Area Agency on Aging of the Capital Area (AAACAP) – Client Services Intake Form

Funded in Part by Health and Human Services

All information, requested is required and used as statistical data for funding purposes. – PLEASE PRINT

Release of Information: Information from this form may be used by the AAACAP and the Health & Human Services. All information will remain confidential and used only for official purposes. Information gathered from intake or assessment may be used to effectively plan, arrange and deliver services. (Client Initials _____ Date: ____/____/_____)

Date Registered/Intake Date [MM/DD/YEAR]: _____/_____/_____

____NEW ____Update _____Reinstatement ____Congregate ____Home Delivered ____Transportation

Mark One Eligibility: Age 60 or 0ver: _____ Spouse of Eligible Client: _____

Other: Person under age 60 with a disability living in elderly housing: ____ Volunteer: ____

_____Person under age 60 with a disability living with person age 60 or over

NAME: [First MI Last] _____ AKA: _____

Date of Birth: [MM/DD/YEAR] _____/_____/_____ Gender: Male ____ Female ____

Lives Alone? Yes ___ No___ Disabled: Yes ____ No ____

Understands English: ___Yes If No, primary language is: _____

Client Annual Income: _____below < $12,600 > _____above Military Service: ____Yes _____No

Phone: _____- _____-_____ Mark if this is a cell phone: _____ No Phone: _____

Residential Address: _____

City: _____ County: _____ Zip Code: _____ TX

Mailing address (If different): _____

Ethnic Race: ___ American Indian/Alaskan Native ___ Asian ___ Black/African American ____ White Hispanic
___ White Non-Hispanic [non-minority] ___ Native Hawaiian/Pacific Islander ___ Other: _____

Ethnicity: _____ Hispanic or Latino _____ Not Hispanic or Latino _____Other: _____

Targeting Criteria: Mark all that apply for Those Age 60 or over for funding purposes only.

____At risk of institutional placement _____Resides in rural area _____Has greatest economic need
____Has greatest social need _____Has Alzheimer's disease or related disorders/dysfunctions
____Has severe disability _____Has limited English proficiency

EMERGENCY CONTACT: List Only One. Mark here if there is NO Emergency contact: _____
Name: _____ Relationship: _____
Phone Number: _____- _____-_____ ____ Check if this is a cell phone.

Release of information has been read by the client on: _____/_____/_____

++FOR OFFICE USE ONLY++

Printed Name of staff/volunteer reviewing intake: _____

Signature of staff/volunteer reviewing intake: _____

Date Form Completed: _____/_____/_____

Provider/Site/Route: _____ Phone: _____-_____-_____

Notes_____