



Area Agency on Aging of the Capital Area (AAACAP) – Client Services Intake Form

Funded in Part by Health and Human Services

All information, requested is required and used as statistical data for funding purposes. – PLEASE PRINT

Release of Information: Information from this form may be used by the AAACAP and the Health & Human Services. All information will remain confidential and used only for official purposes. Information gathered from intake or assessment may be used to effectively plan, arrange and deliver services. (Client Initials _____ Date: ___/___/___)

Date Registered/Intake Date [MM/DD/YEAR]: _____/_____/_____

___ NEW ___ Update ___ Reinstatement ___ Congregate ___ Home Delivered ___ Transportation

Mark One Eligibility: Age 60 or Over: ___ Spouse of Eligible Client: _____

Other: Person under age 60 with a disability living in elderly housing: ___ Volunteer: ___

____ Person under age 60 with a disability living with person age 60 or over

NAME: [First MI Last] _____ AKA: _____

Date of Birth: [MM/DD/YEAR] _____/_____/_____ Gender: Male ___ Female ___

Lives Alone? Yes ___ No ___ Disabled: Yes ___ No ___

Understands English: ___ Yes If No, primary language is: _____

Client Annual Income: ___ below < \$12,600 > ___ above Military Service: ___ Yes ___ No

Phone: _____ - _____ - _____ Mark if this is a cell phone: _____ No Phone: _____

Residential Address: _____

City: _____ County: _____ Zip Code: _____ TX

Mailing address (If different): _____

Ethnic Race: ___ American Indian/Alaskan Native ___ Asian ___ Black/African American ___ White Hispanic ___ White Non-Hispanic [non-minority] ___ Native Hawaiian/Pacific Islander ___ Other: _____

Ethnicity: ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Other: _____

Targeting Criteria: Mark all that apply for Those Age 60 or over for funding purposes only.

- ___ At risk of institutional placement ___ Resides in rural area ___ Has greatest economic need
___ Has greatest social need ___ Has Alzheimer’s disease or related disorders/dysfunctions
___ Has severe disability ___ Has limited English proficiency

EMERGENCY CONTACT: List Only One. Mark here if there is NO Emergency contact: _____

Name: _____ Relationship: _____

Phone Number: _____ - _____ - _____ Check if this is a cell phone. _____

Release of information has been read by the client on: _____/_____/_____

+++++FOR OFFICE USE ONLY+++++
Printed Name of staff/volunteer reviewing intake: _____

Signature of staff/volunteer reviewing intake: _____

Date Form Completed: _____/_____/_____

Provider/Site/Route: _____ Phone: _____ - _____ - _____

Notes _____