

Agency Name: _____ Client Name: _____ Date: _____



UNIVERSAL INTAKE FORM



Funding Identifier:

Title IIIB Title C1 Title C2 Title IIIE Title IIIE(G) Linkages

IDENTIFICATION	1a	Applicant Last Name	First Name	Middle Name	GetCare ID #	
		Date of Birth (D.O.B.)		Age	Social Security # (Optional)	
		Home Address (Number/Street)		City	State Zip Code	
		Mailing Address (If different than home address)		City	State Zip Code	
		Home Phone	Work Phone	Cell Phone		
	Email Address					
DEMOGRAPHICS	1b	Rural Designation <input type="checkbox"/> Rural <input type="checkbox"/> Urban <input type="checkbox"/> Declined to State		Unincorporated City <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State		
		Sex at birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to State		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/ Gender Non-binary <input type="checkbox"/> Not Listed Please Specify: _____ <input type="checkbox"/> Declined to State		
		Sexual Orientation <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same Gender-Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not Listed – Please Specify: _____ <input type="checkbox"/> Declined to State				
		Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State		Spouse of Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No <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"/> Declined to State				
		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				

Agency Name: _____ Client Name: _____ Date: _____

1b Cont.	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 <input type="checkbox"/> Declined to State		Does the individual <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Other <input type="checkbox"/> Declined to State					
	Employment Status <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Declined to State							
	Living Arrangement <input type="checkbox"/> Alone <input type="checkbox"/> Not Alone <input type="checkbox"/> Declined to State		Federal Poverty Guideline (FPG) Is your income <input type="checkbox"/> At or below 100% FPG <input type="checkbox"/> Above 100% FPG <input type="checkbox"/> Declined to State					
	Primary Language <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 <input type="checkbox"/> Declined to State							
	Translation needed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State							
EMERGENCY CONTACTS	2	Contact Last Name		First Name		Middle Name		
	Address (Number/Street)			City	State	Zip Code		
	Home Phone		Work Phone		Cell Phone		Relationship	
	Contact Name (Last, First, Middle Initial) – Optional							
	Address (Number/Street)			City	State	Zip Code		
	Home Phone		Work Phone		Cell Phone		Relationship	
	Primary Physician					Office Phone		
	Physician's Address			City	State	Zip Code		

BENEFITS	3	Are you currently receiving Social Security Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State	Do you currently receive Supplemental Security Income (SSI) Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State			
	Do you participate in CalFresh (Food Stamps, SNAP, EBT)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State					
	Do you have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State		Health Insurer's Name		Policy Number: <i>(Optional)</i>	
	Do you receive Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State		Medi-Cal # <i>(Optional)</i> Issue date:		Do you receive Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State	
	Do you receive In-Home Supportive Services <i>(IHSS)</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State					
	Do you receive any additional benefits? (i.e., Veterans Benefits, CAPI, etc.)					
REFERRAL INFORMATION	4	Referral Source				
	Last Name		First Name		Phone	
	Address		City	State	Zip Code	
	Presenting Problems/Services Requested/Comments/Follow-up:					
NUTRITIONAL RISK FACTORS	5	NUTRITIONAL RISK FACTORS				
	<i>(Add the numbers from each checked box to determine Nutrition Risk Score, if total is 6 or more, participant is at High Nutritional Risk)</i>					
	I have an illness or condition that made me change the kind and/or amount of food I eat.			2 <input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State
	I eat fewer than 2 meals per day.			3 <input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State
	I eat few fruits or vegetables or milk products.			2 <input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State
	I have 3 or more drinks of beer, liquor or wine almost every day.			2 <input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State
	I have tooth or mouth problems that make it hard for me to eat.			2 <input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State
	I do not always have enough money to buy the food I need.			4 <input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State
	I eat alone most of the time.			1 <input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State
	I take 3 or more different prescribed or over-the-counter drugs a day.			1 <input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State
	Without wanting to, I have lost or gained 10 pounds in the last 6 months.			2 <input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State
I am not always physically able to shop, cook and/or feed myself.			2 <input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State	
Total Nutritional Risk Score				Client is High Risk: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State		

6

**ACTIVITIES OF DAILY LIVING (ADL)/INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)
RISK FACTORS & DISABILITY FACTORS (Excluding Title III E Caregiver Program)**

ADL/IADL RISK FACTORS & DISABILITY FACTORS

Activities of Daily Living (ADL)

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Instrumental Activities of Daily Living (IADL)

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Med. Mgmt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Money Mgmt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hvy. Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lt. Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Disability Factors

- Visually Impaired Hearing Impaired Speech Impaired
 Physically Impaired Walking Aid Wheelchair
 Bedbound Memory Impaired Depression
 Cognitively Impaired None Declined to State

Recent Hospital Discharge Yes No

Declined to State

Date of Discharge

Date to Stop Service

Hospital

Diabetic

Yes No

Declined to State

Have you been diagnosed with Alzheimer's or a related neurological disorder?

Yes No Declined to State

CERTIFICATION	9	CERTIFICATION (To be completed by Interviewer and signed by Client)
		<i>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 shared with other providers for the purpose of providing services. Client signature establishes agreement to services.</i>
	Completed by (Print Name)	
	Signature	Phone
		Date
Client Name (Print)		
Client Signature		Date

DISENROLLMENT	10	REASON FOR DISENROLLMENT	Date of disenrollment:
	<input type="checkbox"/> Deceased <input type="checkbox"/> Moved Out of Service Area <input type="checkbox"/> No Longer Desires Services <input type="checkbox"/> No Longer SNF Certifiable <input type="checkbox"/> No Longer Medi-Cal Eligible <input type="checkbox"/> Institutionalization <input type="checkbox"/> High Cost of Services <input type="checkbox"/> Won't Follow Care Plan <input type="checkbox"/> On Hold <input type="checkbox"/> Service No Longer Needed <input type="checkbox"/> Past Active <input type="checkbox"/> On Waiting List <input type="checkbox"/> Other Reason		

NOTES:

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 meet your needs.