TEXAS
Health and Human Services

Form 2276
October 2021-E

Intake

Area Agency on Aging of _____

The information on this form is needed to provide services. All information is confidential and will be guarded against unofficial use and shared only to get services started or changed.

☐ ***Release of Information and Client Rights and Responsibilities* explained.**

Note: All items marked with an asterisk (*) are required.

Part I – Recipient Identification

*Date:	SPURS ID No.:		Primary Language:	
*Last Name:	*First Name:	*MI:	*Date of Birth:	*Gender:
*Street Address and Apt. No.:	*City:	*State:	*ZIP Code:	*County:
*Area Code and Phone No.: Home	Email Address:			
☐ Check if Mailing Address is different from Home Address and enter Mailing Address below:				
*Street Address and Apt. No. or P.O. Box:	*City:	*State:	*ZIP Code:	*County:

***Ethnicity** *(Check One)*:	***Race** *(Check all that apply)*:	**Marital Status** *(Check One)*:
◯ Hispanic or Latino	☐ American Indian or Alaska Native	◯ Married
◯ Not Hispanic or Latino	☐ Asian	◯ Widowed
◯ Unknown	☐ Black or African American	◯ Divorced
	☐ Native Hawaiian or Pacific Islander	◯ Separated
	☐ Non-Minority (White, Non-Hispanic)	◯ Never Married
	☐ White – Hispanic	◯ Not Reported

*Person lives alone? ◯ Yes ◯ No ◯ Don't Know	Total No. of People in Household:	Monthly Household Income:
Use current Department of Health and Human Services Federal Poverty Guidelines for size of household to decide if person is at or below poverty.		*At or below poverty? ◯ Yes ◯ No ◯ Don't Know

Monthly Income from:	**Participant**	**Spouse**
Job		
Social Security		
Supplemental Security Income		
Veterans Affairs		
Other Sources		
Other Benefits [e.g., Supplemental Nutritional Assistance Program (SNAP)]		

Part II – Service(s) Requested *(Completed by AAA or provider staff)*

List of Requested Services:

Are you enrolled in? ☐ Medicaid ☐ Medicare

Part III – Emergency Contact Information *(Completed by AAA or provider staff)*

Contact Name:	Relationship:	Area Code and Phone No.:
Primary Care Physician:		Area Code and Phone No.:

Part IV – Referral *(Completed by AAA or provider staff)*

Referred by: _____

_____ _____
*Name of AAA or Provider Staff Completing Intake *Date

Part V – Nutrition Services *(Completed by AAA or provider staff)*

*Additional Eligibility Requirements if eligible person is under 60. Check which of the following applies:

☐ Eligible person is under 60 and the spouse of person 60 or older who takes part in the nutrition program.

☐ Eligible person is under 60, serves as volunteer at the nutrition site and the provider offers a meal according to AAA procedures.

☐ Eligible person is under 60, has a disability and lives in a housing facility occupied primarily by people 60 and over where congregate meals are served.

☐ Eligible person is under 60, has a disability, lives with a person eligible for a meal and the provider offers a meal according to AAA procedures.

Provider/Center: _____

Client Name: _____

Client ID: _____

Date: _____

DETERMINE
YOUR
NUTRITIONAL
HEALTH

AGING SERVICES NUTRITION RISK 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 Assessments: 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 client here:

1 2 3 4 5 6 7 8 9 10

➡ _____ _____

Staff Providing Nutrition Education **Date**

Funded by the Texas Department of Aging and Disability Services

Form #AIAA_Int_6.0
6/11/21

Edition Date:

TEXAS
Health and Human Services

October 2021

Consumer Needs Evaluation

Part I – Assessment Information

Consumer Name:	
SPURS ID No.:	
Assessment Date:	

Part II - Daily Living Impairment Assessment

Texas Impairment Scoring **0** = None **1** = Mild **2** = Severe **3** = Total Impairment	**ADL**: Activity of Daily Living **IADL**: Instrumental Activity of Daily Living	**State Program Report (SPR) Count =** **# of Questions Scored ≥ 1** **ADLs** questions 1-3 and 5-7 **IADLs** questions 9-13 and 17-19	**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. **S** = Self

Question	Texas Score	ADL/ IADL	SPR Count	Service Arrangement (Select only one.)
1. Do you have any problems taking a bath or shower?		ADL		☐C ☐P ☐A ☐N ☐S
2. Can you dress yourself?		ADL		☐C ☐P ☐A ☐N ☐S
3. Can you feed yourself?		ADL		☐C ☐P ☐A ☐N ☐S
4. Can you groom yourself (shave, brush your teeth, shampoo and comb your hair)?				☐C ☐P ☐A ☐N ☐S
5. Do you have problems with incontinence (getting to the bathroom in time)?		ADL		☐C ☐P ☐A ☐N ☐S
6. Do you have problems getting on or off the toilet or cleaning yourself after using the bathroom?		ADL		☐C ☐P ☐A ☐N ☐S
7. Can you get in and out of your bed or chair?		ADL		☐C ☐P ☐A ☐N ☐S
8. Are you able to walk without help?				☐C ☐P ☐A ☐N ☐S
9. Can you clean your house (sweep, dust, wash dishes, vacuum)?		IADL		☐C ☐P ☐A ☐N ☐S
10. Can you do your own laundry?		IADL		☐C ☐P ☐A ☐N ☐S
11. Can you fix your meals?		IADL		☐C ☐P ☐A ☐N ☐S
12. Can you do your own shopping?		IADL		☐C ☐P ☐A ☐N ☐S
13. Can you take your own medicine?		IADL		☐C ☐P ☐A ☐N ☐S
14. Can you trim your nails?				☐C ☐P ☐A ☐N ☐S
15. Do you have any problems keeping your balance?				☐C ☐P ☐A ☐N ☐S
16. Can you open jars, cans, bottles?				☐C ☐P ☐A ☐N ☐S

Question	Texas Score*	ADL/ IADL	SPR Count	Service Arrangement (Select only one.)
17. Can you use the phone?		IADL		☐C ☐P ☐A ☐N ☐S
18. Are you able to perform transportation on your own?		IADL		☐C ☐P ☐A ☐N ☐S
19. Do you have any trouble managing your money?		IADL		☐C ☐P ☐A ☐N ☐S

Part III - Mental Health Screening and Assessment

Question	Scoring	Texas Score
20. 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?	**0** = No. Go to Part IV. **1** = If "Yes" to Question 20 *and* "No" to Questions 21-24. **2** = If "Yes" to Question 20 *and* "Yes" to only one of Questions 21-24. **3** = If "Yes" to Question 20 *and* "Yes" to two or more of Questions 21-24.	

If "Yes" to Question 20, continue. If "No", skip to Part IV.

In the last two weeks, most of the day, nearly every day: (*Based on Consumer's perception of self*)	**Answer**
21. ...have you had problems sleeping?	☐Yes ☐No
22. ...have you lost the ability to enjoy things that once were fun?	☐Yes ☐No
23. ...do you feel that you have little value as a person?	☐Yes ☐No
24. ...have you had a significant change in your appetite?	☐Yes ☐No

Part IV - Cognition

Self-Evaluation	Scoring	Texas Score
25. During the last two 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.	
Third Party Observation	**Scoring**	**Texas Score**
26. Can the consumer 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 or supervision for most decisions. **3** = Severely impaired, rarely makes own decisions.	

Third Party Observation	Scoring	Texas Score
27. 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 and 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 an inability to perform routine tasks on a daily basis.	

Part V - Assessment Scores

Assessment	Texas Score	SPR Count
Total CNE Impairment Score (out of 60) ☐ **Low (Score 0-19)** ☐ **Moderate (Score 20-39)*** ☐ **Severe (Score 40 and above)**		
SPR ADL Count (Score 0-6)		
SPR IADL Count (Score 0-8)		

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

Signature of AAA or Provider Staff Assessor

Date

Area Agency on Aging OF THE COASTAL BEND

Provider:_____

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 age 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 of 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	
Carmen Pena Osornia- Assistance Director	361-387-6396	
Edward Herrera-Director	361-387-5445	
Area Agency on Aging Information		
Contact:		
Gilbert Guajardo, AAA Asst. Director	361-883-3935 ext/ 5145	1-855-937-2372
Viola Monrreal, AAA Director	361-883-3935 ext/ 5155	1-855-937-2372

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

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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 services 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.

➡ _____ _____

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:

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