AREA AGENCY ON AGING OF NORTH CENTRAL TEXAS
CARE COORDINATION INTAKE/REFERRAL FORM

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

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

DATE:	**CLIENT ID NUMBER: (For internal use only)**

CLIENT INFORMATION:

NAME: (Last, MI, First)

HOME ADDRESS: STREET/Apt. #: (Number, City, State & ZIP) **COUNTY:**

( ) Check if Mailing Address is Home Address:

PHONE: (_____) _____ Home ( ) Cell ( ) Other ( ) (Check One)

GENDER: ( ) M ( ) F

DOB:

ETHNICITY (Check One):
- **( ) Hispanic or Latino**
- **( ) Not Hispanic or Latino**
- **( ) Ethnicity Not Reported**
- **( ) Consumer declined to provide**

PRIMARY LANGUAGE:
- ( ) English
- ( ) Other _____

RACE (Check all that apply):
- **( ) White - Non Hispanic**
- **( ) White - Hispanic**
- **( ) American Indian/Alaska Native**
- **( ) Asian**
- **( ) Black or African American**
- **( ) Native Hawaiian or Pacific Islander**
- **( ) Persons Reporting Some Other Race**
- **( ) Race Not Reported**
- **( ) Consumer declined to provide**

DOES CLIENT LIVE ALONE? ( ) Y ( ) N

Total Number of Family Members in Household Including Client: _____

IS CLIENT RECEIVING MEDICAID? ( ) Y ( ) N

MARITAL STATUS:
- ( ) Married
- ( ) Widowed
- ( ) Divorced
- ( ) Separated
- ( ) Never Married
- ( ) Not Reported

TOTAL MONTHLY HOUSEHOLD INCOME (2020):

- ( ) **Poverty**
  (Single person family unit < =$1,063/mo)
  (Two person family unit <=$1,437/mo)
- ( ) **Low (150% FPL)**
  (Single person family unit <=$1,595/mo)
  (Two person family unit <= $2,155/mo)
- ( ) **Moderate**
  (Single person family unit >$1,595, but <=$9,700/mo)
  (Two person family unit >$2,155, but <=$11,083/mo)
- ( ) **High**
  (Single person family unit > $9,700/mo)
  (Two person unit > $11,083/mo)
- ( ) **Consumer declined to provide**

CARE COORDINATION INTAKE/REFERRAL FORM

EMERGENCY CONTACT INFORMATION:

Name: Phone/s: (____) _____

Relationship to client: Primary Caregiver: ( ) Y ( ) N

SERVICES REQUESTED:

( ) Emergency Response System
( ) Health Maintenance Supplies/Nutritional Supplements
( ) Home-Delivered Meals
( ) Homemaker (Housekeeping)
( ) Medication Management
( ) Personal Care
( ) Prescription Assistance
( ) Residential Repair
( ) Utility Assistance
( ) Benefits Counseling
( ) Transportation
( ) Other:

If client requests in-home services other than home-delivered meals, fax form to 940-222-4741.

REFERRAL SOURCE:

Name:

Phone number: (____) _____

Relationship to Caregiver/Recipient:

DIAGNOSIS/HEALTH STATUS:

WAS A REFERRAL MADE TO HHS? Yes ( ) No ( )

COMMENTS:

To be completed by AAA/provider staff:

Nutrition Services: If participant is "other Older Americans Act (OAA) or Nutrition Service Incentive Program (NSIP) eligible participant under 60 years of age," check which of the following applies:

(1) Spouse is eligible and participates in congregate or home delivered meal program. ☐
(2) Serves as volunteer at the nutrition site in accordance with OAA standards. ☐
(3) Disabled/resides in the housing facility and wants to participate in the congregate meal program provided at the site. ☐
(4) Disabled and lives with a 60+ person who is eligible for congregate or home delivered meal program. ☐

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