



Funding provided by the  
Texas Health & Human Services



GOLDEN CRESCENT AREA AGENCY ON AGING  
1908 N. LAURENT, SUITE 600 VICTORIA, TEXAS 77901  
361-578-1587, EX 215, 1-800-252-9240,  
FAX 361-578-8865

**CLIENT INTAKE AND SERVICE REQUEST FORM**

**FORMA DE ADMISIÓN Y SOLICITUD DE SERVICIOS PARA CLIENTES**

*The information on this form is required by your local service provider, the Area Agency on Aging (AAA), and the Texas Health & Human Services. All information provided will be kept confidential and guarded against unofficial use. Information gathered through an intake or through an assessment may be shared to effectively plan, arrange and deliver services to meet individual client needs.*

*Esta solicitud contiene información que exigen el proveedor de servicios locales, la Agencia del Área para Adultos Mayores (AAA) y el Departamento de Servicios para Adultos Mayores y Personas Discapacitadas de Texas. Toda la información se mantendrá confidencial y protegida contra el uso no oficial. La información obtenida mediante el proceso de admisión o una valoración se puede divulgar para planear, organizar y prestar los servicios eficazmente para satisfacer las necesidades individuales del cliente.*

**CLIENT INTAKE AND SERVICE REQUEST FORM**  
(Items in **BOLD** must be completed)

Client Rights & Responsibilities and Release of Information have been clearly explained to the client.

Date: \_\_\_\_\_ Client ID Number (office use only) \_\_\_\_\_

Last Name: \_\_\_\_\_ MI: \_\_\_\_\_ First Name: \_\_\_\_\_

Gender: Male  Female  Birth Date: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Home Address: Street/Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Check if Mailing Address is Home Address

Mailing Address: Street/Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Home  Cell  Other  (Check One)

**Ethnicity (Check One):**

- (1) Hispanic or Latino
- (2) Not Hispanic or Latino
- (3) Ethnicity Not Reported

**Race (Check all that apply):**

- (1) White -- Non Hispanic
- (2) White -- Hispanic
- (3) American Indian/Alaska Native
- (4) Asian
- (5) Black or African American
- (6) Native Hawaiian or Pacific Islander
- (7) Persons Reporting Some Other Race
- (8) Race Not Reported

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Does client live alone? Yes  No

Client living in poverty (Low Income)? Yes  No

Service(s) Requested: \_\_\_\_\_

Are you enrolled in?  Medicare  Medicaid  Extra Help for Medicare Prescription Drug Plan

QMB & SLMB Would You Like More Information About these Programs? \_\_\_\_\_

To be completed by AAA/provider staff:

Print 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.                                      | <input type="checkbox"/> |
| (2) Serves as volunteer at the nutrition site in accordance with OAA standards.  | <input type="checkbox"/> |
| (3) Disabled/resides in the housing facility and wants to participate in the congregate meal program provided at the site. | <input type="checkbox"/> |
| (4) Disabled and lives with a 60+ person who is eligible for congregate or home delivered meal program.                    | <input type="checkbox"/> |

Optional-Referred By \_\_\_\_\_

Referral Contact Information: \_\_\_\_\_ Phone \_\_\_\_\_ email \_\_\_\_\_

Additional Notes Regarding Referral:



**Area Agency on Aging of Golden Crescent  
Client Rights & Responsibilities for Older Americans Act  
Programs**

The Area Agency on Aging of Golden Crescent welcomes you as a participant in programs for older individuals and family caregivers in our region. This program is mandated by the Older Americans Act of 1965, as amended, and provides access and assistance and other supportive services. The programs and services are administered by the Area Agency on Aging with funding provided through the Texas Department of Aging and Disability Services, client contributions and local funding.

Programs and services are designed for individuals age 60 or older and/or their family members and other caregivers. Our goal is to assist older individuals in leading independent, meaningful and dignified lives in their own homes and communities as long as possible through the provision of limited support services. Information will not be released to anyone, or any agency without your informed consent, with the exception of records subpoenaed by a court of law.

**Client rights and responsibilities:**

1. You have the right to be treated with respect and consideration. You have the right to have your property treated with respect.
2. You may not be denied services on the basis of race, religion, color, national origin, sex, disability, marital status, or inability and/or unwillingness to contribute.
3. You have the right to make a complaint/grievance or recommend changes to policy or service, without restraint, interference, coercion, discrimination or reprisal. To make a complaint or grievance contact the Area Agency on Aging. Contact information is identified below:

<b>Service Provider Information:</b>	<b>Area Agency on Aging Information</b>
Calhoun County Senior Citizens Association Inc.  Rebecca Jernigan, Executive Director  Lilly Munoz, Nutrition Manager  2104 W. Austin Street, P.O. Box 128 Port Lavaca, TX 77979  (361) 552-3350, rebecca@tisd.net	Cindy Cornish, AAA Director Golden Crescent AAA 1908 N. Laurent, Suite 600 Victoria, TX 77901 361-578-1587, ex 223 1-800-252-9240 <a href="mailto:cindyco@gerpc.org">cindyco@gerpc.org</a>  Michael Ada, GCRPC Executive Director Golden Crescent Regional Planning Commission 1908 N. Laurent, Suite 600 Victoria, TX 77901 361-578-1587, ex 204 <a href="mailto:michaela@gerpc.org">michaela@gerpc.org</a>

4. You have the right to participate in the development of a care plan to address unmet needs.  N/A
5. You have the right to be informed in writing of available services and the applicable charges if the services are not covered or are unavailable by Medicare, Medicaid, health insurance, or Older Americans Act funding.  N/A
6. You have the right to make an independent choice of service providers from the list furnished by the Area Agency on Aging where multiple service providers are available and change service providers when desired.  N/A
7. You have the right to be informed of any change in service(s).  N/A
8. You have the right to make a voluntary, confidential, contribution for services received through the Area Agency on Aging. Services will not be denied if an eligible participant is unable or chooses not to make a contribution. All contributions will be kept confidential and will be utilized to expand or enhance the service(s) for which they were provided.
9. You have the responsibility to inform the Area Agency on Aging or its service provider(s) of your intent to withdraw from the program or any known periods of absenteeism when services will not be utilized.  N/A
10. You have the responsibility to provide the Area Agency on Aging or its services provider(s) with complete and accurate information.

I hold harmless this Area Agency on Aging program, its parent organization, funders, and the sponsoring state agencies for any liability arising out of the services provided in accordance with program guidelines.

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Client Signature

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Date



## Area Agency on Aging of Client Information Release

<b>Client Name:</b>	<b>Client ID:</b>
By signing this authorization, you are giving the Area Agency on Aging (AAA) _____ permission to release all or part of your information provided, which includes health information. Failure to provide this authorization will result in limited service by the AAA. This release includes access to a continuum of service(s) available through the AAA or its providers.	

**PARTS A, B & C TO BE COMPLETED BY CLIENT OR PERSONAL REPRESENTATIVE**

I authorize the Area Agency on Aging to release my information to the following person or agency for the purpose(s) stated in Part A. My information will remain available to the person or agency indicated in accordance with the expiration event or date in Part B.

<b>PART A – Release of Information</b>
I understand that my information may contain protected health information. Release my information to the following person or agency: <input type="checkbox"/> Any person or agency necessary to meet my service needs.
<input type="checkbox"/> Only the persons or entities identified:
Check one of the following: <input type="checkbox"/> Release all of my information. <input type="checkbox"/> Release only the following information:

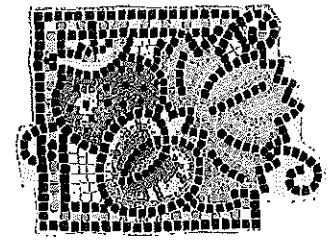
<b>PART B – Purpose of Release</b>
<input type="checkbox"/> General: To assist in assessing, arranging, and meeting individual service needs.
<input type="checkbox"/> Specific:
<input type="checkbox"/> Expiration: This authorization expires at point of reassessment, where applicable, or within three years of effective date.

<b>PART C – Signature</b>	
(Client or Personal Representative)	(Date)
<input type="checkbox"/> Check if you are signing for the client and please describe your authority to act for the client on the following line:	
Note: If the person requesting the release of information cannot sign his/her name, two witnesses to his/her mark (X) must sign below. Accept one witness signature in circumstances where it is not possible to obtain two witness signatures. Document the reason in the client file.	
Witness:	Date:
Witness:	Date:

**Notice to Client:**

- ✓ Once the authorization to release your information is granted, the AAA is not responsible for any redisclosure of the information by the recipient.
- ✓ You can withdraw permission you have given the AAA to use or disclose health information that identifies you, unless the AAA has already taken action based on your permission. You must withdraw your permission in writing.

Provider/Center: CALHOUN COUNTY SCA \_\_\_\_\_  
 Client Name: \_\_\_\_\_  
 Client ID: \_\_\_\_\_  
 Date: \_\_\_\_\_



*The Warning Signs of poor nutritional health are often overlooked. Use this checklist to find out if you are at nutritional risk.*

## DETERMINE YOUR NUTRITIONAL HEALTH

Read the statements below. Circle the number in the yes column for those that apply to you. Add the circled numbers to get your total nutritional risk score. Reassessment Required Annually.

<ul style="list-style-type: none"> <li>Consumer signature means they received Nutrition Education, developed &amp; approved by the AAA Registered dietitian, in accordance with DADS P/I # 313</li> </ul>	YES
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than two meals a day.	3
I eat few fruits or vegetables, or milk products.	2
I have three or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take three or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained ten pounds in the last six month.	2
I am not always physically able to shop, cook and/or feed myself.	2
<b>CLIENT SIGNATURE:</b>	<b>TOTAL</b>

**Nutritional Health Score**

- 0 – 2            Good
- 3 – 5            Moderate Nutritional Risk
- 6 or More      High Nutritional Risk

Refer to the Determine Your Nutritional Health Handout to learn more about the warning signs of poor nutritional health.

**Texas Department of Aging and Disability Services**  
**Area Agency on Aging**  
**AAA Consumer Needs Evaluation**



Consumer Name: \_\_\_\_\_

Consumer Number: \_\_\_\_\_

Assessment Date: \_\_\_\_\_

**Service Arrangement**  
 C = Caregiver  
 P = Service will be purchased by AAA.  
 A = Other agency - non AAA vendor is providing the service.  
 N = Not applicable to this consumer.  
 S = Self

	Texas Score	NAPIS ADL/IADL	NAPIS Count	Scoring/Service Arrangement
<b>I. Daily Living Impairment Assessment</b> <b>I. ADLs, IADL &amp; Other*</b>	ADL - Activity of Daily Living IADL - Independent Activity of Daily Living			* Impairment Scoring 0 = None 1 = Mild 2 = Severe 3 = Total Impairment
1. Do you have any problems taking a bath or shower?		ADL		
2. Can you dress yourself?		ADL		
3. Can you feed yourself?		ADL		
4. Can you groom yourself (shave, brush your teeth, shampoo and comb your hair)?				
5. Do you have problems getting to the bathroom and using the toilet?		ADL		
6. Do you have trouble cleaning yourself after using the bathroom?				
7. Can you get in and out of your bed or chair?		ADL		
8. Are you able to walk without help?		ADL		
9. Can you clean your house (sweep, dust, wash dishes, vacuum)?		IADL		
10. Can you do heavy housework (scrub floors, yard work, shovel snow, take out garbage)?		IADL		
11. Can you do your own laundry?				
12. Can you fix your meals?		IADL		
13. Can you do your own shopping?		IADL		
14. Can you take your own medicine?		IADL		
15. Can you trim your nails?				
16. Do you have any problems keeping your balance?				
17. Can you open jars, cans, bottles?				
18. Can you use the telephone?		IADL		
19. Are you able to perform transportation on your own?		IADL		
20. Do you have any trouble managing your money?		IADL		

**Texas Department of Aging and Disability Services**  
**Area Agency on Aging**  
**AAA Consumer Needs Evaluation - Page 2**



Consumer Name: \_\_\_\_\_

Consumer Number: \_\_\_\_\_

Assessment Date: \_\_\_\_\_

**Service Arrangement**  
**C = Caregiver**  
**P = Service will be purchased by AAA.**  
**A = Other agency-non AA vendor is providing the service.**  
**N = Not applicable to this consumer.**  
**S = Self**

	Texas Score	NAPIS ADL/IADL	NAPIS Count	Scoring/Service Arrangement
<b>II. Mental Health Screening</b>				
21. During the last month, have you been bothered by having little interest or pleasure in doing things, or have you often felt down, depressed, or hopeless?				Scoring for question 21: 0 = If the answer is "No" to question 21. 1 = If the answer is "Yes" to 21 and "No" to questions 22-25. 2 = If the answer is "Yes" to 21 and "Yes" to at least one of questions 22-25. 3 = If the answer is "Yes" to 21 and "Yes" to two or more of questions 22-25.
<b>III. Mental Health Assessment – If the answer is YES to Question 21, continue. Otherwise, SKIP to Section IV.</b>				
In the last two weeks, most of the day, nearly every day:				Based on Consumer's perception of self:
22. ... have you had problems sleeping?				Answer "No" or "Yes" for this question.
23. ... have you lost the ability to enjoy things that once were fun?				Answer "No" or "Yes" for this question.
24. ... do you feel that you have little value as a person?				Answer "No" or "Yes" for this question.
25. ... have you had a significant change in your appetite?				Answer "No" or "Yes" for this question.
<b>Mental Health Assessment Score (II &amp; III)</b>				
<b>IV. Cognition</b>				
<b>A. Self Evaluation</b>				
26. During the last 2 weeks, on how many days have you had trouble concentrating or making decisions? (Based on Consumer's perception of self.)				0= Not at all. 1= Occasionally, a couple of times. 2= Frequently, more than a couple of times, but not every day. 3= Every day.
<b>B. Third Party Observation</b>				
27. Does the consumer have the ability to make decisions independently? (Based on someone's observation of the Consumer.)				0= Makes consistent and reasonable decisions independently. 1= Makes simple decisions without assistance. 2= Makes poor decisions, needs cues/supervision for most decisions. 3= Severely impaired, rarely makes own decisions.
28. Does the consumer appear to have short-term memory impairment? (Based on someone's observation of the Consumer.)				0= No 1= Has some short-term memory problems & can perform task for self with occasional reminders. 2= Has lapses resulting in frequently not performing task even with reminders. 3= Has memory lapses resulting in inability to perform routine tasks on a daily basis.



**Texas Department of Aging and Disability Services  
Area Agency on Aging  
AAA Consumer Needs Evaluation - Page 3**



Consumer Name: \_\_\_\_\_

Consumer Number: \_\_\_\_\_

Assessment Date: \_\_\_\_\_

**Service Arrangement**  
 C = Caregiver  
 P = Service will be purchased by AAA.  
 A = Other agency - non AAA vendor is providing the service.  
 N = Not applicable to this consumer.  
 S = Self

	Texas Score	NAPIS ADL / IADL	NAPIS Count	Scoring / Service Arrangement
<b>V. Assessment Scores</b>				
<b>A. Total CNE Impairment Score (out of 60)</b>  <input type="checkbox"/> Low (Score 0-19) <input type="checkbox"/> Moderate (Score 20-39)* <input type="checkbox"/> Severe (Score 40 and above)				
<b>B. NAPIS ADL COUNT (Score 0-6)</b>				
<b>C. NAPIS IADL COUNT (Score 0-8)</b>				

\*A score of 20 (moderate impairment) or greater is required for home-delivered meals.

\_\_\_\_\_  
Signature of AAA/Provider Staff Assessor

\_\_\_\_\_  
Date

**SCORING THE CNE & NAPIS – ADL'S & IADL'S Rate the Consumer according to the following scale:**

0	None	Able to conduct activities without difficulty and has no need for assistance.
1	Minimal/Mild	Able to conduct activities with minimal difficulty and needs minimal assistance.
2	Extensive/Severe	Has extreme difficulty carrying out activities of daily living and needs extensive assistance.
3	Total	Completely unable to carry out any part of the activity.

The AAA Consumer Needs Evaluation must be completed for the following services: Adult Day Care; Care Coordination (Care Management); Chore Maintenance; Home Delivered Meals; Homemaker; Personal Assistance; and Respite Care. Residential Repair requires service appropriate assessment, which may include the AAA Consumer Needs Evaluation.