# 

# 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. | |