Title III - Intake and Assessment Sample Forms

CALIFORNIA DEPARTMENT OF AGING

HOME AND COMMUNITY LIVING DIVISION

www.aging.ca.gov
916-419-7500

Revised July 2023

Introduction

Because each AAA has tailored programs to meet their community needs, CDA does **not** have required intake or assessment forms. CDA has designed these sample templates to help the AAAs evaluate and create their own forms for collecting and recording required performance data elements.

What is Reviewed

CDA reviews the forms to ensure all required data collection elements are integrated.

AAAs may use these forms, revise them, or create forms to meet local needs. AAAs do not have to use these sample templates.

Forms

This section contains the following templates:

Sample 1

- Title III B, C-1, C-2, and D (Cluster 1& 2, Registered)
- Personal Care, Homemaker, Chore, Home-Delivered Meals, Adult Day Care/Health, Case Management, Congregate Meals, Nutritional Counseling, Assisted Transportation, Other Non-Registered Services

Sample 2

- Title III B, C-2 (Cluster 1)
- Personal Care, Homemaker, Chore, Home-Delivered Meals, Adult Day Care/Health, Case Management

Sample 3

- Title III B, C-1, and D (Cluster 2)
- Congregate Meals, Nutritional Counseling, Assisted Transportation

Sample 4

- Title III C-2
- Home-Delivered Meals

Sample 5

- Title III C-1
- Congregate Meals

Sample 6

- Title III E (Group 1, Registered)
- Caregivers of Older Adults, Older Relative Caregivers

Sample 7

- Title III E (Group 1)
- Caregivers of Older Adults

Sample 8

- Title III E (Group 1)
- Older Relative Caregivers

Sample 9

- Title III B (Cluster III, Non-Registered)
- Information and Assistance

Sample 10

- Title III B (Restricted)
- Legal Assistance

SAMPLE 1, TITLE III

Provider Name:	**Unique Participate ID:** _____
Region/Site Name:	**Registration/Assessment Date:** _____
	Termination Date: ***Reason:**

Service Categories (Titles IIIB, IIIC and IIID):

☐ ***Personal Care (IIIB)** (A, I) ☐ ***Homemaker (IIIB)** (A, I) ☐ ***Chore (IIIB)** (A, I)
☐ ***Home-Delivered Meals** (A, I, N) ☐ ***Adult Day Care/Health (IIIB)** (A, I) ☐ ***Case Management (IIIB)** (A, I)
☐ ***Assisted Transportation (IIIB)** ☐ ***Congregate Meals** (N) ☐ ***Nutrition Counseling** (N)
☐ Other: _____

Notes*: Reference the Data Dictionary for allowable "Other" service categories; Requires **A**-ADLs, **I**-IADLs, **N**-Nutritional Assessments on Page 2*

SECTION 1 (Client)

(*) Required for All Registered Programs

PERSONAL DATA (Please print):	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***What was your sex at birth? (Check only one)**	☐ Male ☐ Female ☐ Declined/not stated
***How do you describe your sexual orientation or sexual identity? (Check only one)**	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***Have you ever served in the United States military?**	☐ Yes ☐ No ☐ Declined/not stated
***Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?**	☐ Yes ☐ No ☐ Declined/not stated

***If you identify as being military affiliated, check below if: "I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for12 months."**

☐ Yes ☐ No

Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.

Residential Address:	
Street:	
City:	
***Zip Code:**	
Mailing Address: Same as Residential? ☐ Yes – Skip	
Street:	
City:	
***Zip Code:**	
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated
***Race: (Check all that apply)**	☐ White ☐ Black ☐ American Indian/Alaska Native Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Declined/not stated

***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated

SECTION 2 – ADL and IADL (Activities of Daily Living and Instrumental Activities of Daily Living – Annual Assessment)

***Required for (III-C):** Home Delivered Meals; **(III-B):** Personal Care, Homemaker, Chore, Adult Day Care, Case Management*

ADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
*Eating						
*Bathing						
*Toileting						
*Transferring In/Out of Bed/Chair						
*Walking						
*Dressing						
Notes:						

IADLS:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
*Meal Preparation						
*Shopping						
*Medication Management						
*Money Management						
*Using Telephone						
*Heavy Housework						
*Light Housework						
*Transportation						
Notes:						

SECTION 3 – Nutritional Risk Assessment (Annual)

*** *Required for (IIIC):** Home-Delivered Meals, Congregate Meals; Nutritional Counseling*

*Nutritional Risk Assessment:	Circle if 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 2 meals per day.	3	
I eat few fruits or vegetables or milk products.	2	
I have 3 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 3 or more different prescribed or over–the-counter drugs a day.	1	
Without wanting to, I have lost or gained 10 pounds in the past 6 months.	2	
I am not always physically able to shop, cook, and/or feed myself.	2	
Total Score:		
Is Nutrition Risk total score 0-5 or 6+?	**0 - 5**	**6+**
☐ **Declined to State**		

SAMPLE 2, CLUSTER 1

Provider Name:	**Unique Participate ID:** _____
Region/Site Name:	**Registration/Assessment Date:** _____
	Termination Date: ***Reason:**

Service Categories (Titles IIIB and IIIC):

☐ ***Personal Care (IIIB)** (A, I) ☐ ***Homemaker (IIIB)** (A, I) ☐ ***Chore (IIIB)** (A, I)
☐ ***Home-Delivered Meals** (A, I, N) ☐ ***Adult Day Care/Health (IIIB)** (A, I) ☐ ***Case Management (IIIB)** (A, I)

Notes*: Reference the Data Dictionary for allowable "Other" service categories; Requires **A**-ADLs, I-IADLs, **N**-Nutritional Assessments on Page 2*

SECTION 1 (Client)

(*) Required for All Registered Programs

PERSONAL DATA (Please print):	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***What was your sex at birth? (Check only one)**	☐ Male ☐ Female ☐ Declined/not stated
***How do you describe your sexual orientation or sexual identity? (Check only one)**	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***Have you ever served in the United States military?**	☐ Yes ☐ No ☐ Declined/not stated
***Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?**	☐ Yes ☐ No ☐ Declined/not stated

***If you identify as being military affiliated, check below if: "I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for12 months."**

☐ Yes ☐ No

Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.

Residential Address:	
Street:	
City:	
***Zip Code:**	
Mailing Address: Same as Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
***Zip Code:**	
Emergency Contact:	Name: Relationship: Phone #: ( )
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated

***Race: (Check all that apply)**	☐ White ☐ Black ☐ American Indian/Alaska Native Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Declined/not stated
***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated

SECTION 2 – ADL and IADL (Activities of Daily Living and Instrumental Activities of Daily Living – Annual Assessment)

***Required for (III-C):** Home Delivered Meals; **(III-B):** Personal Care, Homemaker, Chore, Adult Day Care, Case Management*

ADLs:	**1 – Independent**	**2 – Verbal Assistance**	**3 – Some Human Help**	**4 – Lots of Human Help**	**5 – Dependent**	**Declined to State**
***Eating**						
***Bathing**						
***Toileting**						
***Transferring In/Out of Bed/Chair**						
***Walking**						
***Dressing**						
Notes:						
IADLS:	**1 – Independent**	**2 – Verbal Assistance**	**3 – Some Human Help**	**4 – Lots of Human Help**	**5 – Dependent**	**Declined to State**
***Meal Preparation**						
***Shopping**						
***Medication Management**						
***Money Management**						
***Using Telephone**						
***Heavy Housework**						
***Light Housework**						
***Transportation**						
Notes:						

SECTION 3 – Nutritional Risk Assessment (Annual)

*** *Required for (IIIC):** Home-Delivered Meals, Congregate Meals; Nutritional Counseling*

***Nutritional Risk Assessment:**	**Circle if 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 2 meals per day.	3	
I eat few fruits or vegetables or milk products.	2	
I have 3 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 3 or more different prescribed or over–the-counter drugs a day.	1	
Without wanting to, I have lost or gained 10 pounds in the past 6 months.	2	
I am not always physically able to shop, cook, and/or feed myself.	2	
Total Score:		
Is Nutrition Risk total score 0-5 or 6+?	**0 - 5**	**6+**
☐ **Declined to State**		

SAMPLE 3, CLUSTER 2

Provider Name:	**Unique Participate ID:** _____
Region/Site Name:	**Registration/Assessment Date:** _____ **Termination Date:** ***Reason:**

Service Categories (Titles IIIB and IIIC):

☐ ***Assisted Transportation** ☐ ***Congregate Meals** (N) ☐ ***Nutrition Counseling** (N)

Notes*: Requires **N**-Nutritional Assessments on Page 2*

SECTION 1 (Client)

(*) Required for All Registered Programs

PERSONAL DATA (Please print):	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***What was your sex at birth? (Check only one)**	☐ Male ☐ Female ☐ Declined/not stated
***How do you describe your sexual orientation or sexual identity? (Check only one)**	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***Have you ever served in the United States military?**	☐ Yes ☐ No ☐ Declined/not stated
***Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?**	☐ Yes ☐ No ☐ Declined/not stated

***If you identify as being military affiliated, check below if: "I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for12 months."**

☐ Yes ☐ No

Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.

***Birth Date:**	
Home Phone:	( )
Residential Address:	
Street:	
City:	
***Zip Code:**	
Mailing Address: Same as Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
***Zip Code:**	
Emergency Contact:	Name: Relationship: Phone #: ( )
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated

***Race:** **(Check all that apply)**	☐ White ☐ Black ☐ American Indian/Alaska Native Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Declined/not stated
***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated
Transportation Service Needs: ☐ Walks with no assistance (Non-Assisted) ☐ Walks with assistance (Assisted) ☐ Wheelchair ramp/lift	

SECTION 2 – Nutritional Assessment (Annual)

**** Required for (IIIC):*** *Congregate Meals, Nutritional Counseling*

***Nutritional Assessment:**	**Circle if 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 2 meals per day.	3	
I eat few fruits or vegetables or milk products.	2	
I have 3 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 3 or more different prescribed or over–the-counter drugs a day.	1	
Without wanting to, I have lost or gained 10 pounds in the past 6 months?	2	
I am not always physically able to shop, cook, and/or feed myself.	2	
Total Score:		
Is Nutrition Risk total score 0-5 or 6+?	**0 - 5**	**6+**
☐ **Declined to State**		

Notes:

SAMPLE 4, C-2

Name of Home-Delivered Meals Provider This form is designed to be completed by an intake staff. Items marked with an asterisk (*) are required.	Route:	Intake Date: _____ Active Date: _____ Inactive Date: _____ Active Date: _____ Inactive Date: _____ Active Date: _____ Inactive Date: _____

***Unique Participant ID:**	***Termination Date:** **Reason:**
***Date of Birth:** / /	☐ New client ☐ Annual reassessment ☐ Change in information

First Name:	Last Name:

Home Address	City:	***Zip Code**

Home Phone: ( ) Alternate Phone: ( )	Emergency Contact Name: Address: Phone: ( ) Relationship:

***Living Arrangement # of household members:** ☐ ☐ Declined/not stated	***What is your approximate household income?** $_____ per ☐ month ☐ year ☐ Declined/not stated	***Rural Area:** ☐ Yes ☐ No ☐ Declined/not stated

***What is your gender? (Check only one)** ☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated	***What was your sex at birth? (Check only one)** ☐ Male ☐ Female ☐ Declined/not stated	***How do you describe your sexual orientation or sexual identity? (Check only one)** ☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated

***Have you ever served in the United States military?** ☐ Yes ☐ No ☐ Declined/not stated	***Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?** ☐ Yes ☐ No ☐ Declined/not stated	***If you identify as being military affiliated, check below if: "I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for12 months."** ☐ Yes ☐ No Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.

***Ethnicity:** (Check one) Hispanic ☐ Yes ☐ No ☐ Declined/not stated	Language: ☐ English Speaking ☐ Need interpreter ☐ Non-English/Language

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

☐ White ☐ Black ☐ American Indian/Alaska Native Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian
☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander ☐ Declined/not stated

ADLs: ADLs and IADLs (Activities of Daily Living and Instrumental Activities of Daily Living)
Please rate your functional abilities for the following activities.

ADLs	Rated Value	IADLs	Rated Value	IADLs	Rated Value	RATING SCALE
Feeding		Meal Preparation		Light Housework		1 – Independent 2 – Verbal Assistance 3 – Some Human Help 4 – Lots of Human Help 5 – Dependent 6 - Declined to State
Dressing		Shopping		Heavy Housework		
Bathing		Manage Medication		Notes:		
Transferring In/Out of Chair		Money Management				
Walking		Telephone				
Toileting		Transportation				

Eligibility:
☐ Are you homebound due to an illness, disability, or isolation?
☐ Are you a spouse of a home-delivered meal recipient?
☐ Are you an individual with a disability who resides with a home-delivered meal recipient?

Prioritization:

***Nutritional Risk Assessment:**	**Circle if 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 2 meals per day.	3	
I eat few fruits or vegetables or milk products.	2	
I have 3 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 3 or more different prescribed or over–the-counter drugs a day.	1	
Without wanting to, I have lost or gained 10 pounds in the past 6 months.	2	
I am not always physically able to shop, cook, and/or feed myself.	2	
Total Score:		
***Is Nutrition Risk Total Score 0-5 or 6+ ?**	**0-5**	**6+**
☐ **Declined to State**		

	Yes	No	Comments
Do you have any dietary restrictions?	☐	☐	
Do you have a working refrigerator?	☐	☐	
Do you have a working microwave?	☐	☐	
Are you physically and mentally able to open the food containers?	☐	☐	
Are you physically and mentally able to reheat a meal?	☐	☐	
Are there pets?	☐	☐	
Have you recently been discharged from the hospital?	☐	☐	

Referral(s) Made:
☐ Nutritional education/counseling for at risk client
☐ Other:
☐ Other:

Notes:

_____ _____

Staff Completing Assessment Date

SAMPLE 5, C-1

Name of Congregate Meal Provider
{Provider Name}
Please complete this form to the best of your ability.
Items marked with an asterisk (*) are required.

***Unique Participate ID:** _____
Referred by: _____
Intake Date: _____
Staff: _____
Beginning Date: _____
***Termination Date:** _____
***Reason:** _____

Eligibility:
☐ Age 60+
☐ Spouse of congregate meal participant
☐ Disabled person residing where the congregate site is located
☐ Disabled person who resides with and accompanies a congregate meal participant
☐ Volunteer

First Name:	Last Name:	***Date of Birth:**

Home Address	City:	***Zip Code**
Mailing Address: Same As Residential? ☐ Yes	City:	***Zip Code**

Home Phone: ( ) Alternate Phone: ( )	Emergency Contact Name: Address: Phone: ( ) Relationship:

***Living Arrangement # of household members:** ☐
☐ Declined/not stated

***What is your approximate household income?**
$ _____ per ☐ month ☐ year
☐ Declined/not stated

***Rural Area:**
☐ Yes ☐ No
☐ Declined/not stated

***What is your gender? (Check only one)**
☐ Male ☐ Female
☐ Transgender Male to Female
☐ Transgender Female to Male
☐ Genderqueer/Gender Non-binary
☐ Not Listed, please specify:
_____
☐ Declined/not stated

***What was your sex at birth? (Check only one)**
☐ Male
☐ Female
☐ Declined/not stated

***How do you describe your sexual orientation or sexual identity? (Check only one)**
☐ Straight/Heterosexual
☐ Bisexual
☐ Gay/Lesbian/Same-Gender Loving
☐ Questioning/Unsure
☐ Not Listed, please specify:
_____
☐ Declined/not stated

***Have you ever served in the United States military?**
☐ Yes ☐ No
☐ Declined/not stated

***Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?**
☐ Yes ☐ No
☐ Declined/not stated

***If you identify as being military affiliated, check below if: "I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for12 months."**
☐ Yes ☐ No
Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.

***Ethnicity:** (Check one)
Hispanic ☐ Yes ☐ No ☐ Declined/not stated

Language:
☐ English Speaking ☐ Need interpreter ☐ Non-English/Language

***Race: (Check all that apply)**
☐ White ☐ Black ☐ American Indian/Alaska Native Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian
☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander ☐ Declined/not stated

*Nutritional Risk Assessment:	Circle if 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 2 meals per day.	3	
I eat few fruits or vegetables or milk products.	2	
I have 3 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 3 or more different prescribed or over–the-counter drugs a day.	1	
Without wanting to, I have lost or gained 10 pounds in the past 6 months.	2	
I am not always physically able to shop, cook, and/or feed myself.	2	
Total Score:		
Is Nutrition Risk total score 0-5 or 6+ ?	**0 - 5**	**6+**
☐ **Declined to State**		

I understand that the information I am providing on this form is for registration purposes. I understand it will be kept confidential and that the Area Agency on Aging and service providers may use it to help identify other services for which may benefit.

_____ _____

Signature of participant or person completing the form Date

SAMPLE 6, TITLE III E CAREGIVERS OF OLDER ADULTS, OLDER RELATIVE CAREGIVERS

SECTION 1 – Service Information

Provider Name:	**Registration/Assessment Date:**
Region/Site Name:	***Termination Date:** ***Reason:**

Service Categories:

☐ **Caregivers of Older Adults** ☐ **Older Relative Caregivers**

Notes: Check Eligibility criteria below to determine for which program caregiver qualifies

Title III E, Family Caregiver Support Program Services to be Provided

Support Services:

☐ Caregiver Assessment ☐ Caregiver Support
☐ Caregiver Counseling ☐ Caregiver Training
☐ Caregiver Peer Counseling ☐ Case Management

Respite Care Services: *(Care Receiver must have 2 or more ADL limitations, a cognitive impairment, or be grandparent/elder caregiver to qualify)*

☐ In-Home Supervision
☐ Homemaker Assistance
☐ In-Home Personal Care
☐ Home Chore
☐ Out of Home Day
☐ Out of Home Overnight

Supplemental Services*: (Care Receiver must have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/older caregiver to qualify)*

☐ Assistive Devices ☐ Home Adaptations for Caregiving ☐ Caregiving Services Registry ☐ Cash/Material Aid

Access Assistance:

☐ Information & Assistance ☐ Caregiver Outreach
☐ Interpretation/Translation
☐ Caregiver Legal Resources

Information Services:

☐ Public Information on Caregiving
☐ Community Education on Caregiving

SECTION 2 – Eligibility Criteria

Caregivers of Older Adults Eligibility Criteria

1. Is the Care Receiver an older individual (60 years of age or older) ***or*** an individual (of any age) with Alzheimer's disease or related disorder with neurological and organic brain dysfunction? ☐ Yes ☐ No

2. Is the Caregiver an adult (18 years of age or older) family member or another individual (e.g., friend or neighbor) who is an informal (i.e., unpaid) provider of in-home or community care to an "elderly" Care Receiver? ☐ Yes ☐ No

If answered "yes" to both questions above, check "Family Caregiver Caregivers of Older Adults" box in Section 1. If answered "no" check to see if individual qualifies for "Grandparent/Older Caregiver Older Relative Caregivers" component below.

Older Relative Caregivers Eligibility Criteria

1. Is the Care Receiver an individual who is not more than 18 years of age ***or*** who is an individual (of any age) with a disability? ☐ Yes ☐ No

2. Is the Caregiver a grandparent, step-grandparent, or other older relative of the Care Receiver by blood, marriage, or adoption who is 55 years of age or older, living with the Care Receiver, and identified as the primary caregiver through a legal or informal arrangement. Biological and adoptive parents are excluded. ☐ Yes ☐ No

If answered "yes" to both questions above, check "Older Relative Caregivers" box in Section 1.

If the Care Receiver does not meet any of the criteria above, the Caregiver is ineligible to receive FCSP Older Relative Caregivers services, but may qualify to receive other services provided by the Area Agency on Aging.

SECTION 3 (FCSP Caregiver)

(*) Required for Family Caregiver Support Program Services

Caregiver Personal Data (Please print):	
***Unique Participant ID**	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***What was your sex at birth? (Check only one)**	☐ Male ☐ Female ☐ Declined/not stated
***How do you describe your sexual orientation or sexual identity? (Check only one)**	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***Birth Date:**	
Home Phone:	( )
Residential Address:	
Street:	
City:	
***Zip Code:**	
Mailing Address: Same as Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
***Zip Code:**	
***Have you ever served in the United States military?** ☐ Yes ☐ No ☐ Declined/not stated	
***Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?** ☐ Yes ☐ No ☐ Declined/not stated	

***If you identify as being military affiliated, check below if: "I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for12 months."** ☐ Yes ☐ No Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.	
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated
***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated
***Race: (Check all that apply)**	☐ White ☐ Black ☐ American Indian/Alaska Native Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Declined/not stated
***Relationship to Care Receiver:**	☐ Husband ☐ Wife ☐ Grandparent ☐ Domestic Partner ☐ Daughter/Daughter-in-law ☐ Son/Son-in-law ☐ Brother ☐ Sister ☐ Parents ☐ Other Relative ☐ Non-Relative ☐ Declined/not stated
***Relationship Status:**	☐ Single (never married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined/not stated
***Employment:**	☐ Full Time ☐ Unemployed ☐ Part Time ☐ Declined/not stated ☐ Retired

SECTION 4 (FCSP Care Receiver)

(*) Required for Family Caregiver Support Program Services

Caregiver Personal Data (Please print):	
***Unique Participant ID**	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***What was your sex at birth? (Check only one)**	☐ Male ☐ Female ☐ Declined/not stated
***How do you describe your sexual orientation or sexual identity? (Check only one)**	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***Birth Date:**	
Home Phone:	( )
Residential Address:	
Street:	
City:	
***Zip Code:**	
***Have you ever served in the United States military?** ☐ Yes ☐ No ☐ Declined/not stated	
***Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?** ☐ Yes ☐ No ☐ Declined/not stated	

***If you identify as being military affiliated, check below if: "I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for12 months."** ☐ Yes ☐ No Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.	
Mailing Address: Same as Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
***Zip Code:**	
Demographics:	
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated
***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated
***Race: (Select all that apply)**	
☐ White ☐ Black ☐ American Indian/Alaska Native Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Declined/not stated	
***Relationship Status:**	☐ Single (never married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined/not stated

SECTION 5 – (FCSP Care Receiver)

ADL and IADL (Activities of Daily Living and Instrumental Activities of Daily Living)

**Required for <u>the Care Receiver only</u> in Support Services, Respite Care, and Supplemental Services.*

(Not required for Care Receivers in FCSP Older Adults/Relative)

ADLs:	**1 – Independent**	**2 – Verbal Assistance**	**3 – Some Human Help**	**4 – Lots of Human Help**	**5 – Dependent**	**Declined to State**
***Eating**						
***Bathing**						
***Toileting**						
***Transferring In/Out of Bed/Chair**						
***Walking**						
***Dressing**						
Notes:						

IADLS:	**1 – Independent**	**2 – Verbal Assistance**	**3 – Some Human Help**	**4 – Lots of Human Help**	**5 – Dependent**	**Declined to State**
***Meal Preparation**						
***Shopping**						
***Medication Management**						
***Money Management**						
***Using Telephone**						
***Heavy Housework**						
***Light Housework**						
***Transportation**						
Notes:						

SAMPLE 7, TITLE III E, CAREGIVERS OF OLDER ADULTS

SECTION 1 – Service Information

Provider Name:	**Registration/Assessment Date:**
Region/Site Name:	***Termination Date:** ***Reason:**

Title III E, Family Caregiver Support Program Services to be Provided

Support Services:

- ☐ Caregiver Assessment
- ☐ Caregiver Support
- ☐ Caregiver Counseling
- ☐ Caregiver Training
- ☐ Caregiver Peer Counseling
- ☐ Case Management

Respite Care Services: *(Care Receiver must have 2 or more ADL limitations, a cognitive impairment, or be grandparent/elder caregiver to qualify)*

- ☐ In-Home Supervision
- ☐ Homemaker Assistance
- ☐ In-Home Personal Care
- ☐ Home Chore
- ☐ Out of Home Day
- ☐ Out of Home Overnight

Supplemental Services*: (Care Receiver must have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/older caregiver to qualify)*

☐ Assistive Devices ☐ Home Adaptations for Caregiving ☐ Caregiving Services Registry ☐ Cash/Material Aid

Access Assistance:

- ☐ Information & Assistance
- ☐ Caregiver Outreach
- ☐ Interpretation/Translation
- ☐ Caregiver Legal Resources

Information Services:

- ☐ Public Information on Caregiving
- ☐ Community Education on Caregiving

SECTION 2 – Eligibility Criteria

Caregivers of Older Adults Eligibility Criteria

1. Is the Care Receiver an older individual (60 years of age or older) ***or*** an individual (of any age) with Alzheimer's disease or related disorder with neurological and organic brain dysfunction? ☐ Yes ☐ No

2. Is the Caregiver an adult (18 years of age or older) family member or another individual (e.g., friend or neighbor) who is an informal (i.e., unpaid) provider of in-home or community care to an "elderly" Care Receiver? ☐ Yes ☐ No

If the Care Receiver does not meet any of the criteria above, the Caregiver is ineligible to receive FCSP Caregivers of Older Adults services but may qualify to receive other services provided by the Area Agency on Aging.

Notes:

SECTION 3 (FCSP Caregiver)

(*) Required for Family Caregiver Support Program Services

Caregiver Personal Data (Please print):	
***Unique Participant ID**	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***What was your sex at birth? (Check only one)**	☐ Male ☐ Female ☐ Declined/not stated
***How do you describe your sexual orientation or sexual identity? (Check only one)**	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***Birth Date:**	
Home Phone:	( )
Residential Address:	
Street:	
City:	
***Zip Code:**	
Mailing Address: Same as Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
***Zip Code:**	
***Have you ever served in the United States military?** ☐ Yes ☐ No ☐ Declined/not stated	
***Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?** ☐ Yes ☐ No ☐ Declined/not stated	

***If you identify as being military affiliated, check below if: "I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for12 months."**

☐ Yes ☐ No

Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.

Demographics:	
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated
***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated

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

☐ White ☐ Black ☐ American Indian/Alaska Native

Asian:

☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Vietnamese ☐ Other Asian

Hawaiian/Other Pacific Islander

☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander
☐ Declined/not stated

***Relationship to Care Receiver:**	☐ Husband ☐ Wife ☐ Grandparent ☐ Domestic Partner ☐ Daughter/Daughter-in-law ☐ Son/Son-in-law ☐ Brother ☐ Sister ☐ Other Relative ☐ Non-Relative ☐ Declined/not stated
***Relationship Status:**	☐ Single (never married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined/not stated
***Employment:**	☐ Full Time ☐ Unemployed ☐ Part Time ☐ Declined/not stated ☐ Retired

SECTION 4 (FCSP Care Receiver)

(*) Required for Family Caregiver Support Program Services

Caregiver Personal Data (Please print):	
***Unique Participant ID**	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***What was your sex at birth? (Check only one)**	☐ Male ☐ Female ☐ Declined/not stated
***How do you describe your sexual orientation or sexual identity? (Check only one)**	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***Birth Date:**	
Home Phone:	( )
Residential Address:	
Street:	
City:	
***Zip Code:**	
***Have you ever served in the United States military?** ☐ Yes ☐ No ☐ Declined/not stated	
***Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?** ☐ Yes ☐ No ☐ Declined/not stated	

***If you identify as being military affiliated, check below if: "I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for12 months."**

☐ Yes ☐ No

Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.

Mailing Address:

Same as Residential? ☐ Yes – Skip to Next Section

Street:	
City:	
***Zip Code:**	

Demographics:

***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated
***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated

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

☐ White ☐ Black ☐ American Indian/Alaska Native

Asian:

☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Vietnamese ☐ Other Asian

Hawaiian/Other Pacific Islander

☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander
☐ Declined/not stated

***Relationship Status:**	☐ Single (never married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined/not stated

SECTION 5 – (FCSP Care Receiver)

ADLs: ADLs and IADLs (Activities of Daily Living and Instrumental Activities of Daily Living):
Required for Support Services, Respite Car, and Supplemental Services.
Please rate your functional abilities for the following activities.

ADLs	Rated Value	IADLs	Rated Value	IADLs	Rated Value	RATING SCALE
Feeding		Meal Preparation		Heavy Housework		1 – Independent 2 – Verbal Assistance 3 – Some Human Help 4 – Lots of Human Help 5 – Dependent 6 - Declined to State
Dressing		Shopping		Light Housework		
Bathing		Manage Medication		Notes:		
Transferring In/Out of Chair		Money Management				
Walking		Telephone				
Toileting		Transportation				

SAMPLE 8, TITLE III E, OLDER RELATIVE CAREGIVERS

SECTION 1- Service Information

Provider Name:	**Registration/Assessment Date:**
Region/Site Name:	***Termination Date:** ***Reason:**

Title III E, Family Caregiver Support Program Services to Be Provided

Support Services:

- ☐ Caregiver Assessment
- ☐ Caregiver Counseling
- ☐ Caregiver Peer Counseling
- ☐ Caregiver Support
- ☐ Caregiver Training
- ☐ Case Management

Respite Care Services: *(Care Receiver must have 2 or more ADL limitations, a cognitive impairment, or be grandparent/elder caregiver to qualify)*

- ☐ In-Home Supervision
- ☐ Homemaker Assistance
- ☐ In-Home Personal Care
- ☐ Home Chore
- ☐ Out of Home Day
- ☐ Out of Home Overnight

Supplemental Services*: (Care Receiver must have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/older caregiver to qualify)*

☐ Assistive Devices ☐ Home Adaptations for Caregiving ☐ Caregiving Services Registry ☐ Cash/Material Aid

Access Assistance:

- ☐ Information & Assistance
- ☐ Interpretation/Translation
- ☐ Caregiver Legal Resources
- ☐ Caregiver Outreach

Information Services:

- ☐ Public Information on Caregiving
- ☐ Community Education on Caregiving

SECTION 2 – Eligibility Criteria

1. Is the Care Receiver an individual who is not more than 18 years of age ***or*** an individual (of any age) with a disability?
☐ Yes ☐ No

2. Is the Caregiver a grandparent, step-grandparent, or other older relative of the Care Receiver by blood, marriage, or adoption who is 55 year of age or older living with the Care Receiver, and identified as the primary caregiver through a legal or informal arrangement? Biological and adoptive parents are excluded ☐ Yes ☐ No

If the Care Receiver does not meet any of the criteria above, the Caregiver is ineligible to receive FCSP Older Relative Caregivers services but may qualify to receive other services provided by the Area Agency on Aging.

Notes:

SECTION 3 (Older Caregiver)

(*) Required for Family Caregiver Support Program Services

Caregiver Personal Data (Please print):	
***Unique Participant ID**	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***What was your sex at birth? (Check only one)**	☐ Male ☐ Female ☐ Declined/not stated
***How do you describe your sexual orientation or sexual identity? (Check only one)**	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***Birth Date:**	
Home Phone:	( )
Residential Address:	
Street:	
City:	
***Zip Code:**	
Mailing Address: Same as Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
***Zip Code:**	
***Have you ever served in the United States military?** ☐ Yes ☐ No ☐ Declined/not stated	
***Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?** ☐ Yes ☐ No ☐ Declined/not stated	

***If you identify as being military affiliated, check below if: "I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for12 months."**

☐ Yes ☐ No

Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.

Demographics:	
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated
***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated

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

☐ White ☐ Black ☐ American Indian/Alaska Native

Asian:

☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Vietnamese ☐ Other Asian

Hawaiian/Other Pacific Islander

☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander
☐ Declined/not stated

***Relationship to Care Receiver:**	☐ Grandparent ☐ Parent ☐ Other Relative ☐ Non-Relative ☐ Declined/not stated
***Relationship Status:**	☐ Single (never married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined/not stated
***Employment:**	☐ Full Time ☐ Unemployed ☐ Part Time ☐ Declined/not stated ☐ Retired

SECTION 4 (Care Receiver)

(*) Required for Family Caregiver Support Program Services

Caregiver Personal Data (Please print):	
***Unique Participant ID**	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***What was your sex at birth? (Check only one)**	☐ Male ☐ Female ☐ Declined/not stated
***How do you describe your sexual orientation or sexual identity? (Check only one)**	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***Birth Date:**	
Home Phone:	( )
Residential Address:	
Street:	
City:	
***Zip Code:**	
***Have you ever served in the United States military?** ☐ Yes ☐ No ☐ Declined/not stated	
***Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?** ☐ Yes ☐ No ☐ Declined/not stated	

***If you identify as being military affiliated, check below if: "I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for12 months."**

☐ Yes ☐ No

Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.

Mailing Address:

Same as Residential? ☐ Yes – Skip to Next Section

Street:	
City:	
***Zip Code:**	

Demographics:

***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated
***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated

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

☐ White ☐ Black ☐ American Indian/Alaska Native

Asian:

☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Vietnamese ☐ Other Asian

Hawaiian/Other Pacific Islander

☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander
☐ Declined/not stated

***Relationship Status:**	☐ Single (never married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined/not stated

SAMPLE 9, INFORMATION & ASSISTANCE

Date: _____ **Staff Completing Intake:** _____

***Indicates optional demographic information that is kept confidential and anonymous. This information is important in understanding the people that we serve.**

Demographic Data	
***Unique Participant ID:**	
Name:	
***Birth Date:**	
Home Phone #:	( )
Email:	
Address:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***What was your sex at birth? (Check only one)**	☐ Male ☐ Female ☐ Declined/not stated
***How do you describe your sexual orientation or sexual identity? (Check only one)**	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated

***Race: (Check all that apply)**	☐ White ☐ Black ☐ American Indian/Alaska Native Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Declined/not stated
***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated
***Have you ever served in the United States military?** ☐ Yes ☐ No ☐ Declined/not stated	
***Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?** ☐ Yes ☐ No ☐ Declined/not stated	
***If you identify as being military affiliated, check below if: "I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for12 months."** ☐ Yes ☐ No Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.	
Service Requested:	

Action Taken/Referral:
Follow Up:
Type of I & A: ☐ III B (If Requesting Services for an Older Individual) ☐ III E Caregivers (If Requesting Services for an Older Individual) ☐ III E Relative (If Requesting Services for an Older Individual)

SAMPLE 10, III B LEGAL ASSISTANCE

Date: _____ **Staff Completing Intake:** _____

***Required Information**

PERSONAL DATA	
***Unique Participant ID:**	
Name:	
***Birth Date:**	
Phone #:	( )
Email:	
Address:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***What was your sex at birth? (Check only one)**	☐ Male ☐ Female ☐ Declined/not stated
***How do you describe your sexual orientation or sexual identity? (Check only one)**	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated
***Race: (Check all that apply)**	☐ White ☐ Black ☐ American Indian/Alaska Native Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Declined/not stated

***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated
CASE INFORMATION	
***Unique Case ID:**	
***Case Opened Date:**	
***Case Closed Date:**	
***Service Level:**	☐ Advice ☐ Limited Representation ☐ Representation
***Case Type:**	☐ Income ☐ Health Care ☐ Long Term Care ☐ Nutrition ☐ Housing ☐ Utilities ☐ Abuse/Neglect ☐ Protective Services ☐ Age Discrimination ☐ Other/Miscellaneous
***Hours (Units):**	