# 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 ( ) N  If 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**