last Name: _____ First Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Birthdate: _____ Age: _____
Home Telephone: _____ Cell Phone: _____
Email: _____

EMERGENCY CONTACT

1) Name: _____ Relationship to client: _____
Home Phone: _____ Cell Phone: _____
Email: _____
2) Name: _____ Relationship to client: _____
Home Phone: _____ Cell Phone: _____
Email: _____

Have you been hospitalized recently? _____ When? _____
If so, what for? _____
Do you suffer from: ☐ Heart Problems ☐ Asthma ☐ High Blood Pressure ☐ Seizures
☐ Diabetes ☐ Other: Please Specify: _____

_____
Any known medication, food or other allergies? _____
Please Specify: _____

_____

CURRENT MEDICATION TAKEN

1. _____ Dosage _____
2. _____ Dosage _____
3. _____ Dosage _____
4. _____ Dosage _____
5. _____ Dosage _____
6. _____ Dosage _____
7. _____ Dosage _____
8. _____ Dosage _____
9. _____ Dosage _____
10. _____ Dosage _____

Any other important emergency information: _____

_____

I authorize SCV Senior Center to release any information to medical personnel in the event of an emergency.
Signature: _____ Date: _____