Older Americans Act Services Intake Form

Tell us about yourself.

Today's Date: / /	**Preferred Phone:** ( )	
First Name:	**Last Name:**	**MI:**
Date of Birth: / /	**Email:**	
Address:	**City:** **State:**	**Zip:**

The following data is asked by our funders and will not be disclosed by name.

Gender: ☐ Female ☐ Male ☐ Other

Primary Language: ☐ English ☐ Other:

Check the racial categories that apply to you:

☐ AfricanAmerican/Black
☐ American Indian/Alaskan Native
☐ Asian
☐ Native Hawaiian/Other Pacific Islander
☐ White
☐ Other:

Are you Hispanic or Latino? ☐ Yes ☐ No

Are you a veteran? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

If Yes, is your annual household income more than $14,580? ☐ Yes ☐ No

If No, is your annual household income more than:

If 2 people, is your annual household income more than $19,720? ☐ Yes ☐ No
If 3 people, is your annual household income more than $24,860? ☐ Yes ☐ No
If 4 people, is your annual household income more than $30,000? ☐ Yes ☐ No
If 5 people, is your annual household income more than $35,140? ☐ Yes ☐ No
If 6 or more people, is your annual household income more than $40,280? ☐ Yes ☐ No

Are you interested in learning about any other services?

☐ Caregiver Support
☐ Health and Wellness Classes
☐ Legal Assistance
☐ Meals
☐ Nutrition Counseling
☐ Options to return to home
☐ Options to stay at home
☐ Transportation

Help us serve you better by answering the following questions

Did you need help with:	I did not need help	I needed help sometimes	I always needed help
Cleaning your house?	☐	☐	☐
Managing medications?	☐	☐	☐
Managing your money/paying bills?	☐	☐	☐
Preparing meals?	☐	☐	☐
Shopping?	☐	☐	☐
Sort, load, wash, dry and fold laundry?	☐	☐	☐
Using the telephone?	☐	☐	☐
Using transportation/car?	☐	☐	☐

IADL Data Entry: Independent Sometimes dependent/limited assistance Totally dependent

During the past 7 days did you need help:	I did not need help	I needed help sometimes	I always needed help
Bathing or showering?	☐	☐	☐
Eating?	☐	☐	☐
Getting dressed?	☐	☐	☐
Getting out of or into a bed or chair?	☐	☐	☐
Getting to toilet on time? (able to control bladder/bowels?)	☐	☐	☐
Using the toilet?	☐	☐	☐

ADL Data Entry: Independent Sometimes dependent/limited assistance Totally dependent

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This section to be completed by the provider.

Consumer:

Provider:

☐ New Intake Form ☐ Updated Intake Form

Check the box next to the service provided:

- ☐ Adult Day Care/Health
- ☐ Assisted Transportation
- ☐ Case Management
- ☐ Chore
- ☐ EAPA Assessment & Intervention
- ☐ Emergency Response System
- ☐ Homemaker
- ☐ Material Aid
  - ☐ Assistive Technology/Durable Equipment
  - ☐ Consumable Supplies
  - ☐ Home Modification/Repair
  - ☐ Other
- ☐ Options Counseling
- ☐ Personal Care
- ☐ Transportation