Los Angeles County Area Agency on Aging

Agency Name:	Client Name:	Date:

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CALIFORNIA

UNIVERSAL INTAKE FORM



Cur	ONNIA .							epartment
Funding Identifier:								
Title	IIIB 🗆	Title C1 □ T	itle C2 □	Title IIIE	☐ Title IIIE(C	3) □ Lir	nkages 🗆	
	1a	Applicant Last Nan	ne	First Name		Middle Nar	ne GetCa	re ID#
_	Date of Birth (D.O.B.)			Age Social Security # (Optional			curity # (Optional)	
DENTIFICATION	Date of Birtif (D.C.B.)							
	Home Address (Number/Street)			City		State	Zip Code	
	Mailing	Address (If different	than home a	ddress)	City		State	Zip Code
IDE	Home P	Phone			Work Phone		Cell Phone	e
	Email A	ddress						
	16	Rural Designation			Unincorporated	City		
	1b Rural □ Urban □ Declined to State			☐ Yes ☐ No ☐ Declined to State				
	Sex at birth			Gender				
	☐ Male ☐ Female ☐ Declined to State			☐ Male ☐ Female ☐ Transgender Female to Male				
				☐ Transgender Male to Female ☐ Genderqueer/ Gender				
				Non-binary Not Listed Please Specify:				
SS				☐ Declined to	State			
DEMOGRAPHICS	Sexual Orientation Straight/Heterosexual						estioning/Unsure	
GR		Listed – Please Spe			clined to State			Dealise adda Ctata
<u>N</u>		n 🗆 Yes 🗆 No	□ Declined t □	o State	Spouse of Vete	ran 🗆 Ye	S NO	Declined to State
🛎	Race	- D American India	ا معاممان م	lativa 🗆 Chir	oso 🗆 Japanes	o □ Filinin	n □ Korea	an □ Vietnamese
	☐ White ☐ American Indian or Alaska Native ☐ Chinese ☐ Japanese ☐ Filipino ☐ Korean ☐ Vietname							
☐ Asian Indian ☐ Laotian ☐ Cambodian ☐ Other Asian ☐ Black or African American ☐ Guama							Guairiailiai	
	☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Declined to State							
	Ethnicit		dispanic/Latic	no 🗆 Decline	d to State			
□ Not Hispanic/Latino □ Hispanic/Latino □ Declined to State Relationship Status □ Single (Never Married) □ Married □ Domestic Partner □ Separated □						ated Divorced		
	Relatio				Declined to State		л 🗀 Зерап	ated Divolocu
LIIE (D	evised July		Widowed		Decimed to State	-		

Agency	/ Name:	Client Name:			Date		
	Type of Residence	Does the individual					
	☐ House ☐ Apartment ☐ Hot	☐ Rent ☐ Own ☐ Other					
	☐ Nursing Home ☐ Residential Care Home			☐ Declined to S	☐ Declined to State		
	☐ Room and Board ☐ Homeless ☐ Other ☐ Declined to State						
	Franksyment Status						
	Employment Status						
	☐ Full-time ☐ Part-time ☐	Retired Unemployed	Declined	to State			
nt.				Federal Poverty G	uideline (FPG)		
1b Cont.	Living Arrangement			Is your income \square	At or below 10	0% FPG	
1b	☐ Alone ☐ Not Alone ☐ D	eclined to State		☐ Above 100% FI	PG		
				☐ Declined to Sta	☐ Declined to State		
	Primary Language				_		
	100			☐ Cantonese ☐ Chinese ☐ English			
	☐ Farsi ☐ French ☐ Korean ☐ Laotian ☐ Mandarin ☐ Japanese ☐ Russian ☐ Spanish ☐ Tagalog					agalog	
	☐ Thai ☐ Vietnamese ☐ Other ☐ Declined to State						
	Translation needed ☐ Yes ☐ No ☐ Declined to State						
	2 Contact Last Name		First Nam	ie		Middle Name	
ST	Address (Number/Street)		City		State	Zip Code	
CONTACTS	Home Phone Work Phone Ce		Cell Phone Relationship				
INC.	Address (Number/Street) Home Phone Work Phone Primary Physician		City		State Zip Code		
ERGE	Home Phone Work Phone Ce			Cell Phone Relationship			
EM	Primary Physician				Office Phone		
	Physician's Address		City		State	Zip Code	

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Agency Name:		Client Name:			Date:				
	2	Are you currently receiving Social Security Benefits? Do you curren (SSI) Benefits		tly receive Supplemental Security Income ?					
	J	☐ Yes ☐ No ☐ Declined to State	☐ Decline	☐ Declined to State					
ı	Do you	Do you participate in CalFresh (Food Stamps, SNAP, EBT)?							
	☐ Yes	☐ Yes ☐ No ☐ Declined to State							
BENEFITS	Do you	have Health Insurance? ☐ Yes ☐No	Health Insurer's Name F			Policy Number: (Optional)			
뿔	☐ Dec	clined to State							
出	Do you	receive Medi-Cal?	Medi-Cal # (Optional) Do			o you receive Medicare?			
	☐ Yes	☐ No ☐ Declined to State	leave date:]Yes □ tate	lNo □ De	clined to	
	Do you	receive In-Home Supportive Services (IH	ISS)?	☐ Yes	□ No □	Decline	d to State		
Ī	Do you	receive any additional benefits? (i.e., Vet	erans Be	enefits, CAPI, et	c.)				
	4	Referral Source		æ					
	Last N	t Name		First Name			Phone		
REFERRAL INFORMATION						State		7:- 01-	
	Addre	SS		City			9	Zip Code	
REFE FORI	Prese	Presenting Problems/Services Requested/Comments/Follow-up:							
" Z									
	T	NUTRITI	ONAL F	RISK FACTOR	RS				
	5	(Add the numbers from each checked be	ox to dete at High	e <i>rmine Nutrition</i> Nutritional Risk)	Risk Score)	e, if total is	6 or more, p	articipant is	
ORS		e an illness or condition that made me chant nt of food I eat.	inge the	kind and/or	2 Yes	□ No	□ Decline	d to State	
CTO	I eat f	eat fewer than 2 meals per day.				□ No		ed to State	
FA	I eat f	at few fruits or vegetables or milk products.				□ No		ed to State	
SK	Ihave	ave 3 or more drinks of beer, liquor or wine almost every day.			2 - Yes	□ No	□ Decline	ed to State	
8	I have	e tooth or mouth problems that make it ha	rd for me	e to eat.	2 □ Yes	□ No		ed to State	
MAI	I do n	do not always have enough money to buy the food I need.			4 □ Yes	□ No		ed to State	
힏		alone most of the time.			1 □ Yes	□ No		ed to State	
		3 or more different prescribed or over-the			1 □ Yes	□ No	□ Decline	ed to State	
NUTRITIONAL RISK FACTOR	month	nout wanting to, I have lost or gained 10 pounds in the last 6 nths.			2 - Yes	□ No		ed to State	
	I am r	not always physically able to shop, cook a			2 Yes	□ No	□ Decline High Risk: □	ed to State	
Total Nutritional Risk Score						□ Declin	e to State	. 103 LINU	

RIS	ACTIVITIES OF DAILY LIVING (ADL)/INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) RISK FACTORS & DISABILITY FACTORS (Excluding Title IIIE Caregiver Program) Activities of Daily Living (ADL)							
Activities of bal	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State		
Eating								
Bathing								
Toileting								
Transferring								
Walking								
Dressing			. 🗆					
Instrumental Ad	Independent	y Living (IADL) Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State		
Meal Preparation								
Shopping								
Med. Mgmt.								
Money Mgmt.								
Using Phone								
Hvy. Housework								
Lt. Housework								
Transportation		į –						
Disability Factors	Disability Factors Recent Hospital Discharge □Yes □ No							
☐ Visually Impair	ed 🗆 Hearing	g Impaired □ S _l	peech Impaired	☐ Declined to State				
☐ Physically Imp	☐ Physically Impaired ☐ Walking Aid ☐ Wheelchair							
☐ Bedbound ☐	Memory Impair	Date to Stop Service						
☐ Cognitively Imp	nitively Impaired None Declined to State							
Diabetic ☐ Yes ☐ No ☐ Declined to St	☐ Yes	u been diagnosed		or a related neu	rological disor	der?		

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CERTIFICATION	9	CERTIFICATION (To be completed by Interviewer and signed by Client) I certify that the information on this form, provided to me by the client, is accurate and true to the best of my abilities. I also certify that I have informed the Client that this information may be share with other providers for the purpose of providing services. Client signature establishes agreement.						
	Compl	to services. eted by (Print Name)		Phone				
ERTII	Signat	ıre		Date				
0	Client	Name (Print)						
	Client	Signature		Date				
MENT	10	REASON FOR DISENROLLMENT	Date	of disenrollment:				
DISENROLLMENT	□ No	 □ Deceased □ Moved Out of Service Area □ No Longer Desires Services □ No Longer SNF Certifiable □ No Longer Medi-Cal Eligible □ Institutionalization □ High Cost of Services □ Won't Follow Care Plan □ On Hold □ Service No Longer Needed □ Past Active □ On Waiting List □ Other Reason 						
NOT	ES:							
			9					
rema dema	Thank you for completing the Universal Intake Form (UIF). As the aging population grows and funding remains limited, it is vital to capture this critical information to reinforce and substantiate the increased demand for older adult services. This information will assist the Los Angeles County Area Agency on Aging (AAA) in identifying unmet needs, effectively developing plans, and better coordinate services to							