# AREA AGENCY ON AGING OF NORTH CENTRAL TEXAS

# CAREGIVER SUPPORT PROGRAM INTAKE/REFERRAL FORM

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

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

|  |  |
| --- | --- |
| **DATE:** | **CONSUMER ID NUMBER: (For internal use only)** |
| **CAREGIVER INFORMATION****Eligible caregivers must be:*** Adult family members or other informal caregivers age 18 and older providing care to individuals 60 years of age and older
* Adult family members or other informal caregivers age 18 and older providing care to individuals of any age with Alzheimer’s disease and related disorders
* Older relatives (not parents) age 55 and older providing care to children under the age of 18; and
* Older relatives, including parents, age 55 and older providing care to adults ages 18-59 with severe disabilities, defined as “mental or physical impairment, or a combination of mental and physical impairments that are likely to continue indefinitely and result in substantial functional limitation in three or more major life activities,” including:
	+ self-care;
	+ receptive and expressive language;
	+ learning; mobility;
	+ self-direction;
	+ capacity for independent living;
	+ economic self-sufficiency;
	+ cognitive functioning; and
	+ emotional adjustment.

**Circle at least three functional limitations that apply.** |
| **NAME:** (Last, MI, First) |
| **STREET ADDRESS/Apt. #:** (Number, City, State & ZIP) **COUNTY:****MAILING ADDRESS** (If different):  |
| **PHONE:** (Please indicate if cell, work or home) |
| **GENDER:** ( ) M ( ) F  | **DOB:** |
| **ETHNICITY:**  **( ) Hispanic or Latino ( ) Not Hispanic or Latino** **( ) Ethnicity Not Reported** **( ) Consumer declined to provide** | **TOTAL MONTHLY HOUSEHOLD INCOME (2020):**   ( ) **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** |
| **RACE:**  **( ) 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** |
| **CONSUMER’S (CAREGIVER) PRIMARY LANGUAGE:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **MARITAL STATUS:** ( ) Married ( ) Widowed  ( ) Divorced ( ) Separated( ) Never Married ( ) Not Reported |
| **CAREGIVER INFORMATION (cont.)** |
| **RELATIONSHIP TO CARE RECIPIENT**:**( ) Husband ( ) Niece** **( ) Wife ( ) Nephew****( ) Son/Son-in-Law ( ) Non-Relative****( ) Daughter/Daughter-in-Law ( ) Other Relative****( ) Relationship Missing** | **Relationship to care recipient(s) if 18 years of age or less (Caregiver must be 55+ years of age and fall under OAA, Section 372 as defined):** **( ) Grandparents** **( ) Other Elderly Relative** **( ) Other Elderly Non-Relative** |
| **DOES CAREGIVER LIVE ALONE? ( ) Y ( ) N****DOES CAREGIVER LIVE WITH THE CARE RECIPIENT? ( ) Y ( ) N**If no, how often does the Caregiver have contact with the Care Recipient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **EMERGENCY CONTACT INFORMATION (FOR CAREGIVER):**Contact Name: Relationship:Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| **CARE RECIPIENT INFORMATION** |
| **NAME:** (Last, MI, First)   | **CONSUMER ID NUMBER: (For internal use only)** |
| **STREET ADDRESS/Apt. #:** (Number, City, State & ZIP) **COUNTY:****MAILING ADDRESS** (If different):  |
| **PHONE:** (Please indicate if cell, work or home) |
| **GENDER:** ( ) M ( ) F   | **DOB:** |
| **ETHNICITY:**  **( ) Hispanic or Latino ( ) Not Hispanic or Latino** **( ) Ethnicity Not Reported** **( ) Consumer declined to provide** | **RACE:** **( ) 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**  |
| **LANGUAGE SPOKEN AT HOME:** Does the Care Recipient require an interpreter? ( ) Y ( ) NIf yes, who helps in the interpretation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **DOES CARE RECIPIENT LIVE ALONE?** **( ) Y ( ) N** | **IS CARE RECIPIENT RECEIVING MEDICAID?**  **( ) Y ( ) N** |
| **MARITAL STATUS:** ( ) Married ( ) Widowed ( ) Divorced ( ) Separated ( ) Never Married ( ) Not Reported | **TOTAL MONTHLY HOUSEHOLD INCOME (2020):**  ( ) **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** |
| **If caregiver is a 55+ grandparent or relative of a child 18 years of age or younger who:*** **lives with the child;**
* **is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child; and**
* **has a legal relationship to the child, such as legal custody or guardianship, or is raising the child informally;**

**Complete the following:**Number of children 18 years of age or younger for whom the individual is providing care: \_\_\_\_\_\_\_\_\_\_\_\_List identification number(s), name(s), birth date(s), gender(s) and relationship(s) of children 18 years of age or younger: |
| **Consumer ID Number** | **Name** | **Birth Date** | Gender | Relationship |
|  | 1. |  |  |  |
|  | 2. |  |  |  |
|  | 3. |  |  |  |
|  | 4. |  |  |  |
| **SERVICES REQUESTED:** ( ) Emergency Response System ( ) Benefits Counseling  ( ) Health Maintenance Supplies/ ( ) Caregiver Education Nutritional Supplements ( ) Transportation ( ) Home-Delivered Meals ( ) Other: ( ) Homemaker (Housekeeping) ( ) Medication Management  ( ) Prescription Assistance  ( ) Respite ( ) Residential Repair  ( ) Utility Assistance  | **REFERRAL SOURCE:**Name:Phone number:Relationship to Caregiver/Recipient:  |
| **DIAGNOSIS:**  |
| **WAS A REFERRAL MADE TO HHS? Yes ( ) No ( )****COMMENTS:** |
| **INITIAL SCREENING BY:** |

**Print name of AAA/Provider Staff Completing Intake Date**