## Los Angeles County Area Agency on Aging

Agency Name: _____ _____ _____ Client Name: _____ _____Date: _____

# UNIVERSAL INTAKE FORM

LOS ANGELES COUNTY Aging & Disabilities Department

**Funding Identifier:**

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

**IDENTIFICATION**

| **1a** | Applicant Last Name | First Name | Middle Name | Participant 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<br>☐ Rural ☐ Urban ☐ Declined to State | Unincorporated City<br>☐ Yes ☐ No ☐ Declined to State |
|---|---|---|

Sex at birth
☐ Male ☐ Female ☐ Declined to State

Gender
☐ Male ☐ Female ☐ Transgender Female to Male
☐ Transgender Male to Female ☐ Genderqueer/ Gender Non-binary ☐ Not Listed Please Specify: _____ __
☐ Declined to State

Sexual Orientation
☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same Gender-Loving ☐ Questioning/Unsure
☐ Not Listed – Please Specify: _____ ☐ Declined to State

Veteran ☐ Yes ☐ No ☐ Declined to State

Spouse of Veteran ☐ Yes ☐ No ☐ Declined to State

Race
☐ White ☐ American Indian or Alaska Native ☐ Chinese ☐ Japanese ☐ Filipino ☐ Korean ☐ Vietnamese
☐ Asian Indian ☐ Laotian ☐ Cambodian ☐ Other Asian ☐ Black or African American ☐ Guamanian
☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Declined to State

Ethnicity
☐ Not Hispanic/Latino ☐Hispanic/Latino ☐ Declined to State

Relationship Status ☐ Single (Never Married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined to State

Agency Name: _____ Client Name: _____ ___Date: _____

**1b Cont.**

Type of Residence

☐ House ☐ Apartment ☐ Hotel ☐ Mobile Home

☐ Nursing Home ☐ Residential Care Home

☐ Room and Board ☐ Homeless ☐ Other ☐ Declined to State

Does the individual

☐ Rent ☐ Own ☐ Other

☐ Declined to State

Employment Status

☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Declined to State

Living Arrangement

☐ Alone ☐ Not Alone

Federal Poverty Guideline (FPG)

Is your income ☐ At or below 100% FPG

☐ Above 100% FPG

☐ Declined to State

Primary Language

☐ American Sign Language ☐ Arabic ☐ Armenian ☐ Cambodian ☐ Cantonese ☐ Chinese ☐ English

☐ Farsi ☐ French ☐ Korean ☐ Laotian ☐ Mandarin ☐ Japanese ☐ Russian ☐ Spanish ☐ Tagalog

☐ Thai ☐ Vietnamese ☐ Other ☐ Declined to State

Translation needed ☐ Yes ☐ No ☐ 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 |

Agency Name: _____ _____ Client Name: _____ _____Date: _____

**BENEFITS**

| **3** | Are you currently receiving Social Security Benefits? ☐ Yes ☐ No ☐ Declined to State | Do you currently receive Supplemental Security Income (SSI) Benefits? ☐ Yes ☐ No ☐ Declined to State |
|---|---|---|

Do you participate in CalFresh (Food Stamps, SNAP, EBT)?
☐ Yes ☐ No ☐ Declined to State

| Do you have Health Insurance? ☐ Yes ☐No ☐ Declined to State | Health Insurer's Name | Policy Number: ***(Optional)*** |
|---|---|---|
| Do you receive Medi-Cal? ☐ Yes ☐ No ☐ Declined to State | Medi-Cal # ***(Optional)*** Issue date: | Do you receive Medicare? ☐ Yes ☐ No ☐ Declined to State |

Do you receive In-Home Supportive Services ***(IHSS)?*** ☐ Yes ☐ No ☐ 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**
***(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 have an illness or condition that made me change the kind and/or amount of food I eat. | 2 □ Yes | □ No | □ Declined to State |
| I eat fewer than 2 meals per day. | 3 □ Yes | □ No | □ Declined to State |
| I eat few fruits or vegetables or milk products. | 2 □ Yes | □ No | □ Declined to State |
| I have 3 or more drinks of beer, liquor or wine almost every day. | 2 □ Yes | □ No | □ Declined to State |
| I have tooth or mouth problems that make it hard for me to eat. | 2 □ Yes | □ No | □ Declined to State |
| I don't always have enough money to buy the food I need. | 4 □ Yes | □ No | □ Declined to State |
| I eat alone most of the time. | 1 □ Yes | □ No | □ Declined to State |
| I take 3 or more different prescribed or over-the-counter drugs a day. | 1 □ Yes | □ No | □ Declined to State |
| Without wanting to, I have lost or gained 10 pounds in the last 6 months. | 2 □ Yes | □ No | □ Declined to State |
| I am not always physically able to shop, cook and/or feed myself. | 2 □ Yes | □ No | □ Declined to State |
| **Total Nutritional Risk Score** | | Client is High Risk: □ Yes □ No □ Decline to State | |

Agency Name: _____ _____ Client Name: _____ _____Date: _____

ADL/IADL RISK FACTORS & DISABILITY FACTORS

## 6 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)*

| | Independent | Verbal Assistance | Some Human Help | Lots of Human Help | Dependent | Declined to State |
|---|---|---|---|---|---|---|
| Eating | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bathing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Toileting | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Transferring | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Walking | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Dressing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

### Instrumental Activities of Daily Living *(IADL)*

| | Independent | 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 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**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

Agency Name: _____ _____ Client Name: _____ _____Date: _____

TITLE IIIE CARE RECEIVER DEMOGRAPHICS

## 7 TITLE IIIE CARE RECEIVER DEMOGRAPHICS

***Please make additional copies of Section 7 & 8 if more than one Care Receiver***

**Caregiver Relationship:** ☐Husband ☐ Wife ☐ Domestic Partner ☐Son/Son-in-Law ☐ Daughter/Daughter-in-Law ☐Grandparent ☐Other Relative ☐Sister ☐Brother ☐ Parent/Parent-in-Law ☐Non-Relative ☐ Declined to State

| Care Receiver Last Name | First Name | Middle Name | Care Receiver GetCare ID # |
|---|---|---|---|
| | | | |

| Address (Number & Street) | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Rural Designation: ☐ Rural ☐ Urban ☐ Declined to State | Unincorporated City: ☐ Yes ☐ No ☐ Declined to State |
|---|---|

| Home Phone | Work Phone | Cell Phone | Emergency Contact Phone |
|---|---|---|---|
| | | | |

| Date of Birth (D.O.B.) | Age | Social Security # ***(Optional)*** | Email Address |
|---|---|---|---|
| | | | |

| 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: _____ ☐ Declined to State |

Sexual Orientation
☐ Straight/Heterosexual ☐Bisexual ☐Gay/Lesbian/Same Gender-Loving ☐Questioning/Unsure
☐Not Listed – Please Specify: _____ _ ☐Declined to State

| Veteran: ☐ Yes ☐ No ☐ Declined to State | Spouse of Veteran: ☐ Yes ☐ No ☐ Declined to State |
|---|---|

Race
☐ White ☐ American Indian or Alaska Native ☐ Chinese ☐ Japanese ☐ Filipino ☐ Korean ☐ Vietnamese
☐ Asian Indian ☐ Laotian ☐ Cambodian ☐ Other Asian ☐ Black or African American ☐ Guamanian
☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Declined to State

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State

Relationship Status
☐Single ***(Never Married)*** ☐Married ☐Domestic Partner ☐Separated ☐Divorced ☐ Widowed ☐ Declined to State

| Type of Residence | Does the individual | Living Arrangement |
|---|---|---|
| ☐ House ☐ Apartment ☐ Hotel ☐ Mobile Home ☐ Nursing Home ☐ Residential Care Home ☐ Room and Board ☐ Homeless ☐ Other ☐ Declined to State | ☐ Rent ☐ Own ☐ Other ☐ Declined to State | ☐ Alone ☐ Not Alone ☐ Declined to State |

| Receive In-Home Supportive Services ***(IHSS)?*** | Federal Poverty Guideline (FPG) Is your Care Receiver income: |
|---|---|
| ☐ Yes ☐ No ☐ Declined to State | ☐ At or below 100% FPG ☐ Above 100% FPG ☐ Declined to State |

| Have Health Insurance? | Receive Medicare? | Receive Social Security? | Receive Medi-Cal? |
|---|---|---|---|
| ☐ Yes ☐ No ☐ Declined to State | ☐ Yes ☐ No ☐ Declined to State | ☐ Yes ☐ No ☐ Declined to State | ☐ Yes ☐ No ☐ Declined to State |

Agency Name: _____ _____Client Name: _____ _____Date: _____ _____

TITLE IIIE CARE RECEIVER ADL/IADL RISK FACTORS & DISABILITY FACTORS

**8** **TITLE IIIE CARE RECEIVER ACTIVITIES OF DAILY LIVING (ADL)/ INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) RISK FACTORS & DISABILITY FACTORS**

**Activities of Daily Living *(ADL) (Grandchildren exempt)***

| | Independent | Verbal Assistance | Some Human Help | Lots of Human Help | Dependent | Declined to State |
|---|---|---|---|---|---|---|
| Eating | □ | □ | □ | □ | □ | □ |
| Bathing | □ | □ | □ | □ | □ | □ |
| Toileting | □ | □ | □ | □ | □ | □ |
| Transferring | □ | □ | □ | □ | □ | □ |
| Walking | □ | □ | □ | □ | □ | □ |
| Dressing | □ | □ | □ | □ | □ | □ |

**Instrumental Activities of Daily Living *(IADL) (Grandchildren exempt)***

| | Independent | 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 | □ | □ | □ | □ | □ | □ |

**Disability Factors**

☐ Visually Impaired ☐ Hearing Impaired ☐ Speech Impaired ☐ Physically Impaired ☐ Walking Aid

☐ Wheelchair ☐ Bedbound ☐ Memory Impaired ☐ Depression ☐ Cognitively Impaired ☐ None

☐ Declined to State

Diabetic

☐Yes ☐ No

☐ Declined to State

Has Care Receiver been diagnosed with Alzheimer's or a related neurological disorder?

☐ Yes ☐ No ☐ Declined to State

Agency Name: _____ _____ Client Name: _____ _____Date: _____

**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 shared with other providers for the purpose of providing services. Client signature establishes agreement to services.***

| ***Completed by (Print Name)*** | ***Phone*** |
|---|---|
| ***Signature*** | ***Date*** |
| ***Client Name (Print)*** | |
| ***Client Signature*** | ***Date*** |

**DISENROLLMENT**

**10** **REASON FOR DISENROLLMENT** ***Date of disenrollment:***

☐ 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

**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.**