AREA AGENCY ON AGING OF THE COASTAL BEND
PROVIDER: CITY OF PORT ARANSAS

CLIENT INTAKE AND SERVICE REQUEST FORM

C1	
C2	
Trans	
Access/Assist	

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

Client's Primary Language:

Release of information has been clearly explained to the client. ☒

Date: _____ **Client ID Number:** _____

Last Name: _____ **MI:** _____ **First Name:** _____

Street Address/Apt. #: _____ **P.O. Box:** _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____

Phone: (**)** _____ **Gender: Male** ☐ **Female** ☐ **Birth Date:** _____

Ethnicity (Check One):		**Race (Check all that apply):**		**Marital Status (Check One):**	
(1) Hispanic or Latino	☐	(1) White – Non Hispanic	☐	(1) Married	☐
(2) Not Hispanic or Latino	☐	(2) White – Hispanic	☐	(2) Widowed	☐
(3) Ethnicity Not Reported	☐	(3) American Indian/Alaska Native	☐	(3) Divorced	☐
		(4) Asian	☐	(4) Separated	☐
		(5) Black or African American	☐	(5) Never Married	☐
		(6) Native Hawaiian or Pacific Islander	☐	(6) Not Reported	☐
		(7) Persons Reporting Some Other Race	☐		
		(8) Race Not Reported	☐		

Monthly Income from:		**Individual**		**Spouse**
1. Job (Employment)				
2. Social Security				
3. SSI				
4. VA				
5. Other Sources (Other Income)				
Total Income (Add numbers 1-5)				
Other Benefits (e.g., Food Stamps)				

Does client live alone? Yes ☐ No ☐

Total Number of Family Members in Household Including Client:_____

Monthly Household Income: $_____ Low Income ☐ Moderate Income ☐ High Income ☐

(Low: Single person family unit - $1,005 mo. / $12, 060 annually)
(Moderate: Single unit - $1,006 mo. - $1,746 mo.)
(High: Single unit - $1,747 mo. – Above)
(2017 HHS Poverty Guidelines)

(Two person family unit - $1,353 mo. / $16,240 annually)
(Two person unit - $1,354 - $2,342 mo.)
(Two person unit - $2,343 mo. – Above)

Total Resources: $_____

Emergency Contact Information:

Contact Name: _____ Phone: (____) _____

Relationship: _____

Primary Care Physician: _____ Phone: (____) _____

Service(s) Requested: Congregate: ☐ Hm Delivery Meals: ☐ Trans: ☐ Other: ☐ _____

Are you enrolled in? ☐ Medicare #: _____ ☐ Medicaid #: _____

Referred By:

☐ **Texas Department of Family & Protective Services (DFPS)** ☐ **Texas Department of Assistive & Rehabilitative Services (DARS)**

☐ **Texas Department of State Health Services (DSHS)** ☐ **Doctor** ☐ **Hospital** ☐ **Assisted Living Facility**

☐ **Home & Community Care Organization** ☐ **Family Member** ☐ **Other _____**

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) A. Spouse is eligible and participates at the nutrition site
Name of eligible participant 60 years or older: _____ ☐

B. Spouse is eligible for HDM as the meal has been determined to be in the best interest of the homebound older person
Name of eligible participant 60 years or older: _____ ☐

(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 the person participating in congregate meal program. ☐

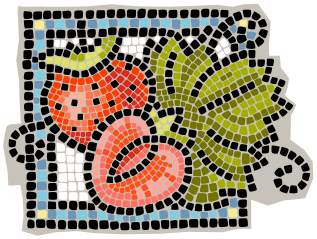
_____ _____
Signature of AAA/Provider Staff Completing Intake Date

Provider/Center: City of Port Aransas

Client Name: _____

Client ID: _____

Date: _____



DETERMINE YOUR NUTRITIONAL HEALTH

AGING SERVICES NUTRITION RICK ASSESSMENT

Good Nutritional health has many benefits, including disease prevention health promotion and increased recovery time from sickness and injury. The warning signs of poor nutritional health are often overlooked. Use this checklist to find out if you are at risk.

TO COMPLETE THE ASSESSMENT: Read the statements below. Circle the number in the YES column for those that apply to you. Add the circled numbers to get your TOTAL SCORE.

	YES
1. I have an illness or condition that made me change the kind and/or amount of food I eat.	2
2. I eat fewer than two meals a day.	3
3. I eat few fruits or vegetables, or milk products.	2
4. I have three or more drinks of beer, liquor or wine almost every day.	2
5. I have tooth or mouth problems that make it hard for me to eat.	2
6. I don't always have enough money to buy the food I need.	4
7. I eat alone most of the time.	1
8. I take three or more different prescribed or over-the-counter drugs a day.	1
9. Without wanting to, I have lost or gained ten pounds in the last six month.	2
10. I am not always physically able to shop, cook and/or feed myself.	2
TOTAL SCORE	

What your TOTAL SCORE means:

0-2 **Good! Recheck your nutritional score in 12 months.**

3-5 **Moderate Nutritional Risk. See what can be done to improve your eating habits and lifestyle.**

6 or More **High Nutritional Risk. Bring this checklist the next time you see your doctor.**

ALL CONGREGATE AND HOME DELIVERED MEAL PARTICIPANTS SHOULD COMPLETE THIS ASSESSMENT ANNUALLY.

Note to Staff Conducting Risk Assessment: Using the practical nutrition tips that are listed as a guide in the attachment, Steps You Can Take To Improve Your Nutritional Health, discuss the nutrition tips associated with Nutrition Risk Statements 1-10 that have been circled. Circle all areas discussed with your client here:

1 2 3 4 5 6 7 8 9 10

Staff Providing Nutrition Education _____ **Date** _____

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

Consumer Name: _____

Consumer Number: _____

Assessment Date: _____

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

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

Notes:

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

Consumer Name: _____

Consumer Number: _____

Assessment Date: _____

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

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

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

Consumer Name: _____

Consumer Number: _____

Assessment Date: _____

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

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

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

_____ _____
Signature of AAA/Provider Staff Assessor Date

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

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

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

Area Agency on Aging of the Coastal Bend

Access & Assistance Program

Client Rights & Responsibilities for Older Americans Act Programs

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

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

Client rights and responsibilities:

1. You have the right to be treated with respect and consideration. You have the right to have your property treated with respect.

2. You may not be denied services on the basis of race, religion, color, national origin, sex, disability, marital status, or inability and/or unwillingness to contribute.

3. You have the right to make a complaint/grievance or recommend changes to policy or service, without restraint, interference, coercion, discrimination or reprisal. To make a complaint or grievance, contact the Area Agency on Aging. Contact information is identified below:

Service Provider Information	Phone Number
Stephanie Montgomery, City of Port Aransas	361-749-4111
Contact: Mary Santos, Assistant Director	361-387-6396
Edward Herrera, Director	361-387-5445
Commissioners Court	361-888-0444
Area Agency on Aging Information	
Gilbert Guajardo, Assistant Director	361-883-3935, ext. 5145 1-800-817-5713
Betty Lamb	361-883-3935, etc. 5143 1-800-817-5743

4. You have the right to participate in the development of a care plan to address unmet needs.
☒ N/A

5. You have the right to be informed in writing of available services and the applicable charges if the services are not covered or are unavailable by Medicare, Medicaid, health insurance, or Older Americans Act funding. ☒ N/A

6. You have the right to make an independent choice of service providers from the list furnished by the Area Agency on Aging where multiple service providers are available, and change service providers when desired. ☒ N/A

7. You have the right to be informed of any change in service(s). ☐ N/A

8. You have the right to make a voluntary, confidential, contribution for services received through the Area Agency on Aging. Services will not be denied if an eligible participant is unable or chooses not to make a contribution. All contributions will be kept confidential and will be utilized to expand or enhance the service(s) for which they were provided.

9. You have the responsibility to inform the Area Agency on Aging or its service provider(s) of your intent to withdraw from the program or any known periods of absenteeism when services will not be utilized. ☐ N/A

10. You have the responsibility to provide the Area Agency on Aging or its service provider(s) with complete and accurate information.

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

_____

Print Client Name

➡ _____ _____

Client Signature Date

Area Agency on Aging of Coastal Bend

Client Information Release

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

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

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

PART A – Release of Information

I understand that my information may contain protected health information. Release my information to the following person or agency: ☒ Any person or agency necessary to meet my service needs.

☐ Only the persons or entities identified:

Check one of the following: ☒ Release all of my information. ☐ Release only the following information:

PART B – Purpose of Release

☒ General: To assist in assessing, arranging, and meeting individual service needs.

☐ Specific:

☐ Expiration: This authorization expires at point of reassessment, where applicable, or within three years of effective date.

PART C – Signature

(Client or Personal Representative)	(Date)

☐ Check if you are signing for the client and please describe your authority to act for the client on the following line:

Note: If the person requesting the release of information cannot sign his/her name, two witnesses to his/her mark (X) must sign below. Accept one witness signature in circumstances where it is not possible to obtain two witness signatures. Document the reason in the client file.

Witness:	Date:
Witness:	Date:

Notice to Client:

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