

Title III - Intake and Assessment Sample Forms

CALIFORNIA DEPARTMENT OF AGING

HOME AND COMMUNITY LIVING DIVISION

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

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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:		
Destion/Site Neme:		Registration/Assessment Date:		
Region/Site Name:		Termination Date: *Reason:		
 *Personal Care *Home-Delivered *Assisted Trans 	ed Meals (A, I, N)	re/Health (IIIB) (A, I)	e 2	
(*) Required for All Re	gistered Programs			
PERSONAL DATA	(Please print):	*If you identify as being military affiliated, check belo "I consent to this agency and the California Departme	ent	
First Name:		of Aging transmitting my name, email address, mailin address, and mobile telephone number to the	ıg	
Middle Initial:		Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits		
Last Name:		which I may be eligible. I understand that this consen		
*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:	valid for12 months." Yes No Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports www.calvet.ca.gov or 1-800-952-5626. Residential Address:	at	
(Oneck only one)		Street:		
	Declined/not stated	City:		
*What was your		*Zip Code:		
sex at birth?		Mailing Address: Same as Residential? Yes – Skip		
	Straight/Heterosexual	Street:		
*How do you describe your	Bisexual	City:		
sexual	Gay/Lesbian/Same-Gender Loving Questioning/Unsure	*Zip Code:		
orientation or sexual identity? (Check only one)	Not Listed, please specify: Declined/not stated	*Ethnicity: Not Hispanic/Latino Bippinic/Latino Declined/not stated		
*Have you ever served in the United States military?	Yes No Declined/not stated	White Black American Indian/Alaska Native Asian: Asian Indian Cambodian Chinese Filipino		
*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	*Race: Japanese Korean (Check all that apply) Laotian Vietnamese Other Asian Hawaiian/Other Pacific Islander Guamanian Hawaiian Samoan Other Pacific Islander Declined/not stated 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	e 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		L

SAMPLE 2, CLUSTER 1

<u> </u>				
Provider Name:		Unique Participate ID:		
Region/Site Name:		Registration/Assessment Date:		
Region/Site Name:		Termination Date:	*Reason:	
-	· ·			
			*Chore (IIIB) (A, I)	
I ∐ *Home-Delivere	ed meals (A, I, N) Adult Day Car	re/Health (IIIB) (A, I)	*Case Management (IIIB) (A, I)	
Notes: Reference the	Data Dictionary for allowable "Other" service cate	gories; Requires A -ADLs, I-I,	ADLs, N -Nutritional Assessments on Page 2	
SECTION 1 (Client)				
		*16	haing militany officiated share below the	
	(Please print):		being military affiliated, check below if: agency and the California Department	
First Name:		of Aging transmitt	ting my name, email address, mailing	
Middle Initial:			ile telephone number to the terans Affairs only for the purpose of	
Last Name:		receiving addition	al information on veterans benefits for	
		which I may be eli valid for12 months	gible. I understand that this consent is	
*What is your	Transgender Female to Male	Yes [No	
gender? (Chock only one)	Genderqueer/Gender Non-binary		nia Department of Veterans Affairs ne eligibility for services and supports at	
		www.calvet.ca.gov		
	Declined/not stated	Residential Addre		
(Check only one)	Declined/not stated	Street:		
*How do you	Straight/Heterosexual	City:		
describe your	Gay/Lesbian/Same-Gender Loving	*Zip Code:		
*Home-Delivered Meals (A, I, N) *Adult Day Notes: Reference the Data Dictionary for allowable "Other" service of 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) *What was your sex at birth? (Check only one) *How do you describe your sexual identity? *How do you miltant *Have you ever served in the United States military? *Yes No *Declined/not stated Peclined/not stated	Mailing Address:	l		
		Same as Residentia	al? 🗌 Yes – Skip to Next Section	
	Declined/not stated	Street:		
		City:		
*Have you ever		*Zip Code:		
served in the			Neme	
	Ueclined/not stated	Emergency	Name: Relationship:	
		Contact:	Phone #: ()	
			Not Hispanic/Latino	
-		*Ethnicity:	Hispanic/Latino	
			Declined/not stated	
or child of a				
•				
in the United				
States military?				

[Page 1 of 3] CDA Sample 2, Cluster 1 Title III B, C-1, C-2, Registration-Assessment Form (2023)

*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	e 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:	
D : (0)(N		Registration/Assessm	ent Date:
Region/Site Name:		Termination Date:	*Reason:
Assisted Tran	s (Titles IIIB and IIIC): sportation	Meals (N)	☐ *Nutrition Counseling (ℕ)
SECTION 1 (Client)			
(*) Required for All Re		*If you identify as	being military affiliated, check below if:
PERSONAL DATA First Name:	(Please print):	"I consent to this	agency and the California Department
Middle Initial:			ing my name, email address, mailing ile telephone number to the
Last Name:			erans Affairs only for the purpose of al information on veterans benefits for
*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:	which I may be eli valid for12 months Yes Contact the Californ	gible. I understand that this consent is s."] No nia Department of Veterans Affairs ne eligibility for services and supports at
	Declined/not stated	*Birth Date:	
*What was your sex at birth? (Check only one)	Male Female Declined/not stated	Home Phone:	()
*How do you	Straight/Heterosexual	Residential Addre	SS:
describe your	Bisexual Gay/Lesbian/Same-Gender Loving	Street:	
sexual orientation or	Questioning/Unsure	City:	
sexual identity?	Not Listed, please specify:	*Zip Code:	
(Check only one)	Declined/not stated	Mailing Address: Same as Residentia	al? 🗌 Yes – Skip to Next Section
*Have you ever		Street:	
served in the United States	Yes No	City:	
military?		*Zip Code:	
*Are you the spouse, legal partner, parent, or child of a		Emergency Contact:	Name: Relationship: Phone #: ()
person who is serving in or who has served in the	Yes No Declined/not stated	*Ethnicity:	Not Hispanic/Latino Hispanic/Latino Declined/not stated
United States military?			

*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 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
	ssistance (Non-Assisted) tance (Assisted)

SECTION 2 – Nutritional Assessment (Annual)

* Required for (IIIC):	Congregate Meals	, Nutritional Counseling
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*Nutritional Assessment:	Circle if ye	es
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+
	Decline	ed 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. *Unique Participant ID:			te: rmination [Inact	tive Date: tive Date: tive Date: Reason:	
· ·							Reason.
*Date of Birth:				New client Annual reas Change in i	nformation		
First Name:				La	st Name:		
Home Address		(City:	I			*Zip Code
Home Phone: () Alternate Phone: ()				Addres	ency Contact Name: s: () Relationsł	nip:	
*Living Arrangement # of household members:	household members: \$				Declined/not	year stated	*Rural Area:
*What is your gender? *What wa (Check only one) birth? (Check only one) Male Female Transgender Male to Female Female		Check o e nale lined/not	only one) t stated	sexual identity? (Check only one) Straight/Hetero Bisexual Gay/Lesbian/S Questioning/U Not Listed, ples	Same-Gende Same-Gende nsure ase specify tated	r	
 *Have you ever served in the United States military? Yes 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 *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 		jal t ofar nor c t [consent to transmittin mobile tele only for the veterans be this conse Yes Contact the	ag my name, email a ephone number to the e purpose of receivi enefits for which I m nt is valid for12 mor No California Departme eligibility for services a	e California address, ma he Departm ing addition nay be eligi nths." nt of Vetera	a Department of Aging ailing address, and nent of Veterans Affairs	
Hispanic Yes No Declined/not stated			Languag	•	ng 🗌 Need interpret	er 🗌 Non-I	English/Language

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		
Dressing		Shopping Heavy Housework			1 – Independent 2 – Verbal	
Bathing		Manage Medication		Notes:		Assistance
Transferring In/Out of Chair		Money Management			3 – Some Human Help	
Walking		Telephone		4 – Lots of Human Help		
Toileting		Transportation				5 – Dependent 6 - Declined to State
Eligibility: Are you homebou Are you a spouse Are you an individ	Prioritization:					

*Nutritional Risk Assessment:	Circl	e 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+
	Decline	ed 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:

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.		R Ir S B	*Unique Participate ID: Referred by: Intake Date: Staff: Beginning Date: *Termination Date: *Reason:		Age Age Spou meal pai Disa UDisa UDisa UDisa UDisa UDisa UDisa UDisa Congre	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	
First Name:	L	ast Name:				*Date of Birt	
Home Address				City:			*Zip Code
Mailing Address: Same As	Residential?	Yes		City:			*Zip Code
Home Phone: () Alternate Phone: ()					Emergency Contact Address: Phone: () R		
		s your th? nly one) e	identity? one) (Check only one) Straight/Heterosexual Bisexual			Yes No Declined/not stated	
 *Have you ever served in the United States military? Yes 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.					
					aotian		

*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.	ć	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	2
I have tooth or mouth problems that make it hard for me to eat.	2	2
I don't always have enough money to buy the food I need.	2	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	l to Stat

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	Signature of	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:				
	*Termination Date: *Reason:				
Region/Site Name:					
Our de la Catalantia de la					
Service Categories:					
Notes: Check Eligibility criteria below to determine for which program caregivers					
Title III E, Family Caregiver Support	Program Services to be Provided				
Support Services:	Respite Care Services: In-Home Supervision				
Caregiver Assessment Caregiver Support	(Care Receiver must have Homemaker Assistance				
Caregiver Counseling Caregiver Training Caregiver Peer Counseling Case Management	2 or more ADL limitations, a I In-Home Personal Care cognitive impairment, or be Home Chore				
	grandparent/elder caregiver				
	to qualify)				
Supplemental Services: (Care Receiver must have 2 or mor					
grandparent/older caregiver to qualify)					
Assistive Devices Home Adaptations for Caregiving	Caregiving Services Registry Cash/Material Aid				
Access Assistance:	Information Services:				
Information & Assistance Caregiver Outreach	Public Information on Caregiving				
Interpretation/Translation Caregiver Legal Resources	Community Education on Caregiving				
	ribility Auitoria				
SECTION 2 – Eli Caregivers of Older Adults Eligibility Criteria	giblinty 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					
2. Is the Caregiver an adult (18 years of age or older) family n					
is an informal (i.e., unpaid) provider of in-home or community	care to an "elderly" Care Receiver? U Yes No				
If answered "yes" to both questions above, check "Family Car	egiver 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 <u>or</u> who is an individual (of any age) with a					
disability? 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	, ,				
legal or informal arrangement. Biological and adoptive parents					
If answered "yes" to both questions above, check "Older Rela					
If the Care Bessiver does not most any of the aritoria above t	the Corectiver is incligible to receive ECSP Older Polative				
If the Care Receiver does not meet any of the criteria above, the Caregivers services, but may qualify to receive other services	· · ·				

SECTION 3 (FCSP Caregiver) (*) Required for Family Caregiver Support Program Services

Caregiver Personal Data (Please print):		*If you identify as being military affiliated, check below if "I consent to this agency and the California Department		
*Unique Participant ID		of Aging transmitt	ing my name, email address, mailing ile telephone number to the	
First Name:		Department of Vet	erans Affairs only for the purpose of	
Middle Initial:			al information on veterans benefits for gible. I understand that this consent is	
Last Name:		valid for12 months		
*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		 No ia Department of Veterans Affairs ne eligibility for services and supports at or 1-800-952-5626. Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated 	
*What was your sex at birth? (Check only one)	Male Female Declined/not stated	*Federal Poverty Level (FPL):	Yes (At or below FPL) No (Above FPL) Declined/not stated	
	Straight/Heterosexual	*Lives Alone?	Yes No Declined/not stated	
*How do you describe your sexual	Bisexual Gay/Lesbian/Same-Gender Loving	*Rural?	Yes No Declined/not stated	
orientation or sexual identity? (Check only one)	Questioning/Unsure Not Listed, please specify: Declined/not stated		White Black American Indian/Alaska Native Asian: Asian Indian Cambodian Chinese Filipino	
*Birth Date:		*Race: (Check all that apply)	Japanese Korean Laotian Vietnamese Other	
Home Phone:	()		Asian Hawaiian/Other Pacific Islander	
Residential Address:			Other Pacific Islander	
Street:				
City:			Grandparent Domestic Partner	
*Zip Code:		*Relationship to	Son/Son-in-law	
Mailing Address: Same as Residential? Yes – Skip to Next Section		Care Receiver:	Brother Sister	
Street:			Non-Relative	
City:			Single (never married) Married	
*Zip Code: *Have you ever served in the United States military?		*Relationship Status:	Domestic Partner Separated Divorced Widowed Declined/not stated	
	No Declined/not stated			
	se, legal partner, parent, or child of a ving in or who has served in the United	*Employment:	Full Time Vnemployed Part Time Stated Retired	

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SECTION 4 (FCSP Care Receiver) (*) Required for Family Caregiver Support Program Services

Caregiver Persona	Il Data (Please print):		being military affiliated, check below if: agency and the California Department
*Unique Participant ID		of Aging transmit	ting my name, email address, mailing
First Name:		Department of Ve	bile telephone number to the terans Affairs only for the purpose of
Middle Initial:			nal information on veterans benefits for igible. I understand that this consent is
Last Name:		valid for12 month	•
*What is your	Male Female Transgender Male to Female Transgender Female to Male	Contact the Califor (CalVet) to determ www.calvet.ca.gov	nia Department of Veterans Affairs ine eligibility for services and supports at or 1-800-952-5626.
gender? (Check only one)	Genderqueer/Gender Non-binary	Mailing Address: Same as Resident	ial? 🔲 Yes – Skip to Next Section
	Declined/not stated	Street:	
*What was your	Male Female	City:	
sex at birth? (Check only one)	Male Female Declined/not stated	*Zip Code:	
(0.000, 0.0, 0.0,		Demographics:	1
*How do you describe your sexual	scribe your		 Not Hispanic/Latino Hispanic/Latino Declined/not stated
orientation or sexual identity? (Check only one)	Not Listed, please specify: Declined/not stated	*Federal Poverty Level (FPL):	 Yes (At or below FPL) No (Above FPL) Declined/not stated
*Birth Date:		*Lives Alone?	Yes No
Home Phone:	()	Lives Alone ?	Declined/not stated
Residential Addres	ss:	*Rural?	Yes No
Street:		*Race: (Select all	that apply)
City:			lack 🗌 American Indian/Alaska Native
*Zip Code:		Asian:	Cambodian Chinese
*Have you ever se	rved in the United States military?	Filipino	☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian
*Are you the spou	se, legal partner, parent, or child of a ving in or who has served in the United	Hawaiian/Other Pa	acific Islander Hawaiian Samoan slander
		*Relationship Status:	Single (never married) Married Domestic Partner Separated Divorced Widowed Declined/not stated

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SECTION 5 – (FCSP Care Receiver)

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

*Required for the Care Receiver only in Support Services, Respite Care, and Supplemental Services.

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

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

SAMPLE 7, TITLE III E, CAREGIVERS OF OLDER ADULTS

SECTION 1 – Service Information				
Provider Name:	Registration/Assessment Date:			
	*Termination Date: *Reason:			
Region/Site Name:	remination Date. Reason.			

Title III E, Family Caregiver Support Program Services to be Provided			
Support Services: Caregiver Assessment Caregiver Counseling Caregiver Peer Counseling Caregiver Peer Counseling	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 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 	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? 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?			
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:			

CECTION 4 Comises Info

SECTION 3 (FCSP Caregiver) (*) Required for Family Caregiver Support Program Services

Caregiver Persona	I Data (Please print):		s being military affiliated, check below if:		
*Unique		"I consent to this agency and the California Departm of Aging transmitting my name, email address, mail			
Participant ID First Name:		address, and mobile telephone number to the Department of Veterans Affairs only for the purpose or			
Middle Initial:		receiving additional information on veterans benefits for			
Last Name:		which I may be e valid for12 mont	eligible. I understand that this consent is hs."		
	Male Female	Yes	No		
	Transgender Male to Female		ornia Department of Veterans Affairs nine eligibility for services and supports at		
*What is your gender?	Transgender Female to Male Genderqueer/Gender Non-binary	ŭ	v or 1-800-952-5626.		
(Check only one)	Not Listed, please specify:	Demographics:			
	Declined/not stated	*Ethnicity:	 Not Hispanic/Latino Hispanic/Latino Declined/not stated 		
*What was your sex at birth?	Male Female C Declined/not stated	*Federal Poverty Level (FPL):	, ☐ Yes (At or below FPL) ☐ No (Above FPL)		
(Check only one)			Declined/not stated		
*How do you	Straight/Heterosexual	*Lives Alone?	Yes No Declined/not stated		
describe your sexual	Bisexual Gay/Lesbian/Same-Gender Loving Questioning/Unsure Not Listed, please specify:	*Rural?	Yes No		
orientation or		*Race: (Check al	*Race: (Check all that apply)		
sexual identity? (Check only one)					
(0.000, 0.0.)	Declined/not stated	Asian:	Cambodian Chinese		
*Birth Date:		🔲 Filipino	🔲 Japanese 🛛 🗌 Korean		
Home Phone:	()	Laotian Hawaiian/Other P	Vietnamese Other Asian		
Residential Address:		Guamanian Hawaiian Samoan			
Street:		Declined/not s			
City:			Husband Grandparent Domestic Partner		
*Zip Code:		*Relationship	Daughter/Daughter-in-law		
Mailing Address:		to Care Receiver:	Brother Sister		
Same as Residentia	al? Yes – Skip to Next Section	Neceivei.	Other Relative		
Street:			Declined/not stated		
City:			Single (never married) Married		
*Zip Code:		*Relationship Status:	Domestic Partner Separated Divorced Widowed		
*Have you ever served in the United States military?			Declined/not stated		
	se, legal partner, parent, or child of a ving in or who has served in the United	*Employment:	Full Time Unemployed Part Time Declined/not stated Retired		
Yes [No Declined/not stated				

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CDA Sample 7, Title III E, Caregivers of Older Adults, Registration-Assessment Form (2023)

SECTION 4 (FCSP Care Receiver)

(*) Required for Family Caregiver Support Program Services

Caregiver Persona	I Data (Please print):	*If you identify as being military affiliated, check below	
*Unique Participant ID		"I consent to this agency and the California Departmen of Aging transmitting my name, email address, mailing address, and mobile telephone number to the	
First Name:		Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for	or
Middle Initial:		which I may be eligible. I understand that this consent i valid for12 months."	S
Last Name:		Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at	
	Male Female	www.calvet.ca.gov or 1-800-952-5626.	
*What is your gender?	Transgender Male to Female Transgender Female to Male Genderqueer/Gender Non-binary	Mailing Address: Same as Residential? Yes – Skip to Next Section	
(Check only one)	Not Listed, please specify:	Street:	
	Declined/not stated	City:	
*What was your		*Zip Code:	
sex at birth?	Male Female Control	Demographics:	
(Check only one)	CK ONIY ONE)	*Ethnicity: Not Hispanic/Latino *Ethnicity: Hispanic/Latino	
*How do you describe your sexual orientation or	Bisexual Gay/Lesbian/Same-Gender Loving Questioning/Unsure	*Federal Poverty Level (FPL):	
sexual identity? (Check only one)	Not Listed, please specify: Declined/not stated	*Lives Alone?	
*Birth Date:		*Rural?	
Home Phone:	()	*Race: (Check all that apply)	
Residential Addres	ss.	White Black American Indian/Alaska Native Asian:	
Street:		Asian Indian Cambodian Chinese	
City:		Filipino Japanese Korean	an
-		Hawaiian/Other Pacific Islander	
*Zip Code:	read in the United States military?	Other Pacific Islander	
Yes	Image: No Image: Declined/not stated	Declined/not stated	
	se, legal partner, parent, or child of a	Single (never married)	
	ving in or who has served in the United	Married	
States military?	No Declined/not stated	*Relationship	
		Status:	

Declined/not stated

SECTION 5 – (FCSP Care Receiver)

		OFOLION				
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
Dressing		Shopping		Light Housework		2 – Verbal Assistance
Bathing		Manage Medication		Notes:		3 – Some Human Help
Transferring In/Out of Chair		Money Management				4 – Lots of Human Help
Walking		Telephone				5 – Dependent 6 - Declined to
Toileting		Transportation				State

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 Peer Counseling	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 Out of Home Day Out of Home Overnight	
Supplemental Services: (Care Receiver must have 2 or mor grandparent/older caregiver to qualify) Assistive Devices Home Adaptations for Caregiving		
Access Assistance: Information & Assistance Caregiver Outreach Interpretation/Translation Caregiver Legal Resources	Information Services: Public Information on Caregiving Community Education on Caregiving	
SECTION 2 – Eli	gibility Criteria	
 Is the Care Receiver an individual who is not more than 18 Yes No Is the Caregiver a grandparent, step-grandparent, or other adoption who is 55 year of age or older living with the Care Relegal or informal arrangement? Biological and adoptive parent If the Care Receiver does not meet any of the criteria above, Caregivers services but may qualify to receive other services Notes: 	older relative of the Care Receiver by blood, marriage, or eceiver, and identified as the primary caregiver through a ts are excluded Yes No the Caregiver is ineligible to receive FCSP Older Relative	

SECTION 3 (Older Caregiver) (*) Required for Family Caregiver Support Program Services

Caregiver Persona	al Data (Please print):		as being military affiliated, check below if: his agency and the California Department
*Unique Participant ID		of Aging trans	mitting my name, email address, mailing
First Name:		Department of	nobile telephone number to the Veterans Affairs only for the purpose of
Middle Initial:		which I may be	tional information on veterans benefits for e eligible. I understand that this consent is
Last Name:		valid for12 mo	nths." □ No
M □ T	Male Female Transgender Male to Female Transgender Female to Male	(CalVet) to dete www.calvet.ca.	lifornia Department of Veterans Affairs ermine eligibility for services and supports at gov or 1-800-952-5626.
gender? (Check only one)	Genderqueer/Gender Non-binary	Demographics	Not Hispanic/Latino
	Declined/not stated	*Ethnicity:	Hispanic/Latino
*What was your sex at birth? (Check only one)	Male Female Declined/not stated	*Federal Pover Level (FPL):	rty Yes (At or below FPL)
*How do you describe your sexual	Straight/Heterosexual Bisexual Gay/Lesbian/Same-Gender Loving	*Lives Alone?	Yes No Declined/not stated
orientation or sexual identity?	Questioning/Unsure Not Listed, please specify:	*Rural?	Yes No Declined/not stated
(Check only one)	Declined/not stated	*Race: (Check	
*Birth Date:		White Asian:	Black American Indian/Alaska Native
Home Phone:	()	Asian Indian	n 🗌 Cambodian 🔄 Chinese
Residential Addres	SS:	🗌 Laotian	Vietnamese Other Asian
Street:		Guamanian	🗌 Hawaiian 🔄 Samoan
City:			
*Zip Code:		*Relationship	Grandparent Parent
Mailing Address: Same as Residentia	al? 🗌 Yes – Skip to Next Section	to Care Receiver:	Non-Relative Declined/not stated
Street:			Single (never married)
City: *Zip Code:		*Relationship Status:	Domestic Partner Separated Divorced Declined/not stated
Yes *Are you the spous	rved in the United States military? No Declined/not stated se, legal partner, parent, or child of a ving in or who has served in the United	*Employment:	Full Time Unemployed Part Time Declined/not stated Retired
States military?	No Declined/not stated		

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CDA Sample 8, Title III E, Older Relative Caregivers, Registration-Assessment Form (2023)

SECTION 4 (Care Receiver) (*) Required for Family Caregiver Support Program Services

Caregiver Persona	Il Data (Please print):		being military affiliated, check below if:
*Unique Participant ID		of Aging transmit	agency and the California Department tting my name, email address, mailing bile telephone number to the
First Name:		receiving addition	eterans Affairs only for the purpose of nal information on veterans benefits for
Middle Initial:		which I may be el valid for12 month	ligible. I understand that this consent is is." No
Last Name:		Contact the Califor	rnia Department of Veterans Affairs ine eligibility for services and supports at
	Male Female	www.calvet.ca.gov	v or 1-800-952-5626.
*What is your	Transgender Male to Female Transgender Female to Male Condensus of Condension	Mailing Address: Same as Resident	ial? 🗌 Yes – Skip to Next Section
gender? (Check only one)	Genderqueer/Gender Non-binary	Street:	
	Declined/not stated	City:	
*What was your		*Zip Code:	
sex at birth?		Demographics:	
(Check only one)	Declined/not stated Straight/Heterosexual	*Ethnicity:	 Not Hispanic/Latino Hispanic/Latino Declined/not stated
*How do you describe your sexual orientation or	*Federal Poverty Level (FPL):	Yes (At or below FPL) No (Above FPL) Declined/not stated	
sexual identity? (Check only one)	Not Listed, please specify: Declined/not stated	*Lives Alone?	Yes No
*Birth Date:		*Rural?	Yes No Declined/not stated
Home Phone:	()	*Race: (Check all	
Residential Addres	· · ·	B White B Asian:	lack 🗌 American Indian/Alaska Native
	55.	Asian Indian	🗌 Cambodian 🛛 🗌 Chinese
Street:		Filipino	Japanese Korean
City:		Hawaiian/Other Pa	
*Zip Code:		Guamanian	Hawaiian Samoan
	rved in the United States military?	Declined/not st	
	No Declined/not stated se, legal partner, parent, or child of a ving in or who has served in the United No 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	l		☐ White ☐ Black	
*Unique Participant ID:			American Indian/Alaska Native Asian: Asian Indian Cambodian Chinese Filipino Japanese Korean	
Name:		*Race:		
*Birth Date:		(Check all that apply)	Laotian Vietnamese Other Asian	
Home Phone #:	()		Hawaiian/Other Pacific Islander	
Email:			Other Pacific Islander Declined/not stated	
Address:		*Federal Poverty Level (FPL):	Yes (At or below FPL) No (Above FPL) Declined/not stated	
*What is your	Male Female Transgender Male to Female Transgender Female to Male	*Lives Alone?	Yes No Declined/not stated	
gender?Genderqueer/Gender Non-binary(Check only one)Not Listed, please specify:	*Rural?	Yes No Declined/not stated		
	Declined/not stated	*Have you ever se	*Have you ever served in the United States military?	
*What was your sex at birth? (Check only one)	Male Female Declined/not stated		se, legal partner, parent, or child of a ving in or who has served in the United	
*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 	 *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 		
*Ethnicity:	Not Hispanic/Latino Hispanic/Latino Declined/not stated	(CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.		
		Service Requested	d:	

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: 	
*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):	