

# Title III - Intake and Assessment Sample Forms

**CALIFORNIA DEPARTMENT OF AGING  
HOME AND COMMUNITY LIVING DIVISION**

[www.aging.ca.gov](http://www.aging.ca.gov)

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## Introduction

Because each AAA has tailored programs to meet their community needs, CDA does **not** have required intake or assessment forms. CDA has designed these sample templates to help the AAAs evaluate and create their own forms for collecting and recording required performance data elements.

## What is Reviewed

CDA reviews the forms to ensure all required data collection elements are integrated.

AAAs may use these forms, revise them, or create forms to meet local needs. AAAs do not have to use these sample templates.

## Forms

This section contains the following templates:

### [Sample 1](#)

- Title III B, C-1, C-2, and D (Cluster 1& 2, Registered)
- Personal Care, Homemaker, Chore, Home-Delivered Meals, Adult Day Care/Health, Case Management, Congregate Meals, Nutritional Counseling, Assisted Transportation, Other Non-Registered Services

### [Sample 2](#)

- Title III B, C-2 (Cluster 1)
- Personal Care, Homemaker, Chore, Home-Delivered Meals, Adult Day Care/Health, Case Management

### [Sample 3](#)

- Title III B, C1, and D (Cluster 2)
- Congregate Meals, Nutritional Counseling, Assisted Transportation

### [Sample 4](#)

- Title III C-2
- Home-Delivered Meals

### [Sample 5](#)

- Title III C-1
- Congregate Meals

#### Sample 6

- Title III E (Group 1, Registered)
- Caring for Elderly, Caring for Child

#### Sample 7

- Title III E (Group 1)
- Caring for Elderly

#### Sample 8

- Title III E (Group 1)
- Caring for Child

#### Sample 9

- Title III B (Cluster III, Non-Registered)
- Information and Assistance

#### Sample 10

- Title III B
- Legal Assistance

**SAMPLE 1, TITLE III**

<b>Provider Name:</b>	<b>Unique Participate ID:</b> _____
<b>Region/Site Name:</b>	<b>Registration/Assessment Date:</b> _____
<b>Termination Date:</b> _____ <b>*Reason:</b> _____	
<b>Service Categories (Titles IIIB, IIIC and IIID):</b>	
<input type="checkbox"/> <b>*Personal Care (IIIB)</b> (A, I)	<input type="checkbox"/> <b>*Homemaker (IIIB)</b> (A, I)
<input type="checkbox"/> <b>*Home-Delivered Meals</b> (A, I, N)	<input type="checkbox"/> <b>*Adult Day Care/Health (IIIB)</b> (A, I)
<input type="checkbox"/> <b>*Assisted Transportation (IIIB)</b>	<input type="checkbox"/> <b>*Congregate Meals</b> (N)
<input type="checkbox"/> <b>Other:</b> _____	<input type="checkbox"/> <b>*Chore (IIIB)</b> (A, I)
	<input type="checkbox"/> <b>*Case Management (IIIB)</b> (A, I)
	<input type="checkbox"/> <b>*Nutrition Counseling</b> (N)
<b>Notes:</b> Reference the Data Dictionary for allowable "Other" service categories; Requires <b>A-ADLs</b> , <b>I-IADLs</b> , <b>N-Nutritional Assessments</b> on Page 2	

**SECTION 1 (Client)**

*(\*) Required for All Registered Programs*

<b>PERSONAL DATA (Please print):</b>	
First Name:	
Middle Initial:	
Last Name:	
<b>*What is your gender? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated
<b>*What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated
<b>*How do you describe your sexual orientation or sexual identity? (Check only one)</b>	<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/not stated
<b>Residential Address:</b>	
Street:	
City:	
<b>*Zip Code:</b>	
<b>Mailing Address:</b>	
Same as Residential? <input type="checkbox"/> Yes – Skip to Next Section	

Street:	
City:	
<b>*Zip Code:</b>	
<b>*Ethnicity:</b>	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined/not stated
<b>*Race: (Check all that apply)</b>	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Hawaiian/Other Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined/not stated
<b>*Federal Poverty Level (FPL):</b>	<input type="checkbox"/> Yes (At or below FPL) <input type="checkbox"/> No (Above FPL) <input type="checkbox"/> Declined/not stated
<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>*Rural?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated

**SECTION 2 – ADL and IADL (Activities of Daily Living and Instrumental Activities of Daily Living – Annual Assessment)**

*\*Required for (III-C): Home Delivered Meals; (III-B): Personal Care, Homemaker, Chore, Adult Day Care, Case Management*

ADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
*Eating						
*Bathing						
*Toileting						
*Transferring In/Out of Bed/Chair						
*Walking						
*Dressing						

Notes:

IADLS:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
*Meal Preparation						
*Shopping						
*Medication Management						
*Money Management						
*Using Telephone						
*Heavy Housework						
*Light Housework						
*Transportation						

Notes:

**SECTION 3 – Nutritional Risk Assessment (Annual)**

*\* Required for (IIIC): Home-Delivered Meals, Congregate Meals; Nutritional Counseling*

*Nutritional Risk Assessment:	Circle if yes	
I have an illness or condition that made me change the kind and/or amount of food I eat.	2	
I eat fewer than 2 meals per day.	3	
I eat few fruits or vegetables or milk products.	2	
I have 3 or more drinks of beer, liquor or wine almost every day.	2	
I have tooth or mouth problems that make it hard for me to eat.	2	
I don't always have enough money to buy the food I need.	4	
I eat alone most of the time.	1	
I take 3 or more different prescribed or over-the-counter drugs a day.	1	
Without wanting to, I have lost or gained 10 pounds in the past 6 months.	2	
I am not always physically able to shop, cook, and/or feed myself.	2	
Total Score:		
<b>Is Nutrition Risk total score 0-5 or 6+?</b>		
<b>0 - 5</b>		<b>6+</b>
<input type="checkbox"/> <b>Declined to State</b>		

**SAMPLE 2, CLUSTER 1**

<b>Provider Name:</b>	<b>Unique Participate ID:</b> _____
<b>Region/Site Name:</b>	<b>Registration/Assessment Date:</b> _____
<b>Termination Date:</b> _____ <b>*Reason:</b> _____	
<b>Service Categories (Titles IIIB and IIIC):</b>	
<input type="checkbox"/> <b>*Personal Care (IIIB)</b> (A, I)	<input type="checkbox"/> <b>*Homemaker (IIIB)</b> (A, I)
<input type="checkbox"/> <b>*Home-Delivered Meals</b> (A, I, N)	<input type="checkbox"/> <b>*Adult Day Care/Health (IIIB)</b> (A, I)
<input type="checkbox"/> <b>*Chore (IIIB)</b> (A, I)	
<input type="checkbox"/> <b>*Case Management (IIIB)</b> (A, I)	
<b>Notes:</b> Reference the Data Dictionary for allowable "Other" service categories; Requires A-ADLs, I-IADLs, N-Nutritional Assessments on Page 2	

**SECTION 1 (Client)**

*(\*) Required for All Registered Programs*

<b>PERSONAL DATA (Please print):</b>	
First Name:	
Middle Initial:	
Last Name:	
<b>*What is your gender? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated
<b>*What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated
<b>*How do you describe your sexual orientation or sexual identity? (Check only one)</b>	<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/not stated
<b>Residential Address:</b>	
Street:	
City:	
<b>*Zip Code:</b>	
<b>Mailing Address:</b>	
Same as Residential? <input type="checkbox"/> Yes – Skip to Next Section	
Street:	

City:	
<b>*Zip Code:</b>	
Emergency Contact:	Name: Relationship: Phone #: (    )
<b>*Ethnicity:</b>	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined/not stated
<b>*Race: (Check all that apply)</b>	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Hawaiian/Other Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined/not stated
<b>*Federal Poverty Level (FPL):</b>	<input type="checkbox"/> Yes (At or below FPL) <input type="checkbox"/> No (Above FPL) <input type="checkbox"/> Declined/not stated
<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>*Rural?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated

**SECTION 2 – ADL and IADL (Activities of Daily Living and Instrumental Activities of Daily Living – Annual Assessment)**

*\*Required for (III-C): Home Delivered Meals; (III-B): Personal Care, Homemaker, Chore, Adult Day Care, Case Management*

ADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
*Eating						
*Bathing						
*Toileting						
*Transferring In/Out of Bed/Chair						
*Walking						
*Dressing						

Notes:

IADLS:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
*Meal Preparation						
*Shopping						
*Medication Management						
*Money Management						
*Using Telephone						
*Heavy Housework						
*Light Housework						
*Transportation						

Notes:

**SECTION 3 – Nutritional Risk Assessment (Annual)**

*\* Required for (IIIC): Home-Delivered Meals, Congregate Meals; Nutritional Counseling*

*Nutritional Risk Assessment:	Circle if yes	
I have an illness or condition that made me change the kind and/or amount of food I eat.	2	
I eat fewer than 2 meals per day.	3	
I eat few fruits or vegetables or milk products.	2	
I have 3 or more drinks of beer, liquor or wine almost every day.	2	
I have tooth or mouth problems that make it hard for me to eat.	2	
I don't always have enough money to buy the food I need.	4	
I eat alone most of the time.	1	
I take 3 or more different prescribed or over-the-counter drugs a day.	1	
Without wanting to, I have lost or gained 10 pounds in the past 6 months.	2	
I am not always physically able to shop, cook, and/or feed myself.	2	
Total Score:		
<b>Is Nutrition Risk total score 0-5 or 6+?</b>		
<b>0 - 5</b>		<b>6+</b>
<input type="checkbox"/> <b>Declined to State</b>		

### SAMPLE 3, CLUSTER 2

<b>Provider Name:</b>	<b>Unique Participate ID:</b> _____
<b>Region/Site Name:</b>	<b>Registration/Assessment Date:</b> _____
<b>Termination Date:</b> _____ <b>*Reason:</b> _____	
<b>Service Categories (Titles IIIB and IIIC):</b>	
<input type="checkbox"/> <b>*Assisted Transportation</b> <input type="checkbox"/> <b>*Congregate Meals (N)</b> <input type="checkbox"/> <b>*Nutrition Counseling (N)</b>	
<i>Notes: Requires N-Nutritional Assessments on Page 2</i>	

#### SECTION 1 (Client)

*(\*) Required for All Registered Programs*

<b>PERSONAL DATA (Please print):</b>	
First Name:	
Middle Initial:	
Last Name:	
<b>*What is your gender? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated
<b>*What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated
<b>*How do you describe your sexual orientation or sexual identity? (Check only one)</b>	<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/not stated
<b>*Birth Date:</b>	
Home Phone:	(    )
<b>Residential Address:</b>	
Street:	
City:	
<b>*Zip Code:</b>	
<b>Mailing Address:</b>	
Same as Residential? <input type="checkbox"/> Yes – Skip to Next Section	
Street:	
City:	
<b>*Zip Code:</b>	

Emergency Contact:	Name: Relationship: Phone #: (    )
<b>*Ethnicity:</b>	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined/not stated
<b>*Race: (Check all that apply)</b>	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Hawaiian/Other Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined/not stated
<b>*Federal Poverty Level (FPL):</b>	<input type="checkbox"/> Yes (At or below FPL) <input type="checkbox"/> No (Above FPL) <input type="checkbox"/> Declined/not stated
<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>*Rural?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>Transportation Service Needs:</b>	
<input type="checkbox"/> Walks with no assistance (Non-Assisted) <input type="checkbox"/> Walks with assistance (Assisted) <input type="checkbox"/> Wheelchair ramp/lift	



**SECTION 2 – Nutritional Assessment (Annual)**

*\* Required for (IIC): Congregate Meals, Nutritional Counseling*

<b>*Nutritional Assessment:</b>	<b>Circle if yes</b>	
I have an illness or condition that made me change the kind and/or amount of food I eat.	2	
I eat fewer than 2 meals per day.	3	
I eat few fruits or vegetables or milk products.	2	
I have 3 or more drinks of beer, liquor or wine almost every day.	2	
I have tooth or mouth problems that make it hard for me to eat.	2	
I don't always have enough money to buy the food I need.	4	
I eat alone most of the time.	1	
I take 3 or more different prescribed or over-the-counter drugs a day.	1	
Without wanting to, I have lost or gained 10 pounds in the past 6 months?	2	
I am not always physically able to shop, cook, and/or feed myself.	2	
Total Score:		
<b>Is Nutrition Risk total score 0-5 or 6+?</b>	<b>0 - 5</b>	<b>6+</b>
<input type="checkbox"/> <b>Declined to State</b>		

Notes:

**SAMPLE 4, C-2**

<p><b>Name of Home-Delivered Meals Provider</b> This form is designed to be completed by an intake staff. Items marked with an asterisk (*) are required.</p>	Route: _____	Intake Date: _____ Active Date: _____ Inactive Date: _____ Active Date: _____ Inactive Date: _____ Active Date: _____ Inactive Date: _____
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<b>*Unique Participant ID:</b>	<b>*Termination Date:</b>	<b>Reason:</b>
<b>*Date of Birth:</b> / /	<input type="checkbox"/> New client <input type="checkbox"/> Annual reassessment <input type="checkbox"/> Change in information	

First Name:	Last Name:
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Home Address	City:	*Zip Code
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Home Phone: ( ) Alternate Phone: ( )	Emergency Contact Name: Address: Phone: ( ) Relationship:
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<b>*Living Arrangement # of household members:</b> <input type="checkbox"/> Declined/not stated	<b>*What is your approximate household income?</b> \$ _____ per <input type="checkbox"/> month <input type="checkbox"/> year <input type="checkbox"/> Declined/not stated	<b>*Rural Area:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
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<b>*What is your gender? (Check only one)</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated	<b>*What was your sex at birth? (Check only one)</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated	<b>*How do you describe your sexual orientation or sexual identity? (Check only one)</b> <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/not stated
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<b>*Ethnicity: (Check one)</b> Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated	Language: <input type="checkbox"/> English Speaking <input type="checkbox"/> Need interpreter <input type="checkbox"/> Non-English/Language
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**\*Race: (Check all that apply)**

<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> American Indian/Alaska Native Asian:
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Chinese <input type="checkbox"/> Filipino
<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian
<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Declined/not stated	<input type="checkbox"/> Hawaiian/Other Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan

**ADLs: ADLs and IADLs (Activities of Daily Living and Instrumental Activities of Daily Living)**  
 Please rate your functional abilities for the following activities.

ADLs	Rated Value	IADLs	Rated Value	IADLs	Rated Value	<b>RATING SCALE</b>
Feeding		Meal Preparation		Light Housework		
Dressing		Shopping		Heavy Housework		
Bathing		Manage Medication		Notes:		
Transferring In/Out of Chair		Money Management				
Walking		Telephone				
Toileting		Transportation				

<b>Eligibility:</b> <input type="checkbox"/> Are you homebound due to an illness, disability, or isolation? <input type="checkbox"/> Are you a spouse of a home-delivered meal recipient? <input type="checkbox"/> Are you an individual with a disability who resides with a home-delivered meal recipient?	<b>Prioritization:</b>
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<b>*Nutritional Risk Assessment:</b>	<b>Circle if yes</b>	
I have an illness or condition that made me change the kind and/or amount of food I eat.	2	
I eat fewer than 2 meals per day.	3	
I eat few fruits or vegetables or milk products.	2	
I have 3 or more drinks of beer, liquor or wine almost every day.	2	
I have tooth or mouth problems that make it hard for me to eat.	2	
I don't always have enough money to buy the food I need.	4	
I eat alone most of the time.	1	
I take 3 or more different prescribed or over-the-counter drugs a day.	1	
Without wanting to, I have lost or gained 10 pounds in the past 6 months.	2	
I am not always physically able to shop, cook, and/or feed myself.	2	
Total Score:		
<b>*Is Nutrition Risk Total Score 0-5 or 6+ ?</b>	<b>0-5</b>	<b>6+</b>
<input type="checkbox"/> <b>Declined to State</b>		

	Yes	No	Comments
Do you have any dietary restrictions?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a working refrigerator?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a working microwave?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you physically and mentally able to open the food containers?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you physically and mentally able to reheat a meal?	<input type="checkbox"/>	<input type="checkbox"/>	
Are there pets?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you recently been discharged from the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Referral(s) Made:</b> <input type="checkbox"/> Nutritional education/counseling for at risk client <input type="checkbox"/> Other: <input type="checkbox"/> Other:
<b>Notes:</b>

\_\_\_\_\_  
Staff Completing Assessment

\_\_\_\_\_  
Date

**SAMPLE 5, C-1**

<p><b>Name of Congregate Meal Provider</b> {Provider Name}</p> <p>Please complete this form to the best of your ability. Items marked with an asterisk (*) are required.</p>	<p><b>*Unique Participate ID:</b> _____</p> <p>Referred by: _____</p> <p>Intake Date: _____</p> <p>Staff: _____</p> <p>Beginning Date: _____</p> <p><b>*Termination Date:</b> _____</p> <p><b>*Reason:</b> _____</p>	<p>Eligibility:</p> <p><input type="checkbox"/> Age 60+</p> <p><input type="checkbox"/> Spouse of congregate meal participant</p> <p><input type="checkbox"/> Disabled person residing where the congregate site is located</p> <p><input type="checkbox"/> Disabled person who resides with and accompanies a congregate meal participant</p> <p><input type="checkbox"/> Volunteer</p>
First Name: _____	Last Name: _____	<b>*Date of Birth:</b> _____
Home Address _____	City: _____	<b>*Zip Code</b> _____
Mailing Address: Same As Residential? <input type="checkbox"/> Yes	City: _____	<b>*Zip Code</b> _____
Home Phone: ( ) _____ Alternate Phone: ( ) _____	Emergency Contact Name: _____ Address: _____ Phone: ( ) _____ Relationship: _____	
<p><b>*Living Arrangement</b></p> <p><b># of household members:</b> <input type="text"/></p> <p><input type="checkbox"/> Declined/not stated</p>	<p><b>*What is your approximate household income?</b></p> <p>\$ _____ per <input type="checkbox"/> month <input type="checkbox"/> year</p> <p><input type="checkbox"/> Declined/not stated</p>	<p><b>*Rural Area:</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Declined/not stated</p>
<p><b>*What is your gender?</b> (Check only one)</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p><input type="checkbox"/> Transgender Male to Female</p> <p><input type="checkbox"/> Transgender Female to Male</p> <p><input type="checkbox"/> Genderqueer/Gender Non-binary</p> <p><input type="checkbox"/> Not Listed, please specify: _____</p> <p><input type="checkbox"/> Declined/not stated</p>	<p><b>*What was your sex at birth? (Check only one)</b></p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Declined/not stated</p>	<p><b>*How do you describe your sexual orientation or sexual identity?</b> (Check only one)</p> <p><input type="checkbox"/> Straight/Heterosexual</p> <p><input type="checkbox"/> Bisexual</p> <p><input type="checkbox"/> Gay/Lesbian/Same-Gender Loving</p> <p><input type="checkbox"/> Questioning/Unsure</p> <p><input type="checkbox"/> Not Listed, please specify: _____</p> <p><input type="checkbox"/> Declined/not stated</p>
<p><b>*Ethnicity:</b> (Check one)</p> <p>Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated</p>	<p>Language: _____</p> <p><input type="checkbox"/> English Speaking <input type="checkbox"/> Need interpreter <input type="checkbox"/> Non-English/Language</p>	
<p><b>*Race: (Check all that apply)</b></p> <p><input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native Asian:</p> <p><input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian</p> <p><input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Hawaiian/Other Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan</p> <p><input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined/not stated</p>		
<p><b>Notes:</b></p>          		

<b>*Nutritional Risk Assessment:</b>	<b>Circle if yes</b>	
I have an illness or condition that made me change the kind and/or amount of food I eat.	2	
I eat fewer than 2 meals per day.	3	
I eat few fruits or vegetables or milk products.	2	
I have 3 or more drinks of beer, liquor or wine almost every day.	2	
I have tooth or mouth problems that make it hard for me to eat.	2	
I don't always have enough money to buy the food I need.	4	
I eat alone most of the time.	1	
I take 3 or more different prescribed or over-the-counter drugs a day.	1	
Without wanting to, I have lost or gained 10 pounds in the past 6 months.	2	
I am not always physically able to shop, cook, and/or feed myself.	2	
Total Score:		
<b>Is Nutrition Risk total score 0-5 or 6+ ?</b>		
		<b>0 - 5</b>
		<b>6+</b>
<input type="checkbox"/> <b>Declined to State</b>		

I understand that the information I am providing on this form is for registration purposes. I understand it will be kept confidential and that the Area Agency on Aging and service providers may use it to help identify other services for which may benefit.

\_\_\_\_\_  
Signature of participant or person completing the form

\_\_\_\_\_  
Date



### SECTION 3 (FCSP Caregiver)

(\*) Required for Family Caregiver Support Program Services

<b>Caregiver Personal Data (Please print):</b>	
<b>*Unique Participant ID</b>	
First Name:	
Middle Initial:	
Last Name:	
<b>*What is your gender? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated
<b>*What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated
<b>*How do you describe your sexual orientation or sexual identity? (Check only one)</b>	<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/not stated
<b>*Birth Date:</b>	
Home Phone:	(    )
<b>Residential Address:</b>	
Street:	
City:	
<b>*Zip Code:</b>	
<b>Mailing Address:</b>	
Same as Residential? <input type="checkbox"/> Yes – Skip to Next Section	
Street:	
City:	
<b>*Zip Code:</b>	

<b>Demographics:</b>	
<b>*Ethnicity:</b>	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined/not stated
<b>*Federal Poverty Level (FPL):</b>	<input type="checkbox"/> Yes (At or below FPL) <input type="checkbox"/> No (Above FPL) <input type="checkbox"/> Declined/not stated
<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>*Rural?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>*Race: (Check all that apply)</b>	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Hawaiian/Other Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined/not stated	
<b>*Relationship to Care Receiver:</b>	<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Grandparent <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Daughter/Daughter-in-law <input type="checkbox"/> Son/Son-in-law <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Parents <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative <input type="checkbox"/> Declined/not stated
<b>*Relationship Status:</b>	<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/not stated
<b>*Employment:</b>	<input type="checkbox"/> Full Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Part Time <input type="checkbox"/> Declined/not stated <input type="checkbox"/> Retired

## SECTION 4 (FCSP Care Receiver)

(\*) Required for Family Caregiver Support Program Services

<b>Caregiver Personal Data (Please print):</b>	
<b>*Unique Participant ID</b>	
First Name:	
Middle Initial:	
Last Name:	
<b>*What is your gender? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated
<b>*What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated
<b>*How do you describe your sexual orientation or sexual identity? (Check only one)</b>	<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/not stated
<b>*Birth Date:</b>	
Home Phone:	(    )
<b>Residential Address:</b>	
Street:	
City:	
<b>*Zip Code:</b>	

<b>Mailing Address:</b>	
Same as Residential? <input type="checkbox"/> Yes – Skip to Next Section	
Street:	
City:	
<b>*Zip Code:</b>	
<b>Demographics:</b>	
<b>*Ethnicity:</b>	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined/not stated
<b>*Federal Poverty Level (FPL):</b>	<input type="checkbox"/> Yes (At or below FPL) <input type="checkbox"/> No (Above FPL) <input type="checkbox"/> Declined/not stated
<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>*Rural?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>*Race: (Select all that apply)</b>	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Hawaiian/Other Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined/not stated	
<b>*Relationship Status:</b>	<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/not stated



**SECTION 5 – (FCSP Care Receiver)**

**ADL and IADL (Activities of Daily Living and Instrumental Activities of Daily Living)**

*\*Required for the Care Receiver only in Support Services, Respite Care, and Supplemental Services.*

*(Not required for Care Receivers in FCSP Older Adults/Relative)*

<b>ADLs:</b>	<b>1 – Independent</b>	<b>2 – Verbal Assistance</b>	<b>3 – Some Human Help</b>	<b>4 – Lots of Human Help</b>	<b>5 – Dependent</b>	<b>Declined to State</b>
*Eating						
*Bathing						
*Toileting						
*Transferring In/Out of Bed/Chair						
*Walking						
*Dressing						

Notes:

<b>IADLS:</b>	<b>1 – Independent</b>	<b>2 – Verbal Assistance</b>	<b>3 – Some Human Help</b>	<b>4 – Lots of Human Help</b>	<b>5 – Dependent</b>	<b>Declined to State</b>
*Meal Preparation						
*Shopping						
*Medication Management						
*Money Management						
*Using Telephone						
*Heavy Housework						
*Light Housework						
*Transportation						

Notes:

**SAMPLE 7, TITLE III E, CAREGIVERS OF OLDER ADULTS**

**SECTION 1 – Service Information**

<b>Provider Name:</b>	<b>Registration/Assessment Date:</b>
<b>Region/Site Name:</b>	<b>*Termination Date:</b> <b>*Reason:</b>

**Title III E, Family Caregiver Support Program Services to be Provided**

<b>Support Services:</b> <input type="checkbox"/> Caregiver Assessment <input type="checkbox"/> Caregiver Support <input type="checkbox"/> Caregiver Counseling <input type="checkbox"/> Caregiver Training <input type="checkbox"/> Caregiver Peer Counseling <input type="checkbox"/> Case Management	<b>Respite Care Services:</b> <i>(Care Receiver must have 2 or more ADL limitations, a cognitive impairment, or be grandparent/elder caregiver to qualify)</i>	<input type="checkbox"/> In-Home Supervision <input type="checkbox"/> Homemaker Assistance <input type="checkbox"/> In-Home Personal Care <input type="checkbox"/> Home Chore <input type="checkbox"/> Out of Home Day <input type="checkbox"/> Out of Home Overnight
<b>Supplemental Services:</b> <i>(Care Receiver must have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/elder caregiver to qualify)</i> <input type="checkbox"/> Assistive Devices <input type="checkbox"/> Home Adaptations for Caregiving <input type="checkbox"/> Caregiving Services Registry <input type="checkbox"/> Cash/Material Aid		
<b>Access Assistance:</b> <input type="checkbox"/> Information & Assistance <input type="checkbox"/> Caregiver Outreach <input type="checkbox"/> Interpretation/Translation <input type="checkbox"/> Caregiver Legal Resources	<b>Information Services:</b> <input type="checkbox"/> Public Information on Caregiving <input type="checkbox"/> Community Education on Caregiving	

**SECTION 2 – Eligibility Criteria**

<b>Caregivers of Older Adults Eligibility Criteria</b> 1. Is the Care Receiver an older individual (60 years of age or older) <u>or</u> an individual (of any age) with Alzheimer’s disease or related disorder with neurological and organic brain dysfunction? <input type="checkbox"/> Yes <input type="checkbox"/> No  2. Is the Caregiver an adult (18 years of age or older) family member or another individual (e.g., friend or neighbor) who is an informal (i.e., unpaid) provider of in-home or community care to an “elderly” Care Receiver? <input type="checkbox"/> Yes <input type="checkbox"/> No
If the Care Receiver does not meet any of the criteria above, the Caregiver is ineligible to receive FCSP Caregivers of Older Adults services but may qualify to receive other services provided by the Area Agency on Aging.

<b>Notes:</b>
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### SECTION 3 (FCSP Caregiver)

(\*) Required for Family Caregiver Support Program Services

<b>Caregiver Personal Data (Please print):</b>	
<b>*Unique Participant ID</b>	
First Name:	
Middle Initial:	
Last Name:	
<b>*What is your gender? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated
<b>*What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated
<b>*How do you describe your sexual orientation or sexual identity? (Check only one)</b>	<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/not stated
<b>*Birth Date:</b>	
Home Phone:	(    )
<b>Residential Address:</b>	
Street:	
City:	
<b>*Zip Code:</b>	
<b>Mailing Address:</b>	
Same as Residential? <input type="checkbox"/> Yes – Skip to Next Section	
Street:	
City:	
<b>*Zip Code:</b>	

<b>Demographics:</b>	
<b>*Ethnicity:</b>	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined/not stated
<b>*Federal Poverty Level (FPL):</b>	<input type="checkbox"/> Yes (At or below FPL) <input type="checkbox"/> No (Above FPL) <input type="checkbox"/> Declined/not stated
<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>*Rural?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>*Race: (Check all that apply)</b>	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Hawaiian/Other Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined/not stated	
<b>*Relationship to Care Receiver:</b>	<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Grandparent <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Daughter/Daughter-in-law <input type="checkbox"/> Son/Son-in-law <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative <input type="checkbox"/> Declined/not stated
<b>*Relationship Status:</b>	<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/not stated
<b>*Employment:</b>	<input type="checkbox"/> Full Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Part Time <input type="checkbox"/> Declined/not stated <input type="checkbox"/> Retired

## SECTION 4 (FCSP Care Receiver)

(\*) Required for Family Caregiver Support Program Services

<b>Caregiver Personal Data (Please print):</b>	
<b>*Unique Participant ID</b>	
First Name:	
Middle Initial:	
Last Name:	
<b>*What is your gender? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated
<b>*What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated
<b>*How do you describe your sexual orientation or sexual identity? (Check only one)</b>	<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/not stated
<b>*Birth Date:</b>	
Home Phone:	(    )
<b>Residential Address:</b>	
Street:	
City:	
<b>*Zip Code:</b>	

<b>Mailing Address:</b>	
Same as Residential? <input type="checkbox"/> Yes – Skip to Next Section	
Street:	
City:	
<b>*Zip Code:</b>	
<b>Demographics:</b>	
<b>*Ethnicity:</b>	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined/not stated
<b>*Federal Poverty Level (FPL):</b>	<input type="checkbox"/> Yes (At or below FPL) <input type="checkbox"/> No (Above FPL) <input type="checkbox"/> Declined/not stated
<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>*Rural?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>*Race: (Check all that apply)</b>	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Hawaiian/Other Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined/not stated	
<b>*Relationship Status:</b>	<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/not stated

**SECTION 5 – (FCSP Care Receiver)**

**ADLs: ADLs and IADLs (Activities of Daily Living and Instrumental Activities of Daily Living):**

Required for Support Services, Respite Care, and Supplemental Services.

Please rate your functional abilities for the following activities.

ADLs	Rated Value	IADLs	Rated Value	IADLs	Rated Value	<b>RATING SCALE</b> 1 – Independent 2 – Verbal Assistance 3 – Some Human Help 4 – Lots of Human Help 5 – Dependent 6 - Declined to State
Feeding		Meal Preparation		Heavy Housework		
Dressing		Shopping		Light Housework		
Bathing		Manage Medication		Notes:		
Transferring In/Out of Chair		Money Management				
Walking		Telephone				
Toileting		Transportation				

**SAMPLE 8, TITLE III E, OLDER ELDERLY RELATIVE**

**SECTION 1- Service Information**

<b>Provider Name:</b>	<b>Registration/Assessment Date:</b>
<b>Region/Site Name:</b>	<b>*Termination Date:      *Reason:</b>

**Title III E, Family Caregiver Support Program Services to Be Provided**

<b>Support Services:</b> <input type="checkbox"/> Caregiver Assessment <input type="checkbox"/> Caregiver Support <input type="checkbox"/> Caregiver Counseling <input type="checkbox"/> Caregiver Training <input type="checkbox"/> Caregiver Peer Counseling <input type="checkbox"/> Case Management		<b>Respite Care Services:</b> <i>(Care Receiver must have 2 or more ADL limitations, a cognitive impairment, or be grandparent/elder caregiver to qualify)</i>	<input type="checkbox"/> In-Home Supervision <input type="checkbox"/> Homemaker Assistance <input type="checkbox"/> In-Home Personal Care <input type="checkbox"/> Home Chore <input type="checkbox"/> Out of Home Day <input type="checkbox"/> Out of Home Overnight
<b>Supplemental Services:</b> <i>(Care Receiver must have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/older caregiver to qualify)</i> <input type="checkbox"/> Assistive Devices <input type="checkbox"/> Home Adaptations for Caregiving <input type="checkbox"/> Caregiving Services Registry <input type="checkbox"/> Cash/Material Aid			
<b>Access Assistance:</b> <input type="checkbox"/> Information & Assistance <input type="checkbox"/> Caregiver Outreach <input type="checkbox"/> Interpretation/Translation <input type="checkbox"/> Caregiver Legal Resources		<b>Information Services:</b> <input type="checkbox"/> Public Information on Caregiving <input type="checkbox"/> Community Education on Caregiving	

**SECTION 2 – Eligibility Criteria**

**Caregivers of Older Adults Eligibility Criteria**

1. Is the Care Receiver an individual who is not more than 18 years of age or an individual (of any age) with a disability?  
 Yes       No

2. Is the Caregiver a grandparent, step-grandparent, or other older relative of a child by blood, marriage, or adoption who is 55 year of age or older living with the child, and identified as the primary caregiver through a legal or informal arrangement? Biological and adoptive parents are excluded       Yes       No

If the Care Receiver does not meet any of the criteria above, the Caregiver is ineligible to receive FCSP Grandparent Caring for Child services but may qualify to receive other services provided by the Area Agency on Aging.

**Notes:**

**SECTION 3 (Grandparent/Older Caregiver)**  
 (\*) Required for Family Caregiver Support Program Services

<b>Caregiver Personal Data (Please print):</b>	
<b>*Unique Participant ID</b>	
First Name:	
Middle Initial:	
Last Name:	
<b>*What is your gender? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated
<b>*What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated
<b>*How do you describe your sexual orientation or sexual identity? (Check only one)</b>	<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/not stated
<b>*Birth Date:</b>	
Home Phone:	(    )
<b>Residential Address:</b>	
Street:	
City:	
<b>*Zip Code:</b>	
<b>Mailing Address:</b>	
Same as Residential? <input type="checkbox"/> Yes – Skip to Next Section	
Street:	

City:	
<b>*Zip Code:</b>	
<b>Demographics:</b>	
<b>*Ethnicity:</b>	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined/not stated
<b>*Federal Poverty Level (FPL):</b>	<input type="checkbox"/> Yes (At or below FPL) <input type="checkbox"/> No (Above FPL) <input type="checkbox"/> Declined/not stated
<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>*Rural?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>*Race: (Check all that apply)</b>	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Hawaiian/Other Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined/not stated	
<b>*Relationship to Care Receiver:</b>	<input type="checkbox"/> Grandparent <input type="checkbox"/> Parent <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative <input type="checkbox"/> Declined/not stated
<b>*Relationship Status:</b>	<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/not stated
<b>*Employment:</b>	<input type="checkbox"/> Full Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Part Time <input type="checkbox"/> Declined/not stated <input type="checkbox"/> Retired

## SECTION 4 (Child)

(\*) Required for Family Caregiver Support Program Services

<b>Caregiver Personal Data (Please print):</b>	
<b>*Unique Participant ID</b>	
First Name:	
Middle Initial:	
Last Name:	
<b>*What is your gender? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: <hr style="width: 50%; margin-left: 0;"/> <input type="checkbox"/> Declined/not stated
<b>*What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated
<b>*How do you describe your sexual orientation or sexual identity? (Check only one)</b>	<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: <hr style="width: 50%; margin-left: 0;"/> <input type="checkbox"/> Declined/not stated
<b>*Birth Date:</b>	
Home Phone:	(    )
<b>Residential Address:</b>	
Street:	
City:	
<b>*Zip Code:</b>	

<b>Mailing Address:</b>	
Same as Residential? <input type="checkbox"/> Yes – Skip to Next Section	
Street:	
City:	
<b>*Zip Code:</b>	
<b>Demographics:</b>	
<b>*Ethnicity:</b>	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined/not stated
<b>*Federal Poverty Level (FPL):</b>	<input type="checkbox"/> Yes (At or below FPL) <input type="checkbox"/> No (Above FPL) <input type="checkbox"/> Declined/not stated
<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>*Rural?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>*Race: (Check all that apply)</b>	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Hawaiian/Other Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined/not stated	
<b>*Relationship Status:</b>	<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/not stated



# SAMPLE 9, INFORMATION & ASSISTANCE

Date: \_\_\_\_\_

Staff Completing Intake: \_\_\_\_\_

\*Indicates optional demographic information that is kept confidential and anonymous. This information is important in understanding the people that we serve.

Demographic Data	
<b>*Unique Participant ID:</b>	
Name:	
<b>*Birth Date:</b>	
Home Phone #:	(    )
Email:	
Address:	
<b>*What is your gender? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated
<b>*What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated
<b>*How do you describe your sexual orientation or sexual identity? (Check only one)</b>	<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/not stated
<b>*Ethnicity:</b>	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined/not stated

<b>*Race: (Check all that apply)</b>	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Hawaiian/Other Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined/not stated
<b>*Federal Poverty Level (FPL):</b>	<input type="checkbox"/> Yes (At or below FPL) <input type="checkbox"/> No (Above FPL) <input type="checkbox"/> Declined/not stated
<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>*Rural?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>Service Requested:</b>	
<b>Action Taken/Referral:</b>	
<b>Follow Up:</b>	
<b>Type of I &amp; A:</b>	
<input type="checkbox"/> III B (If Requesting Services for an Older Individual) <input type="checkbox"/> III E Caregivers (If Requesting Services for an Older Individual) <input type="checkbox"/> III E Relative (If Requesting Services for an Older Individual)	

# SAMPLE 10, III B LEGAL ASSISTANCE

Date: \_\_\_\_\_

Staff Completing Intake: \_\_\_\_\_

## \*Required Information

PERSONAL DATA	
<b>*Unique Participant ID:</b>	
Name:	
<b>*Birth Date:</b>	
Phone #:	(    )
Email:	
Address:	
<b>*What is your gender? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated
<b>*What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated
<b>*How do you describe your sexual orientation or sexual identity? (Check only one)</b>	<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/not stated
<b>*Ethnicity:</b>	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined/not stated
<b>*Race: (Check all that apply)</b>	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Hawaiian/Other Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined/not stated

<b>*Federal Poverty Level (FPL):</b>	<input type="checkbox"/> Yes (At or below FPL) <input type="checkbox"/> No (Above FPL) <input type="checkbox"/> Declined/not stated
<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
<b>*Rural?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
CASE INFORMATION	
<b>*Unique Case ID:</b>	
<b>*Case Opened Date:</b>	
<b>*Case Closed Date:</b>	
<b>*Service Level:</b>	<input type="checkbox"/> Advice <input type="checkbox"/> Limited Representation <input type="checkbox"/> Representation
<b>*Case Type:</b>	<input type="checkbox"/> Income <input type="checkbox"/> Health Care <input type="checkbox"/> Long Term Care <input type="checkbox"/> Nutrition <input type="checkbox"/> Housing <input type="checkbox"/> Utilities <input type="checkbox"/> Abuse/Neglect <input type="checkbox"/> Protective Services <input type="checkbox"/> Age Discrimination <input type="checkbox"/> Other/Miscellaneous
<b>*Hours (Units):</b>	