

# UNIVERSAL INTAKE FORM

**Funding Identifier: Title III B**  **C1**  **C2**  **Title III D**  **Title III E**  **Linkages**  *(Optional)*

CLIENT DEMOGRAPHICS	1	Applicant Name <i>(Last, First, Middle Initial)</i>			Participant ID #	
	Home Address <i>(Number/Street)</i>			City	State	Zip Code
	Birth Date		Rural Designation: <input type="checkbox"/> Rural <input type="checkbox"/> Urban <input type="checkbox"/> Declined to state		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to state	
	Client Race: <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Filipino <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Laotian <input type="checkbox"/> Cambodian <input type="checkbox"/> Other Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race <input type="checkbox"/> Declined to state					
	Client Ethnicity: <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to state					
	Relationship Status: <input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to state					
	Type of Residence: <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Hotel <input type="checkbox"/> Mobile Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residential Care Home <input type="checkbox"/> Room and Board <input type="checkbox"/> Homeless <input type="checkbox"/> Other				Does the individual <i>(Optional)</i> : <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Other	
	Mailing Address <i>(If different than home address)</i>			City	State	Zip Code
	Home Phone		Work and/or Cell Phone		Email Address:	
	Social Security # <i>(Optional)</i>					
	Age	Veteran or Spouse of Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No		Veteran #		
	Primary Language Spoken <i>(Optional)</i> : <input type="checkbox"/> American Sign Language <input type="checkbox"/> Arabic <input type="checkbox"/> Armenian <input type="checkbox"/> Cambodian <input type="checkbox"/> Cantonese <input type="checkbox"/> Chinese <input type="checkbox"/> English <input type="checkbox"/> Farsi <input type="checkbox"/> French <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Mandarin <input type="checkbox"/> Japanese <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Tagalog <input type="checkbox"/> Thai <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other					
Translation needed: <input type="checkbox"/> Yes <input type="checkbox"/> No						

<b>EMERGENCY CONTACT</b>	<b>2</b>	Contact Name: <i>(Last, First, Middle Initial)</i>			
	Address <i>(Number/Street)</i>		City	State	Zip Code
	Home Phone		Work and/or Cell Phone		Relationship
	Contact Name: <i>(Last, First, Middle Initial) – Optional</i>				
	Address <i>(Number/Street)</i>		City	State	Zip Code
	Home Phone		Work and/or Cell Phone		Relationship
	Physician's Name			Office Phone	
Physician's Address		City	State	Zip Code	
<b>FINANCIAL/BENEFITS</b>	<b>3</b>	Are you currently receiving Social Security Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Optional)</i> What benefit(s) are you receiving? _____			
	Do you have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Health Insurer's Name:		Policy Number: <i>(Optional)</i>
	Do you receive Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medi-Cal # <i>(Optional)</i>	Is your personal income:	
			Issue date:	<input type="checkbox"/> Yes (At or below Federal Poverty Level) <input type="checkbox"/> No (Above Federal Poverty Level) <input type="checkbox"/> Declined to state	
	Do you receive In-Home Supportive Services <i>(IHSS)</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No			Living Arrangement?	
		<input type="checkbox"/> Alone <input type="checkbox"/> Not Alone <input type="checkbox"/> Declined to state			
Employment Status <i>(Check One)</i>					
<input type="checkbox"/> Fulltime <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Declined to state					
<b>REFERRAL INFORMATION</b>	<b>4</b>	Referral Source Name:		Referral Source relationship to client:	
	Referrer's name:			Phone number:	
	Referrer's address:			State	Zip Code
	Interview mode: <input type="checkbox"/> Face-to-Face <i>(Appointment)</i> <input type="checkbox"/> Telephone <input type="checkbox"/> Drop-In <input type="checkbox"/> In-Home				
	Presenting problems/Services requested/Comments/Follow-up:				

<b>NUTRITIONAL RISK FACTORS</b>	<b>5</b>	<b>NUTRITIONAL RISK</b> <i>(Add the numbers from each checked box to determine Nutrition Risk Score)</i>																																																																			
	<div style="display: flex; flex-direction: column; align-items: flex-start;"> <ul style="list-style-type: none"> <li><input type="checkbox"/> 2 - Has an illness or condition that has changed the kind and/or amount of food eaten;</li> <li><input type="checkbox"/> 3 - Eats fewer than 2 meals per day;</li> <li><input type="checkbox"/> 1 - Eats few fruits, vegetables;</li> <li><input type="checkbox"/> 1 - Eats or drinks very few milk products;</li> <li><input type="checkbox"/> 1 - Drinks less than 5 cups (8 oz. per cup) of fluids a day;</li> <li><input type="checkbox"/> 1 - Has 3 or more alcoholic beverages per every day;</li> <li><input type="checkbox"/> 2 - Has tooth or mouth problems that make it hard to eat;</li> <li><input type="checkbox"/> 4 - Doesn't always have enough money to buy needed food;</li> <li><input type="checkbox"/> 1 - Eats alone most of the time;</li> <li><input type="checkbox"/> 1 - Takes 3 or more prescribed or over-the-counter medications a day;</li> <li><input type="checkbox"/> 2 - Has involuntarily lost or gained 10 pounds in the last 6 months;</li> <li><input type="checkbox"/> 2 - Is not always physically able to shop, cook and/or eat.</li> </ul> <p><b>Total Nutritional Risk Score: _____ (If total is 6 or more, participant is at Nutritional Risk)</b></p> <p><input type="checkbox"/> Declined to state</p> </div>																																																																				
<b>ADL / IADL RISK FACTORS</b>	<b>6</b>	<b>ACTIVITIES OF DAILY LIVING (ADL) / INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)</b> <i>Includes Title III E Care Receiver (Grandchildren exempt)</i>																																																																			
	<b>Activities of Daily Living (ADL)</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Independent</th> <th style="text-align: center;">Verbal Assistance</th> <th style="text-align: center;">Some Human Help</th> <th style="text-align: center;">Lots of Human Help</th> <th style="text-align: center;">Dependent</th> <th style="text-align: center;">Declined to state</th> </tr> </thead> <tbody> <tr><td>Eating</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Bathing</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Toileting</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Transferring</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Walking</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Dressing</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table>								Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to state	Eating	<input type="checkbox"/>	Bathing	<input type="checkbox"/>	Toileting	<input type="checkbox"/>	Transferring	<input type="checkbox"/>	Walking	<input type="checkbox"/>	Dressing	<input type="checkbox"/>																																											
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<b>DISABILITY FACTORS</b>	<b>Disability</b> <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Physically Impaired <input type="checkbox"/> Cognitively Impaired <input type="checkbox"/> Declined to State																																																																				
	Are you diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been diagnosed with Alzheimer's or a related neurological disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																			

<b>7</b>		<b>TITLE III E CARE RECEIVER DEMOGRAPHICS</b>			
<b>TITLE III E CARE RECEIVER DEMOGRAPHICS</b>	<b>Care Receiver 1</b>	Caregiver Relationship: <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Son/Son-in-Law <input type="checkbox"/> Daughter/Daughter-in-Law <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative <input type="checkbox"/> Declined to state			
	Name: (Last, First, Middle)			Care Receiver Participant I.D #:	
	Address (Number & Street)		City:	State:	Zip Code
	Birth Date	Rural Designation: <input type="checkbox"/> Rural <input type="checkbox"/> Urban <input type="checkbox"/> Declined to state	Care Receiver's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to state		
	Race: <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Filipino <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Laotian <input type="checkbox"/> Cambodian <input type="checkbox"/> Other Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race <input type="checkbox"/> Declined to state				
	Ethnicity: <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to state				
	Is your personal income: <input type="checkbox"/> Yes (At or below Federal Poverty Level) <input type="checkbox"/> No (Above Federal Poverty Level) <input type="checkbox"/> Declined to state			Living Arrangement: <input type="checkbox"/> Alone <input type="checkbox"/> Not Alone <input type="checkbox"/> Declined to state	
	Relationship Status: <input type="checkbox"/> Single ( <i>Never Married</i> ) <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to state				
	Receive Medi-Cal ( <i>Optional</i> )? <input type="checkbox"/> Yes <input type="checkbox"/> No		Receive Social Security ( <i>Optional</i> )? <input type="checkbox"/> Yes <input type="checkbox"/> No		Social Security # ( <i>Optional</i> )
	<b>Care Receiver 2</b>	Caregiver Relationship: <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Son/Son-in-Law <input type="checkbox"/> Daughter/Daughter-in-Law <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative <input type="checkbox"/> Declined to state			
	Name: (Last, First, Middle)			Care Receiver Participant I.D #:	
	Address (Number & Street)		City:	State:	Zip Code
	Birth Date	Rural Designation: <input type="checkbox"/> Rural <input type="checkbox"/> Urban <input type="checkbox"/> Declined to state	Care Receiver's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to state		
	Race: <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Filipino <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Laotian <input type="checkbox"/> Cambodian <input type="checkbox"/> Other Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race <input type="checkbox"/> Declined to state				
Ethnicity: <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to state					
Is your personal income: <input type="checkbox"/> Yes (At or below Federal Poverty Level) <input type="checkbox"/> No (Above Federal Poverty Level) <input type="checkbox"/> Declined to state			Living Arrangement: <input type="checkbox"/> Alone <input type="checkbox"/> Not Alone <input type="checkbox"/> Declined to state		
Relationship Status: <input type="checkbox"/> Single ( <i>Never Married</i> ) <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to state					
Receive Medi-Cal ( <i>Optional</i> )? <input type="checkbox"/> Yes <input type="checkbox"/> No		Receive Social Security ( <i>Optional</i> )? <input type="checkbox"/> Yes <input type="checkbox"/> No		Social Security # ( <i>Optional</i> )	

\* If more than two Care Receivers, please make additional copies of Section 7.

