

COUNTY OF LOS ANGELES

Area Agency on Aging
Universal Client Intake Form

Tracking # _____
 Originating Agency _____
 Original _____
 Update _____

Place Barcode
Label Here

CLIENT INFORMATION	1	Applicant Name (Last, First, Middle)		Signature		
	Social Security Number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Birth Date	Military Services <input type="checkbox"/> Yes <input type="checkbox"/> No
	Employment Status (Check one) <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed					
	Disability <input type="checkbox"/> Blind <input type="checkbox"/> Deaf <input type="checkbox"/> Physically Disabled <input type="checkbox"/> Cognitive Impairment					
	Marital Status (Check one) <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Living Together <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated					
	Home Address (Number & Street)			City	State	Zip Code
	Mailing Address (If different from above)			City	State	Zip Code
	Home Phone ()		Work Phone ()		Ethnic Group (write code number from bottom) Ethnic Code:	
	Primary Language (write code number from bottom) Language Code: _____ Translation Needed <input type="checkbox"/> Yes <input type="checkbox"/> No					
	EMERGENCY CONTACT	2	Contact Name (Last, First, Middle)			
Home Phone ()		Work Phone ()		Relationship (write code number from bottom) Relationship Code:		
Caregiver Contact (complete only if you have a Caregiver)				Caregiver Phone Number ()		
Caregiver Address (Number & Street)			City	State	Zip Code	
Home Phone ()		Work Phone ()		Relationship (write code number from bottom) Relationship Code:		
Physician Name				Office Phone ()		
Physician Address (Number & Street)			City	State	Zip Code	
CODE	Ethnic 01 - Non-Minority(white, not Hispanic) 02 - Black/African American 03 - Alaskan Native/American Indian 04 - Hispanic(of any race) 05 - Asian Indian 06 - Cambodian 07 - Chinese 08 - Filipino 09 - Guamanian 10 - Native Hawaiian 11 - Japanese 12 - Korean 13 - Laotian 14 - Samoan 15 - Vietnamese 16 - Other					
	Relationship 01 - Self 02 - Spouse 03 - Significant Other 04 - Son/Daughter 05 - Relative 06 - Friend 07 - Neighbor 08 - Clergy 09 - Landlord 10 -Legal Representative 11 - Health Care Provider 12 - Mental Health Provider 13 - Social Services Provider 14 - APS/Emergency Services 15 - Public Utilities 16 - Private Industry 17 - Gov't/Elected Official 18 - Caregiver 19 - Other					
	Language 01- Arabic 02 - Armenian 03 - Cambodian 04 - Cantonese 05 - English 06 - French 07 - Japanese 08 - Korean 09 - Mandarin 10 - Spanish 11 - Tagalog 12 - Vietnamese					

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SCREENING INFORMATION	3	Nutritional Risk Points: <input type="checkbox"/> 3-Eats fewer than 2 meals per day <input type="checkbox"/> 1-Eats alone most of the time <input type="checkbox"/> 2-Eats few fruit, vegetables or milk products <input type="checkbox"/> 2-Has 3 or more drinks of beer, liquor or wine almost every day <input type="checkbox"/> 2-An illness or condition caused change in kind/amount of food eaten <input type="checkbox"/> 4-Doesn't always have enough money to buy food needed <input type="checkbox"/> 2-Has tooth or mouth problems that make it hard to eat <input type="checkbox"/> 1-Takes 3 or more different prescribed or over-the-counter drugs a day <input type="checkbox"/> 2-Has involuntarily lost or gained 10 pounds in the last 6 months <input type="checkbox"/> 2-Is not always physically able to shop, cook &/or feed <div style="text-align: right;">Total Points-Risk Score _____</div>	
	Needs Assistance – ADL: <input type="checkbox"/> Walking <input type="checkbox"/> Transferring <input type="checkbox"/> Dressing <input type="checkbox"/> Bathing <input type="checkbox"/> Toileting <input type="checkbox"/> Eating <div style="text-align: right;">Total ADLs _____</div>		
	Needs Assistance – IADL: <input type="checkbox"/> Heavy Housework <input type="checkbox"/> Light Housework <input type="checkbox"/> Shopping <input type="checkbox"/> Transportation Ability <input type="checkbox"/> Preparing Meals <input type="checkbox"/> Managing Medication <input type="checkbox"/> Using Telephone <input type="checkbox"/> Managing Money <div style="text-align: right;">Total IADLs _____</div>		
	Are you currently receiving SSI (<i>Supplemental Security Income</i>) / SSP (<i>State Supplementary Payment</i>)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do you have Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No	Low Income? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you receive In-Home Supportive Services (IHSS)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	REFERRAL INFORMATION	4	Were you referred to our agency? <input type="checkbox"/> Yes <input type="checkbox"/> No
Referrer's Name		Phone Number ()	
Additional Information			
CODE	Relationship 01 – Self 02 – Spouse 03 – Significant Other 04 – Son/Daughter 05 – Relative 06 – Friend 07 – Neighbor 08 – Clergy 09 – Landlord 10 –Legal Representative 11 – Health Care Provider 12 – Mental Health Provider 13 – Social Services Provider 14 – APS/Emergency Services 15 – Public Utilities 16 – Private Industry 17 – Gov't/Elected Official 18 – Caregiver 19 – Other		

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CAREGIVER INFORMATION	5	Are you a Caregiver? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list number of individuals you are caring for _____		
	I	Recipient Name (Last, First, Middle)		Birth Date
	Recipient Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Low Income? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does recipient live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Relationship to recipient: <input type="checkbox"/> Spouse <input type="checkbox"/> Grandparent <input type="checkbox"/> Son/Daughter <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Family <input type="checkbox"/> Non- Family			
	Ethnic Group (write in code number from bottom)			
	Ethnic Code: _____			
	Address (Number & Street)		City	State Zip Code
	II	Recipient Name (Last, First, Middle)		Birth Date
	Recipient Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Low Income? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does recipient live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Relationship to recipient: <input type="checkbox"/> Spouse <input type="checkbox"/> Grandparent <input type="checkbox"/> Son/Daughter <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Family <input type="checkbox"/> Non- Family			
	Ethnic Group (write in code number from bottom)			
	Ethnic Code: _____			
	Address (Number & Street)		City	State Zip Code
	III	Recipient Name (Last, First, Middle)		Birth Date
	Recipient Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Low Income? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does recipient live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Relationship to recipient: <input type="checkbox"/> Spouse <input type="checkbox"/> Grandparent <input type="checkbox"/> Son/Daughter <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Family <input type="checkbox"/> Non- Family			
Ethnic Group (write in code number from bottom)				
Ethnic Code: _____				
Address (Number & Street)		City	State Zip Code	
IV	Recipient Name (Last, First, Middle)		Birth Date	
Recipient Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Low Income? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does recipient live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship to recipient: <input type="checkbox"/> Spouse <input type="checkbox"/> Grandparent <input type="checkbox"/> Son/Daughter <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Family <input type="checkbox"/> Non- Family				
Ethnic Group (write in code number from bottom)				
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CERTIFICATION	CERTIFICATION I certify that the information on this form is accurate and true to the best of my knowledge. I also certify that I have informed the client that this information may be shared with other providers for the purpose of providing services.	
	Form Completed By:	Date
	Signature:	
INTERNAL USE ONLY	APS Client Number:	
	Additional Information	