RIVERSIDE COUNTY OFFICE ON AGING

Title III-B Intake Form

Title III-B Service Name of Provider This form is designed to be completed by an intake staff. Items marked with asterisk (*) are required.	Route:	Intake Date: _____ Active Date:_____ Inactive Date:_____ Active Date:_____ Inactive Date:_____ Active Date:_____ Inactive Date:_____
*Unique Participant ID:	***Termination Date:**	***Reason:**

***First Name:**	***Last Name:**	MI:	***Date of Birth:** / /
***Home Address:**	***City:**	***County:**	***Zip Code:**
Directions/Identifiers:			
Mailing Address: Same As Residential? ☐ Yes	City:	County:	* Zip Code:
Best Contact Phone: ( ) Alternate Phone: ( )	Emergency Contact Name: Phone: ( ) Relationship to you:		

***Veteran**

***Have you ever served in the United States military?** ☐ **YES** ☐ **NO** ☐ **Declined/not stated**	***Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?** ☐ **YES** ☐ **NO** ☐ **Declined/not stated**

***If you identify as being military affiliated, check below if:**
"I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for 12 months.

☐ **YES** ☐ **NO**	Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626

***What is your approximate household income?** $_____ per ☐ month ☐ year ☐ Declined to State	***Rural Area?** ☐ Yes ☐ No ☐ Declined to State

***Poverty Status:** (calculate from household income)
☐ At or Below 100% of the Federal Poverty Level (FPL) ☐ Above 100% of the FPL ☐ Declined to State

*** What is your gender? (Check only one)**
☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female
☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated

*** What was your sex at birth? (Check only one)** ☐ Male ☐ Female ☐ Declined/not stated	*** How do you describe your sexual orientation or sexual identity? (Check only one)** ☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated

***Marital Status:** ☐ Single (Never Married) ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Separated ☐ Widowed Since When: _____ ☐ Declined to State

***Ethnicity** (Check One): Hispanic ☐ Yes ☐ No ☐ Decline to State

Language: ☐ English speaking ☐ Need interpreter ☐ Non-English/Language: _____

***Race**: (Check One) ☐ White ☐ Black ☐ American Indian/Alaska Native ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Multiple Race ☐ Other Race_____ ☐ Declined to State

***Living Arrangement:** ☐ Live Alone ☐ Do Not Live Alone ☐ Decline to State ☐ # of Household Members

ADLs and IADLs (Activities of Daily Living and Instrumental Activities of Daily Living)
Use the rating scale to rate the client's current functional ability for each of the following activities.

ADLs	Rating	IADLs	Rating	IADLs	Rating	RATING SCALE
***Eating**		***Meal Preparation**		***Telephone (1-3 & 5)**		1 = Independent
***Bathing**		***Shopping/Errands (1,3,5)**		***Heavy Housework**		2 = Verbal Assistance
***Toileting**		***Manage Medications**		***Light Housework**		3 = Some Human Help
***Transferring in/out of bed/chair**		***Money Management (1-3 & 5)**		***Transportation (1-3 & 5)**		4 = Lots of Human Help
***Walking**		**Total IADLs** (how many activities above are rated "2" to "5")				5 = Dependent
*** Dressing**						6 = Declined to State
***Total ADLs** (how many activities above are rated from "2" to "5")		Notes:				

Receiving IHSS Services? ☐ Yes ☐ No ☐ Declined to State
If yes, number of IHSS hours receiving? _____Weekly _____Monthly ☐ Declined to State

Nutritional Risk Assessment:** ***(for each item, circle the number in the appropriate column)	**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:	
(If equal to or greater than 6, the client is at high nutritional risk)	☐ **Declined to State**

Referral(s) Made:

☐ Nutritional education/counseling for at risk client

☐ _____

☐ _____

☐ _____

Notes:

I understand the information I am providing will be kept confidential and that it may be used to identify other services for which I qualify.

_____ _____ _____ _____

Staff Completing Assessment Date Client Signature Date