Title III – Intake and Assessment Forms Guide

CALIFORNIA DEPARTMENT OF AGING

HOME AND COMMUNITY LIVING DIVISION

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Title III - Intake and Assessment Forms Guide

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Overview

Introduction

Data and the information created from data elements contribute to valuable knowledge about service use and client demographics. It is a source for Area Agencies on Aging (AAA), California Department of Aging (CDA), and U.S. Administration for Community Living (ACL) performance measures.

Background

AAA staff spend a large percentage of their time reading, completing, processing, and retrieving forms created or received by the agency.

Forms are an important part of the operations that aid in the collection and documentation of information. Well-designed and well-managed forms can reduce errors and save time and money.

Purpose

The purpose of this guide is to help AAA staff identify the required ACL and CDA Title III data elements. This guide provides AAAs with guidance, resources, and sample layouts and forms tohelp AAAs evaluate and design agency intake forms.

NOTE: *This guide does not address Community Based Service Programs (CBSP), Health Insurance Counseling and Advocacy Program (HICAP), Multipurpose Senior Services Program (MSSP), Long-Term Ombudsman Program, Senior Community Services Employment Program (Title V), or fiscal forms.*

Data Performance Reporting Requirements

Purpose

The Older Americans Act (OAA) requires a report of statistical data reflecting the number of service units provided and the number of registered clients or the estimated clients/audience reached.

Process

Data Performance Management Process

Entity	Role
Provider or AAA	• collects and tracks client/user information and service units • reports service utilization units, consumer demographics and expenditures • maintains records
AAA	• plans and administers OAA data management system(s) • implements CDA data reporting requirements • develops and maintains written procedures • analyzes, corrects, and verifies data • monitors and evaluates local services • trains staff and provides technical assistance to the providers, clients, and caregivers • reports data to CDA via the statewide California Aging Reporting System (CARS)
CDA	• sets data reporting standards • monitors and evaluates AAA programs • plans and administers the CARS • provides AAAs with training and technical assistance as needed • reports data and program information to ACL and the California State Legislature
ACL	• provides Congress, states, and other stakeholders with Older Americans Act Performance System (OAAPS) data

CARS Approval

AAAs shall ensure that all data submitted is complete, accurate, timely, and verifiable.

AAA staff must approve CARS File Upload quarterly data and SPR annual data within 10 days of notice of passed status. If the data cannot be corrected within 10 days, AAA staff must provide an explanation in the comments box on the report screen. CDA will be able to review the data after the 10-day approval period.

OAAPS Validation

As part of the annual year-end performance reporting process, the AAA Director, or designee, will be required to validate the OAAPS data.

What is Reviewed?

CDA reviews the accuracy and completeness of the reported data on a regular basis. CDA reviews intake and assessment forms, reporting performance information, supporting documents, and reporting procedures during the CDA monitoring process.

AAAs shall keep complete records/documents on file to support all reports submitted to CDA. All paper and electronic client information records, data elements, and printouts collected are confidential and shall be secured and remain protected from unauthorized disclosure.

Designing Forms that Work

Introduction

The arrangement of the questions on the form will make it easier to enter, complete, and retrieve information.

Group Data

Group related items with clearly defined sections to make the form easier to fill out. It can also eliminate the need for backtracking and reduces incomplete or missing data elements.

Databases may have separate data entry screens for

- Client Detail Identification
- Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), and/or
- Nutritional Risk Screening

Establish Item Sequence

Arrange questions in a sequence that will match the structure of the database configuration. This will allow for easier data entry from one section to the next without having to search the form for the correct entry area.

Make Required Questions Clear

Make required data elements clear and visible. Design forms to clearly define form fields with bound boxes and headers.

What is Reviewed?

CDA reviews AAA forms to ensure all required data collection elements are integrated. See Chart Guidelines.

Required Title III B and C (Clusters I & II), Registered/Restricted Client Fields

Chart Guidelines

Apply the following chart to determine if intake form(s) have required data collection and reporting elements for Title III B and C (Clusters I and II) Programs.

CARS Title III B and C Required Registered/Restricted Client Fields – Cluster I

Service Category	Service Units	Registered/ Restricted Client [1]	ADL & IADL [2]	Nutritional Risk [3]	Case Information [4]	Funding Source
Personal Care	**X** Hour	**X**	**X**			III B
Homemaker	**X** Hour	**X**	**X**			III B
Chore	**X** Hour	**X**	**X**			III B
Adult Day Care/Health	**X** Hour	**X**	**X**			III B
Case Management	**X** Hour	**X**	**X**			III B
Home-Delivered Meals	**X** Meal	**X**	**X**	**X**		III C

(X) Required Element

CARS Title III B and C Required Registered/Restricted Client Fields – Cluster II

Service Category	Service Units	Registered/ Restricted Client [1]	ADL & IADL [2]	Nutritional Risk [3]	Case Information [4]	Funding Source
Congregate Meals	**X** Meal	**X**		**X**		III C
Nutrition Counseling	**X** Session	**X**		**X**		III C
Assisted Transportation	**X** One-way Trip	**X**				III B
Legal Assistance	**X** Hour	**X**			**X**	III B

(X) Required Element

[1]Registered/Restricted Client Required Client Level Detail

- Participant IDto Determine Unduplicated Count
- Birth Date
- Zip Code
- Rural Designation
- Gender
- Sex at Birth
- Sexual Orientation or Sexual Identity
- Race
- Ethnicity
- Poverty Status
- Living Arrangement
- Veteran Status (registered only)

Required Title III B and C (Clusters I & II), Registered Client Fields, Continued

[2] ADL/IADL Required Functional Rating Scale for each of the following:

- ADL: Eating
- ADL: Bathing
- ADL: Toileting
- ADL: Transferring in/out of bed/chair
- ADL: Walking
- ADL: Dressing
- IADL: Meal Preparation
- IADL: Shopping
- IADL: Medication Management
- IADL: Money Management
- IADL: Using Telephone
- IADL: Heavy Housework
- IADL: Light Housework
- IADL: Transportation

ADL & IADL Functional Impairment Rating Scale

(1) Independent: Can perform a task without human assistance.
(2) Verbal Assistance: Requires verbal prompting to begin or complete a task.
(3) Some Human Help: Requires some physical assistance to perform a task.
(4) Lots of Human Help: Requires substantial assistance to perform a task.
(5) Dependent: Totally dependent on another person to perform a task.
(6) Declined to State
(0) Missing

Or as default, report only three levels: 1, 3, or 5 (and 6 – Declined to State).

[3] Nutritional Risk - Required Score

(1) Yes: Nutritional risk with score of 6 or higher.
(2) No: Nutritional score with 5 or lower.
(3) Declined to State
(0) Missing

Scores are based on the *Determine Your Nutritional Health* checklist.

[4] Case Information

- Case ID
- Case Opened Date
- Case Closed Date
- Service Type
- Service Level

Required Title III E, Registered/Restricted Caregiver Fields

Chart Guidelines

Apply the following chart to determine if intake form(s) have the required data collection and reporting elements for the Title III E Family Caregiver Support Program (FCSP), **Caregivers of Older Adults** and **Older Relative Caregivers**.

Required Caregiver Fields

Family Caregiver Service Category	Service Units		Client Level Detail [1]
Assessment	**X**	Hour	**X**
Counseling	**X**	Hour	**X**
Training	**X**	Hour	**X**
Case Management	**X**	Hour	**X**
Respite In-Home	**X**	Hour	**X**
Respite Other	**X**	Hour	**X**
Legal Consultation	**X**	Hour	**X**
Respite Out-of-Home Day Care	**X**	Hour	**X**
Respite Out-of-Home Overnight Care	**X**	Hour	**X**
Assistive Technology	**X**	Device/Occurrence	**X**
Home Modifications	**X**	Modification/Occurrence	**X**
Registry	**X**	Hour/Occurrence	**X**
Consumable Supplies	**X**	Assistance/Occurrence	**X**

(X) Required Element

[1] Caregiver Client Level Detail

- Participant ID to Determine Unduplicated Count
- Birth Date
- Zip Code
- Rural Designation
- Gender
- Sex at Birth
- Sexual Orientation or Sexual Identity
- Race
- Ethnicity
- Poverty Status
- Living Arrangement
- Relationship Status
- Caregiver Relationship
- Veteran Status

Required Title III E, Registered Care Receiver Fields

Chart Guidelines

Apply the following chart to determine if intake form(s) have required data collection and reporting elements for the Care Receiver in the Title III E, Family Caregiver Support Program (FCSP), "**Caregivers of Older Adults and Older Relative Caregivers."** Note that ADL & IADL requirements do not apply to Older Relative Caregivers programs and services.

Required Care Receiver Fields

Family Caregiver Service Category	**Client Level Detail [2]**	**ADL & IADL [3]** ("Caregivers of Older Adults" programs only)
Assessment	**X**	**X**
Counseling	**X**	**X**
Training	**X**	**X**
Case Management	**X**	**X**
Respite In-Home	**X**	**X**
Respite Other	**X**	**X**
Legal Consultation	**X**	n/a
Respite Out-of-Home Day Care	**X**	**X**
Respite Out-of-Home Overnight Care	**X**	**X**
Assistive Technology	**X**	**X**
Home Modifications	**X**	**X**
Registry	**X**	**X**
Consumable Supplies	**X**	**X**

(X) Required Element

[2] Care Receiver Client Level Detail

- Participant ID to Determine Unduplicated Count
- Birth Date
- Zip Code
- Rural Designation
- Gender
- Sex at Birth
- Sexual Orientation or Sexual Identity
- Race
- Ethnicity
- Poverty Status
- Living Arrangement
- Relationship Status
- Veteran Status

Required Title III E, Registered Care Receiver Fields, Continued

[3] ADL/IADL Required Functional Rating Scale for each of the following:

- ADL: Eating
- ADL: Bathing
- ADL: Toileting
- ADL: Transferring in/out of bed/chair
- ADL: Walking
- ADL: Dressing
- IADL: Meal Preparation
- IADL: Shopping
- IADL: Medication Management
- IADL: Money Management
- IADL: Using Telephone
- IADL: HeavyHousework
- IADL: Light Housework
- IADL: Transportation

ADL & IADL Functional Impairment Rating Scale

(1) Independent: Can perform a task without human assistance.
(2) Verbal Assistance: Requires verbal prompting to begin or complete a task.
(3) Some Human Help: Requires some physical assistance to perform a task.
(4) Lots of Human Help: Requires substantial assistance to perform a task.
(5) Dependent: Totally dependent on another person to perform a task.
(6) Declined to State
(0) Missing

Or as default, report only three levels: 1, 3, or 5 (and 6 – Declined to State).

NOTE: *There is no ADL or IADL data collection requirements for Care Receivers in FCSP Older Relative Caregivers services.*

Required Registered/Restricted Client Level Detail

Introduction

OAA programs use client demographic elements for targeting and/or reporting purposes. The required registered/restricted client level details are birth date, zip code, rural designation, gender, sex at birth, sexual orientation or gender identity, race, ethnicity, poverty status, veteran status (registered only), relationship status, and living arrangement.

Service Categories Required

The following are the programs that require collecting client level details for registered/restricted clients,or FCSP caregivers *and* care receivers.

Title III B Supportive Services and III C Nutrition Services

- Personal Care
- Homemaker
- Chore
- Home-Delivered Meals
- Adult Day Care/Health
- Case Management
- Congregate Meals
- Nutritional Counseling
- Assisted Transportation
- Legal Assistance

Title III E, FCSP Caregivers of Older Adults/Older Relative Caregivers: Caregiver & Care Receiver

ACCESS ASSISTANCE

- Case Management

SUPPORT SERVICES

- Counseling
- Training

RESPITE CARE

- In-Home
- Other
- Out-of-Home Day Care
- Out-of-Home Overnight Care

SUPPLEMENTAL SERVICES

- Assistive Technology
- Home Modifications
- Legal Consultation
- Assessment
- Registry
- Consumable Supplies

Required Registered/Restricted Client Level Detail, Continued

What is Reviewed?

CDA reviews registered/restricted client level details for completeness. The client's information is self- reported and collected annually. If a client declines to provide information, document the action. Service cannot be denied to eligible clients declining to provide information.

All the listed data elements, except for birth date, include a "Declined to State" option which is calculated separately from "missing" information. Missing information occurs when a client is not asked to identify the required demographic data element or information was not entered into the AAA database.

Birthday

Collect the month (##), day (##), and year (####) of birth.

Elements Zip Code

Zip Code can be collected as ##### or ##### - ####.

Sexual Orientation and Gender Identity (SOGI)

The following reflects California's Government Code Section 8310.8 reporting requirements for collecting different sexual orientation and gender identity groups.

Gender CARS Options

- Male
- Female
- Transgender Female toMale
- Transgender Male to Female
- Genderqueer/GenderNon-binary
- Not listed.
  Please specify: ____
- Declined to State
- Missing

Sex at Birth CARS Options

- Male
- Female
- Declined to State
- Missing

Sexual Orientation or Sexual Identity CARS Options

- Straight/ Heterosexual
- Bisexual
- Gay/Lesbian/Same-Gender Loving
- Questioning/ Unsure
- Not listed.
  Please specify: ____
- Declined to State
- Missing

Rural Designation

The Administration of Community Living (ACL) requires that rural designation now be determined by Rural-Urban Commuting Area (RUCA) codes. These codes classify census tracts using measures such as population density, urbanization, and daily commuting. Each zip code has a corresponding RUCA code.

Rural RUCA codes: 4.0, 4.2, 5.0, 5.2, 6.0, 6.1, 7.0, 7.2, 7.3, 7.4, 8.0, 8.2, 8.3, 8.4, 9.0, 9.1, 9.2, 10.0, 10.2, 10.3, 10.4, 10.5, and 10.6.

Urban RUCA codes: 1.0, 1.1, 2.0, 2.1, 3.0, 4.1, 5.1, 7.1, 8.1, and 10.1.

To find more information on RUCA codes visit the USDA Economic Research Service's Rural-Urban Commuting Area codes website at www.ers.usda.gov/data-products/.

Rural Designation CARS Options

- Rural
- Urban
- Declined to State
- Missing

Race

The following reflects the Office of Management and Budget's (OMB) reporting requirement for collecting race, and California's Government Code Section 8310.5 reporting requirement for collecting different Asian and Native Hawaiian/Other Pacific Islander groups.

Race CARS Options

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

Ethnicity

The following reflects the OMB's ethnicity reporting requirement. Hispanic or Latino origin is **a separate question from the race category**.

Ethnicity CARS Options

- Not Hispanic/Latino
- Hispanic/Latino
- Declined to State
- Missing

Living Arrangement

ACL defines "living alone" as a one-person household (using the Census definition of household) where the householder lives by his or herself in an owned or rented place of residence in a non-institutional setting.

Living Arrangement CARS Options

- Alone
- Not Alone
- Declined to State
- Missing

Relationship Status

The following reflects ACL's reporting requirements for collecting relationship status.

Relationship Status CARS Options

- Single (Never Married)
- Married
- Domestic Partner
- Separated
- Divorced
- Widowed
- Declined to State
- Missing

Veteran Status

The following reflects the California's Government Code Section 11019.12 reporting requirements for collecting veteran status.

Veteran Status CARS Options

- Yes
- No
- Declined to State
- Missing

Required Registered/Restricted Client Level Detail, Continued

Unique Participant ID

ACL requires that State Units on Aging (SUA) report the total unduplicated clients who were served in registered/restricted services. The most accurate method to avoid duplicating information is by assigning a unique participant identifier to a client (generally, each AAA data management system creates this identifier once the minimum data elements are entered into the system). All services received by the client can be tracked by tying them to the client's unique participant identifier.

When developing a unique identification number, AAAs must ensure that personal, sensitive, and confidential information is protected from inappropriate or unauthorized access or disclosure. AAAs must have written confidentiality procedures to ensure that no personal information is disclosed by the AAA or provider without the informed consent of the client.

OAA services cannot be denied to eligible clients if they do not wish to disclose their information.

The unique "Participant ID" must be collected as an integer.

Termination Date

This is the date on which the participant stopped receiving a service. This date must be collected as YYYY-MM-DD.

Termination Reason

This field identifies the reason for terminating services (i.e., deactivating a client).

Reason for Deactivation CARS Options

- Deceased
- No Longer MSSP Eligible
- Moved out of Service Area
- Will not Follow Care Plan
- No Longer Desires Services
- On Hold
- No Longer SNF Certifiable
- Past Active
- Institutionalization
- On Waiting List
- High Cost of Services
- Other Reason

Federal Poverty Determination

Introduction

While the OAA is concerned with the provision of services to all older people, it requires assurance that preference is given to older individuals with greatest economic or social need, with particular attention to low-income minority individuals.

Under the OAA, “greatest economic need” means the need resulting from an income level at or below poverty levels established by OMB.

ACL uses the Federal Poverty Guidelines for targeting and reporting.

Service Categories Required

The following are the programs that require collecting poverty status for registered/restricted clients, or FCSP caregivers *and* care receivers.

Title III B, C, and D, Supportive and Nutrition Services

- Personal Care
- Homemaker
- Chore
- Home-Delivered Meals
- Adult Day Care/Health
- Case Management
- Congregate Meals
- Nutritional Counseling
- Assisted Transportation
- Legal Assistance

Title III E, FCSP Caregivers of Older Adults/Older Relative Caregivers: Caregiver & Care Receiver

ACCESS ASSISTANCE

- Case Management

SUPPORT SERVICES

- Counseling
- Training

RESPITE CARE

- In-Home
- Other
- Out-of-Home Day Care
- Out-of-Home Overnight Care

SUPPLEMENTAL SERVICES

- Assistive Technology
- Home Modifications
- Legal Consultation
- Assessment
- Registry
- Consumable Supplies

Federal Poverty Determination, Continued

What to Include?

Create a question to determine if the client, caregiver, or care receiver is at or below 100 percent of the federal poverty level.

Information is self-reported and collected annually.

What is Reviewed?

CDA will review demographic data to determine if AAAs are reaching individuals who are at or below the federal poverty line.

Use one of the examples below or create one. If the form does not list the federal poverty amounts, include an instructional sheet.

Example 1
☐ At or Below FPL *(Low Income)*
☐ Above FPL
☐ Declined to State

Example 2
Total # Living in Household: _____
Approx. Monthly Gross Income: $____
☐ Declined to State

Example 3
# of Household Members (Circle One) **1 2 3 4 5 6 7 8+**
What is Your Approximate Household Income? $_____Per Month/ Per Year
☐ Declined to State

Example 4
☐ Living Alone: Less than $#,### Per Month
☐ Two Person Household: Less than $#,### Per Month
☐ Other
☐ Declined to State

Resources

The U.S. Department of Health and Human Services (HHS) updates information periodically. The Federal Register Poverty Guidelines are normally published in late January each year. The guidelines can also be found on the Assistant Secretary for Planning and Evaluation website.

Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Functional Impairment Status

Introduction

OAA programs use the Activities of Daily Living (ADL) and Instrumental Activities of Daily Living(IADL) functional impairment scale to identify individuals with functional limitations. AAAs must also review functional limitations to determine eligibility for the provision of FCSP Caregivers of Older Adults Respite Care and Supplemental Services.

The OAA preference is to give services to older individuals with greatest social need. The term “greatest social need” means the need caused by non-economic factors that include

(A) physical and mental disabilities
(B) language barriers
(C) cultural, social, or geographical isolation, including isolation caused by racial or ethnic status that
    (i) restricts an individual’s ability to perform normal daily tasks
    (ii) threatens such individuals’ capacity to live independently

Service Categories Required

The table below lists the programs that require ADL and IADL limitation status for registered clients.

Title III B and C-2, Supportive and Nutrition Services

- Personal Care
- Homemaker
- Chore
- Home-Delivered Meals
- Adult Day Care/Health
- Case Management

ADL and IADL Functional Impairment Status, Continued

Service Categories Required, Continued

The table below lists the programs that require ADL and IADL limitation status for registered care receivers in the FCSP Caregivers of Older Adults.

Title III E, FCSP Caregivers of Older Adults: Care Receiver

ACCESS ASSISTANCE

- Case Management

SUPPORT SERVICES

- Counseling
- Training

RESPITE CARE

- In-Home
- Other
- Out-of-Home Day Care
- Out-of-Home Overnight Care

SUPPLEMENTAL SERVICES

- Assistive Technology
- Home Modifications
- Legal Consultation
- Assessment
- Registry
- Consumable Supplies

What to Include?

Create six (6) ADL and eight (8) IADL questions with the functional ability rating scale to determine the impairment level of the applicant or client.

Information is self-reported and collected annually. Conduct reassessment as needed, based on changes in the client's status within the year.

NOTE: Arrange questions to match database entry sequence.

How to Determine Score?

ACL defines "impairment in Activities of Daily Living (ADL)" as the inability to perform one or more of the following six activities of daily living without personal assistance, stand-by assistance, supervision, or cues: eating, dressing, bathing, toileting, transferring in and out of bed/chair, and walking.

ACL defines "impairment in Instrumental Activities of Daily Living (IADL)" as the inability to perform one or more of the following eight instrumental activities of daily living without personal assistance, or stand-by assistance, supervision or cues: preparing meals, shopping for personal items, medication management, managing money, using the telephone, doing heavy housework, doing light housework, and transportation ability (transportation ability refers to the individual's ability to make use of available transportation without assistance).

ADL and IADL Functional Impairment Status, Continued

The ADL and IADL functional ability rating scale is applied to each question. The CARS system will count the number of ADLs and IADLs where verbal or human assistance is required. An applicant's or client's sum determines the overall level of functional impairment.

- If the Combined Total Number of ADLs & IADLs is **0**
  Then Client is **independent, has no functional limitations.**
- If the Combined Total Number of ADLs & IADLs is **1-2**
  Then Client is **impaired, has minimal or mild functional impairments.**
- If the Combined Total Number of ADLs & IADLs is **3 or more**
  Then Client is **severely disabled and vulnerable to loss of independence.**

What is Reviewed?

CDA will review demographic data to determine if the AAA is reaching individuals who are functionally impaired.

To qualify for Title III E, FCSP Caregivers of Older Adults Respite Care and Supplemental Services care receivers must have two or more ADL limitations or a cognitive impairment.

ADL and IADL Functional Impairment Status, Continued

Example 1:

Displays descriptive questions with ADL and IADL examples.

ADLs and IADLs - How would you rate your ability to perform the following daily activities?

1=No Assistance Needs, 2=Requires Verbal Assistance, 3=Some Human Help,4=Lots of Human Help, 5=Cannot Do It at All

ACTIVITIES OF DAILY LIVING (RATE 1-5)

Can you manage to eat without any help? ___
Can you bathe or shower without any help? ___
Can you use the toilet without any help? ___
Can you get in and out of bed or chair without any help? ___
Can you walk around inside without any help? ___
Can you dress without any help? ___

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (RATE 1-5)

Can you prepare meals for yourself without help? ___
Can you shop for food and other things you need without help? ___
Can you take your medications without help? ___
Can you handle your own money, like keeping track of bills without help? ___
Can you answer the telephone or make a phone call without help? ___
Can you do heavy housecleaning, like yard work and laundry, without any help? ___
Can you do light housekeeping, like dusting or sweeping, without help? ___
Can you use public transportation or drive beyond walking distances without help? ___
Notes: _____

☐ Declined to State

Example 2:

Displays a list of the ADLs and IADLs. Staff may provide description information.

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

Please rate your functional abilities for the following activities.

RATING SCALE: 1 = Independent, 2 = Verbal Assistance, 3 = Some Human Help,4 = Lots of Human Help, 5 = Dependent, 6 = Declined to State

ADLS:		**IADLs**	
Eating	_____	Meal Preparation	_____
Dressing	_____	Shopping	_____
Transferring	_____	Medication Management	_____
In/Out of Chair	_____	Money Management	_____
Walking	_____	Using Telephone	_____
Toileting	_____	Heavy Housework	
		Light Housework	
		Transportation	_____

ADL and IADL Functional Impairment Status, Continued

Notes: _____

Example 3:

Displays descriptive questions with ADL and IADL examples.

Displays all 5 functional ability rating scale options plus "Declined to State." Staff may provide descriptive information.

Client ADL and IADL
(Activities of Daily Living and Instrumental Activities of Daily Living – Annual Assessment)

Please check the level of functional ability.

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: _____

ADL and IADL Functional Impairment Status, Continued

Example 4:

Displays the minimum functional ability 3-option rating scale plus "Declined to State."

Activities of Daily Living (ADL): *Circle One for Each* *1=No Assistance, 3=Some Human Help, 5=Cannot Perform (Dependent),*				**Instrumental of Daily Living (IADL):** *Circle One for Each* *1=No Assistance, 3=Some Human Help, 5=Cannot Perform (Dependent)*			
Eating	**1**	3	5	Meal Preparation	**1**	3	5
Bathing	**1**	3	5	Shopping	**1**	3	5
Toileting	**1**	3	5	Medication Management	**1**	3	5
Transferring In/Out of Bed/Chair	**1**	3	5	Money Management	**1**	3	5
Walking	**1**	3	5	Using Telephone	**1**	3	5
Dressing	**1**	3	5	Heavy Housework	**1**	3	5
			5	Light Housework	**1**	3	5
				Transportation	1	3	5
Declined to State				Declined to State		3	5

Example 5:

Displays ADL and IADLs with descriptive functional ability rating scales.

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

Care Receiver Activities of Daily Living (ADL) Fields

Eating (Rated Level_____)
Reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth, chewing, swallowing food and liquids, manipulating food on plate. Cleaning face and hands as necessary following a meal.
(1) Independent (able to feed self)
(2) Verbal assistance (able to feed self but needs verbal assistance such as reminding or encouragement to eat)
(3) Some human help (assistance needed during meals, e.g., to apply assistive devices, get beverages or push more food within reach, etc., but constant presence of another person is not required)
(4) Lots of human help (able to feed self but cannot hold utensils, cups, glasses, etc., constant presence of another person is required)
(5) Dependent (unable to feed self at all)

Example 5, Continued

Bathing (Rated Level_____)
Bathing means cleaning the body using a tub, shower, or sponge bath including getting a basin of water, managing faucets, getting in and out of a tub, reaching head and body parts for soaping, rinsing, and drying.
(1) Independent (able to bathe safely)
(2) Verbal assistance (able to bathe self with direction or intermittent monitoring; may need reminding to maintain personal hygiene)
(3) Some human help (generally able to bathe self, but needs assistance)
(4) Lots of human help (requires direct assistance with most aspects of bathing; would be at risk if left alone)
(5) Dependent (totally dependent on others for bathing)

Toileting (Rated Level_____)
Able to move to and from, on and off toilet or commode, empty commode, manage clothing and wipe and clean body after toileting, use empty bedpans, ostomy and/or catheter receptacles and urinals, apply diapers and disposable barrier pads. Menstrual care: able to apply external sanitary napkin and clean body.
(1) Independent (no assistance needed)
(2) Verbal assistance (requires reminding and direction only)
(3) Some human help (requires minimal assistance with some activities, but the constant presence of the provider is not necessary)
(4) Lots of human help (unable to carry out most activities without assistance)
(5) Dependent (requires physical assistance in all areas of care)

Transferring In/Out of Bed/Chair (Rated Level_____)
Moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or repositioning to prevent skin breakdown.
(1) Independent (able to do all transfers safely)
(2) Verbal assistance (able to transfer but needs encouragement or direction)
(3) Some human help (requires some help from another person; e.g., routinely requires a boost or assistance with positioning)
(4) Lots of human help (unable to complete most transfers without physical assistance; would be at risk if unassisted)
(5) Dependent (totally dependent upon another person for all transfers)

Example 5, Continued

Walking (Rated Level_____)
Walking or moving inside, moving from one area of indoor space to another without necessity ofhandrails. Can respond adequately to the presence of obstacles that must be stepped around.
Includes ability to go from inside to outside and back.

(1) Independent (no assistance needed)
(2) Verbal assistance (able to walk or move with encouragement, or reminders to watch for steps, or to use a cane or walker)
(3) Some human help (requires minimal assistance from another person to negotiate a wheelchair or to steady the person or guide them in the desired direction)
(4) Lots of human help (requires constant attention from another person, at risk of being lost or unsafe if not accompanied)
(5) Dependent (totally dependent upon another person, must be carried, lifted, or pushed in a wheelchair or on a gurney at all times)

Dressing (Rated Level_____)
Putting on and taking off, fastening and unfastening garments and undergarments, special devices such as back braces, corsets, elastic stockings/garments and artificial limbs or splints.

(1) Independent (able to put on, fasten and remove all clothing and devices without assistance; clothes self appropriately for health and safety)
(2) Verbal assistance (able to dress self, but requires reminding or directions with clothing selection)
(3) Some human help (unable to dress completely, without the help of another person, e.g., tying shoes, buttoning, zipping, putting on hose or brace, etc.)
(4) Lots of human help (unable to put on most clothing items by self; without assistance would be inappropriately or inadequately clothed)
(5) Dependent (unable to dress self at all)

Example 5, Continued

Care Receiver Instrumental Activities of Daily Living (IADL) Fields

Meal Preparation (Rated Level_____)
Planning menus. Washing, peeling, slicing vegetables, opening packages, cans, and bags, mixing ingredients, lifting pots and pans, re-heating food, cooking, safely operating stove, setting the table, serving the meal, cutting food into bite-sized pieces. Washing, drying, and putting away the dishes.

(1) Independent (no assistance needed)
(2) Verbal assistance (needs only reminding or guidance in menu planning, meal preparation, and/or cleanup)
(3) Some human help (requires another person to prepare and clean up main meals on less than a daily basis; e.g., can reheat food prepared by someone else, can prepare simple meals and/or needs help with cleanup on a less than daily basis)
(4) Lots of human help (requires another person to prepare and clean up main meal(s) on a daily basis)
(5) Dependent (totally dependent upon another person to prepare and clean up all meals)

Shopping (Rated Level_____)
Compile list, bending, reaching, and lifting, managing cart, or basket, identifying items needed, transferring items to home, putting items away, ordering prescriptions over the phone and picking them up, and buying clothing.

(1) Independent (can perform all tasks without assistance)
(2) Verbal assistance (able to perform tasks, but needs only reminding or direction, guidance orreminder)
(3) Some human help (requires the help of another person for some tasks while shopping such as reaching and carrying items)
(4) Lots of human help (unable to carry out most activities without assistance)
(5) Dependent (unable to perform any tasks for self)

Medication Management (Rated Level_____)
Physically and mentally able to identify, organize, schedule, handle, and consume (inject, instill or insert) the correct amount of the prescribed medication at the specified time according to a doctor's prescription.

(1) Independent (can identify, measure, organize, and self-administer prescribed medication)
(2) Verbal assistance (able to perform tasks but needs verbal direction, guidance or reminder to do it, without risk to safety)
(3) Some human help (requires some human help such as scheduling medications, opening the container, measuring the amount of medication)
(6) Lots of human help (cannot perform some parts of this function; may require some human help with installing or injecting multiple medications)
(7) Dependent (cannot perform any part of this function)

Example 5, Continued

Money Management (Rated Level_____)
Physically and mentally handles the receipt of monies, expenditures, and receipt and payment of bills in a timely and primarily correct manner.
(1) Independent (handles all financial matters)
(2) Verbal assistance (is able to perform all financial transactions but may need to be reminded to pay bills or obtain cash from the bank)
(3) Some human help (for either physical or mental reasons may need assistance in doing banking, writing checks, etc.)
(4) Lots of human help (unable to carry out most activities without assistance)
(5) Dependent (unable to attend to any part of the necessary financial transactions to receive and disburse funds to meet daily needs)

Using Telephone (Rated Level_____)
Obtains number, dials, handles receiver, can speak and hear response, and terminates call, may include use of instrument with loudspeaker or hearing devices. Able to use the telephone during emergency situations to call 911 or other help.
(1) Independent (can obtain and dial number without assistance)
(2) Verbal assistance (needs only reminder on how to use the phone)
(3) Some human help (needs human assistance to obtain number or dial)
(4) Lots of human help (currently not defined)
(5) Dependent (unable to use phone at all)

Heavy Housework (Rated Level_____)
Cleaning oven and stove, cleaning and defrosting refrigerator, moving light furniture to clean under and behind, vacuuming upholstery and under cushions, providing deep cleaning activities such as washing and cleaning baseboards, window tracks, cabinets, doors, drapes/blinds, etc.
(1) Independent (able to perform all domestic chores)
(2) Verbal Assistance (able to perform domestic chores but needs direction)
(3) Some human help (requires physical assistance from another person for some domestic chores)
(4) Lots of human help (unable to carry out most domestic chores without assistance)
(5) Dependent (totally dependent upon others for all domestic chores)

ADL and IADL Functional Impairment Status, Continued

Example 5, Continued

Light Housework (Rated Level_____)
Sweeping, vacuuming, mopping floors, washing kitchen counters and sinks, cleaning bathroom, taking out garbage, doing laundry, dusting and picking up.
(1) Independent (able to perform all light domestic chores)
(2) Verbal assistance (able to perform domestic chores but needs direction)
(3) Some human help (requires physical assistance from another person for some domestic chores)
(4) Lots of human help (unable to carry out most domestic chores without assistance)
(5) Dependent (totally dependent upon others for all domestic chores)

Transportation (Rated Level_____)
Using private or public vehicles, cars, buses, trains, or other forms of transportation to get to medical appointments, purchase food, shop, pay bills, or arrange for services, to socialize and participate in entertainment or religious activities. Can arrange for getting and using public transportation; or get to, enter and operate a private vehicle.
(1) Independent (can arrange, get to, enter and travel in public or private vehicles)
(2) Verbal assistance (can use public transportation or ride in a private vehicle when reminded to plan)
(3) Some human help (requires physical assistance to make transportation arrangements; i.e., calling, writing instructions about time and place, can ride with others if assisted into and out of the vehicle)
(4) Lots of human help (unable to carry out most activities without assistance)
(5) Dependent (unable to travel at all by self)

☐ Check if Declined to State ADL and IADL Functional Abilities

Resources

The OAA defines “frail” as an older individual that is functionally impaired because the individual “is unable to perform at least two ADLs without substantial human assistance, including verbal reminding, physical cueing, or supervision; or due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another person.” (Section 102(a) (22))

Nutritional Risk Screening

Introduction

Title III C Congregate and Home-Delivered Meal programs are required to perform a nutrition risk screening to identify individuals at nutrition risk or at risk for malnutrition. OAAPS reporting requirements define a person at nutritional risk as one who scores six or higher on the Determine Your Nutritional Risk Checklist (hereafter referred to as the “DETERMINE Checklist”) published by the Nutrition Screening Initiative (NSI).

Service Categories Required

The following programs require collecting nutritional risk scores for registered clients.

- Home-Delivered Meals
- Congregate Meals
- Nutritional Counseling

What to Include?

Title III C nutrition programs shall only use the DETERMINE Checklist to evaluate the client’s nutrition risk score.

The nutrition risk questionnaire must be filled out at initial intake or registration along with other client information then reported through the data collection system. After initial intake/registration, annually update and report nutrition risk information and other basic client data.

How to Determine Score?

Each question has a weighted point value. The sum determines the reported nutritional risk score.

- If score is **0-5** Then client is **not at nutritional risk**
- If score is **6 or greater** Then client is **at nutritional risk**

Nutritional Risk Screening, Continued

What is Reviewed?

CDA will review data to determine if the AAA is serving individuals at nutritional risk. CDA bases its target ranges on statewide analysis of the average number of participants at nutritional risk. Target percentages may be adjusted on an annual basis.

Program	Target Percentage of all reported participants
For the Congregate Meals (C-1)	21% or higher at nutritional risk
Home-Delivered Meals (C-2)	65% or higher at nutritional risk

DETERMINE Checklist

The following is the DETERMINE Checklist with weighted/scored values. The interviewer may need to provide additional clarification.

Determine Your Nutritional Health	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 last 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 nutritional risk)	
Declined to State	

Legal Assistance Service Category - Case Information

Case Information

The Legal Assistance Service category is a restricted service. In addition to the required aggregate client data, the following case information is needed:

- Case ID
- Case Opened Date
- Case Closed Date
- Service Type
- Service Level

Optional Client Level Detail

Introduction

There may be other questions added to provide more helpful client information. Some common ones are listed below. These are **not** required CARS elements and must not be reported in CARS.

Assessment Type

Assessment types (may be helpful) are as follows:

- New Client
- Annual Reassessment
- Significant Change in Condition

Office Notes

Identification of intake/ assessment date and the staff reviewing the information is useful.

Contact Information

To assign a unique identification number to each participant to be used internally only data management systems may use any combination of name, address, phone number, or the last four digits of the participant's Social Security Number for record identification. This avoids duplicating information by recording client level details for each participant and will enable tracking the client's services by provider and program.

- First Name
- Middle Name
- Last Name
- Other name(s)
- Home Address
- City
- Mailing if Different
- Telephone Number
- Cell Number
- Email Address

Optional Client Level Detail, Continued

Living Arrangement with others

This section can help to identify the following client living arrangements when not living alone:

☐ Lives w/Spouse
☐ Lives w/Child
☐ Lives w/Relative
☐ Lives w/Other(s)
☐ Senior Apartment

Source of Support

This section can help to identify the following various types of caregiving support:

☐ Family
☐ Friend/ Neighbor
☐ Paid Help
☐ Unsure
☐ None

Transportation Services

The following options can help to identify the type(s) of transportation assistance needed:

☐ Walks with No Assistance (Non-Assisted)
☐ Walks with Assistance
☐ Wheelchair ramp/lift (Assisted)

Other Characteristics

The following options can help to identify if other conditions or assistance are needed.

CHECK AIDS CURRENTLY USED:

☐ Cane
☐ Glasses/ Contacts
☐ Hearing Aid
☐ Oxygen
☐ Pacemaker
☐ TTY Phone
☐ Walker
☐ Wheelchair
☐ Other:

ABILITY TO SPEAK ENGLISH:

☐ Speaks English
☐ Non-English Language
☐ Need Interpreter

DO YOU RECEIVE HELP FROM OTHER ORGANIZATION(S)?

☐ Yes
☐ No
☐ If so, which one(s):_____

Optional Client Level Detail, Continued

Emergency Identification

This section can allow the client to designate a contact person to call during or after an emergency event:

Emergency Contact Person

Name: _____
Address: _____
Relationship to Client: _____
Telephone number: (____) _____- _____

Disaster Registry

In case of an emergency declaration, the following identification can help build a Disaster Registry to identify those high-risk clients that may need evacuation assistance.

A client is considered High Risk under Emergency Declaration if any of the following exists. *Check all that apply.*

- ☐ Housebound seniors and people with physical disabilities that DO NOT have an existing network of support
- ☐ Significant mobility, vision, or hearing impairment
- ☐ Elderly or medically fragile
- ☐ Disabling mental illness or developmental disability
- ☐ Requires refrigeration of medication and/or is insulin dependent
- ☐ Reliance on life-support, oxygen, or dialysis
- ☐ Not Applicable

Eligibility for Title III B Registered Services

To determine eligibility for registered Supportive Services (Title III B) the following question can be asked: Are you age 60 or over?

- ☐ Yes
- ☐ No

Optional Client Level Detail, Continued

Eligibility for Title III C-1 & C-2

To determine eligibility for Congregate Meals (Title III C-1) and Home-Delivered Meals (Title III C-2) the following questions can be asked.

QUESTIONS FOR THE CONGREGATE MEALS (C-1) ELIGIBILITY:

- ☐ Are you over 60?
- ☐ Are you the spouse or domestic partner of an Elderly Nutrition Program (ENP) participant who is over the age of 60?
- ☐ Are you a person with a disability who resides in housing where the congregate site is located?
- ☐ Are you a person with a disability who resides with and accompanies an ENP participant?
- ☐ Are you a volunteer under the age of 60? (May have a meal if it does not deprive a senior of a meal.)

QUESTIONS FOR HOME-DELIVERED MEALS (C-2) ELIGIBILITY:

- ☐ Are you homebound due to an illness, disability, or isolation?
- ☐ Are you a spouse of a person who is homebound?
- ☐ Are you an individual with a disability who resides with a homebound meal recipient?

QUESTIONS TO DETERMINE EQUIPMENT CONDITIONS AND CLIENT ABILITIES:

- ☐ Does the client have any dietary restrictions?
- ☐ Does the client have a working refrigerator?
- ☐ Does the client have a working microwave?
- ☐ Is the client physically and mentally able to open the food containers?
- ☐ Is the client physically and mentally able to reheat a meal?
- ☐ Are there pets inside or outside the home?

Eligibility for Title III E

To determine eligibility for Title III E, FCSP Caregivers of Older Adults or Older Relative Caregivers, the following questions may be asked.

CAREGIVERS OF OLDER ADULTS CRITERIA

1. Is the **Care Receiver** an older individual (60 years of age or older) ***or*** an individual (of any age) with Alzheimer's disease or a related disorder with neurological and organic brain dysfunction?

☐ Yes ☐ 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?

☐ Yes ☐ No

If answered "yes" to both questions above, the individual is qualified for "Family Caregivers of Older Adults." If requesting "Respite Care" or "Supplemental Services," the Care Receiver must also have two or more ADL deficiencies or a cognitive impairment.

OLDER RELATIVE CAREGIVERS ELIGIBILITY CRITERIA

1. Is the Care Receiver an individual who is not more than 18 years of age or who is an individual (of any age) with a disability?

☐ Yes ☐ No

2. In the case of a caregiver for a child, is the Caregiver a grandparent, step-grandparent, parent, or other older relative by blood, marriage, or adoption who is 55 years 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

3. In the case of a caregiver for an individual with a disability, is the Caregiver a parent, grandparent, or other relative by blood, marriage, or adoption who is 55 years of age or older, and living with the individual with a disability?

☐ Yes ☐ No

If answered "yes" to either questions 1 and 2 ***or*** *1 and 3 above, the individual is qualified for "Older Relative Caregivers Services."*

If the Care Receiver does not meet any of the criteria above, the Caregiver is ineligible to receive FCSP services but may qualify to receive other services provided by the AAA.

Resources to Determine Eligibility

The following links are to reference documents for the Title III E, Family Caregiver Support Program.

CDA Statistical Fact Sheets and Program Narratives
www.aging.ca.gov/Data_and_Statistics/#Statistical
Provide information on the purpose of the program, eligibility requirements, and history.

CDA Service Categories Data Dictionary
www.aging.ca.gov/Providers_and_Partners/Area_Agencies_on_Aging
Provides category definitions.

Required Title III B, C, D and VII (Cluster III), Non-Registered Client Fields

Introduction

Some OAA programs do **not** require collecting any client-level demographic information. These programs target groups or provide sensitive services that may make client-level data collection difficult.

What to Include?

Report estimated total clients/audience by each service category for each quarter. AAAs will be required to report at least:

- Nutrition Education
- Information and Assistance
- Disease Prevention and Health Promotion
- Elder Abuse Prevention, and
- Other OAAPS Services

There are no required client fields in non-registered services. It is **optional** for AAAs to collect this information based on the guidelines described in the required client fields for Registered Services.

What is Reviewed?

CDA reviews the estimated enrollments and service units on a quarterly and annual basis.

Required Title III B, C, D and VII (Cluster III), Non-Registered Client Fields, Continued

Chart Guidelines

Apply the following chart to determine if form(s) or records have the required data collection and reporting elements for Title III B, C, D, and VII Non-Registered services.

CARS - Required Title III B, C, D, and VII Non-Registered Fields

Service Category	Service Units	Estimated Clients/ Audience	Funding Source
Transportation	**X** One-way Trip	**X**	III B
Nutrition Education[1]	**X** Session	**X**	III C
Information and Assistance[1]	**X** Contact	**X**	III B
Outreach	**X** Contact	**X**	III B
Health Promotion[1]	**X** Session	**X**	III D
Alzheimer's Day Care Services ("Other" OAAPS Services)	**X** Day of Attendance	**X**	III B
Cash/Material Aid ("Other" OAAPS Services)	**X** Assistance	**X**	III B
Community Education ("Other" OAAPS Services)	**X** Activity	**X**	III B
Comprehensive Assessment ("Other" OAAPS Services)	**X** Hour	**X**	III B
Disaster Preparedness Materials ("Other" OAAPS Services)	**X** Product	**X**	III B
Elder Abuse Prevention Public Education	**X** Session	**X**	VII
Elder Abuse Prevention Educational Materials	**X** Product	**X**	VII
Elder Abuse Prevention Training for Professionals	**X** Session	**X**	VII
Elder Abuse Prevention Training for Caregivers	**X** Session	**X**	VII
Elder Abuse Prevention Development	**X** Hour	**X**	VII
Employment ("Other" OAAPS Services)	**X** Activity	**X**	III B
Health ("Other" OAAPS Services)	**X** Hour	**X**	III B
Housing ("Other" OAAPS Services)	**X** Hour	**X**	III B
Interpretation/ Translation ("Other" OAAPS Services)	**X** Contact	**X**	III B
Mobility Management Activities ("Other" OAAPS Services)	**X** Hour	**X**	III B
Mental Health ("Other" OAAPS Services)	**X** Hour	**X**	III B
Peer Counseling ("Other" OAAPS Services)	**X** Hour	**X**	III B

(X) Required Element

Required Title III B, C, D and VII (Cluster III), Non-Registered Client Fields, Continued

CARS Required Title III B, C, D, and VII Non-Registered Fields, Continued

Service Category	Service Units	Estimated Clients/ Audience	Funding Source
Personal Affairs Assistance (“Other” OAAPS Services)	**X** Contact	**X**	III B
Personal/Home Security (“Other” OAAPS Services)	**X** Product	**X**	III B
Public Information (“Other” OAAPS Services)	**X** Activity	**X**	III B
Registry (“Other” OAAPS Services)	**X** Hour	**X**	III B
Residential Repairs/Modifications (“Other” OAAPS Services)	**X** Modification	**X**	III B
Respite Care (“Other” OAAPS Services)	**X** Hour	**X**	III B
Senior Center Activities (“Other” OAAPS Services)	**X** Hour	**X**	III B
Telephone Reassurance (“Other” OAAPS Services)	**X** Contact	**X**	III B
Visiting (“Other” OAAPS Services)	**X** Hour	**X**	III B

(X) Required Element

[1]Required service categories. Elder Abuse Prevention requires at least one reported service category.

Chart Guidelines

Apply the following chart to determine if form(s) or records have the required data collection and reporting elements for Title III E Non-Registered services.

CARS Title III E, FCSP Caregivers of Older Adults or Older Relative Caregivers Required Non-Registered Fields

Service Category	Service Units	Estimated Clients/Audience
Support Groups (Support Services)	**X** Session	**X**
Information and Assistance (Access Assistance)	**X** Contact	**X**
Information Services (Information Services)	**X** Activity	**X**

(X) Required Element

Data Performance References

The following list contains web links of applicable laws/regulations/policies:

- *Area Plan Contract - www.aging.ca.gov/Contracts_Download_Page*
- *CARS Specifications*
- *Services Categories and Data Dictionary*
- *www.aging.ca.gov/Providers_and_Partners/Area_Agencies_on_Aging/.*
- *CCR - California Code of Regulations, Title 22 Division 1.8 - www.govt.westlaw.com/calregs*
- *CFR - Code of Federal Regulations, Title 45 Part 1321 - www.ecfr.gov*
- *OAA - Older Americans Act - www.acl.gov/about-acl/authorizing-statutes/older-americans-act*
- *OCA - California Welfare and Institutions (W&I) Code, Division 8.5 Mello-Granlund Older Californians Act - www.leginfo.legislature.ca.gov*
- *OAAPS SPR – ACL Older Americans Act Performance System State Program Reports - www.acl.gov/programs/state-program-reports*
- *PM - CDA Program Memoranda - www.aging.ca.gov/Program_Memos*

Sample Forms

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 (Clusters 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, C-1, 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 (Registered)
- Caregivers of Older Adults, Older Relative Caregivers

Sample 7

- Title III E
- Caregivers of Older Adults

Sample 8

- Title III E
- Older Relative Caregivers

Sample 9

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

Sample 10

- Title III B (Restricted)
- Legal Assistance

SAMPLE 1, TITLE III

Provider Name:	**Unique Participate ID:** _____
Region/Site Name:	**Registration/Assessment Date:** _____
	Termination Date: ***Reason:**

Service Categories (Titles IIIB, IIIC and IIID):

☐ ***Personal Care (IIIB)** (A, I) ☐ ***Homemaker (IIIB)** (A, I) ☐ ***Chore (IIIB)** (A, I)
☐ ***Home-Delivered Meals** (A, I, N) ☐ ***Adult Day Care/Health (IIIB)** (A, I) ☐ ***Case Management (IIIB)** (A, I)
☐ ***Assisted Transportation (IIIB)** ☐ ***Congregate Meals** (N) ☐ ***Nutrition Counseling** (N)
☐ Other: _____

Notes*: Reference the Data Dictionary for allowable "Other" service categories; Requires **A**-ADLs, **I**-IADLs, **N**-Nutritional Screenings on the following pages*

SECTION 1 (Client)

(*) Required for All Registered Programs

PERSONAL DATA (Please print):	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ 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
***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 for12 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.	
Residential Address:	
Street:	
City:	
***Zip Code:**	
Mailing Address: Same as Residential? ☐ Yes – Skip	
Street:	

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

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

***Nutritional Risk Checklist:**	**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:		
Is Nutrition Risk a total score 0-5 or 6+?	**0 - 5**	**6+**
☐ **Declined to State**		

SAMPLE 2, CLUSTER 1

Provider Name:	**Unique Participate ID:** _____
Region/Site Name:	**Registration/Assessment Date:** _____ **Termination Date:** ***Reason:**

Service Categories (Titles IIIB and IIIC):

☐ ***Personal Care (IIIB)** (A, I) ☐ ***Homemaker (IIIB)** (A, I) ☐ ***Chore (IIIB)** (A, I)
☐ ***Home-Delivered Meals** (A, I, N) ☐ ***Adult Day Care/Health (IIIB)** (A, I) ☐ ***Case Management (IIIB)** (A, I)

Notes*: Reference the Data Dictionary for allowable "Other" service categories; Requires **A**-ADLs, I-IADLs, **N**-Nutritional Screenings on the following pages*

SECTION 1 (Client)

(*) Required for All Registered Programs

PERSONAL DATA (Please print):	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ 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

***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 for12 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.

Residential Address:	
Street:	
City:	
***Zip Code:**	
Mailing Address: Same as Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
***Zip Code:**	
Emergency Contact:	Name: Relationship: Phone #: ( )
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated
***Race: (Check all that apply)**	☐ White ☐ Black ☐ American Indian/Alaska Native Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race ☐ Declined/not stated
***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ 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 Screening (Annual)

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

*Nutritional Risk Checklist:	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:		
Is Nutrition Risk a total score 0-5 or 6+?	**0 - 5**	**6+**
☐ **Declined to State**		

SAMPLE 3, CLUSTER 2

Provider Name:	**Unique Participate ID:** _____
Region/Site Name:	**Registration/Assessment Date:** _____ **Termination Date:** ***Reason:**

Service Categories (Titles IIIB and IIIC):

☐ ***Assisted Transportation** ☐ ***Congregate Meals** (N) ☐ ***Nutrition Counseling** (N)

Notes*: Requires **N**-Nutritional Screening on the following pages*

SECTION 1 (Client)

(*) Required for All Registered Programs

PERSONAL DATA (Please print):	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ 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
***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 for12 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.	
***Birth Date:**	
Home Phone:	( )
Residential Address:	
Street:	
City:	
***Zip Code:**	

Mailing Address: Same as Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
***Zip Code:**	
Emergency Contact:	Name: Relationship: Phone #: ( )
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated
***Race: (Check all that apply)**	☐ White ☐ Black ☐ American Indian/Alaska Native Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race ☐ Declined/not stated
***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated
Transportation Service Needs: ☐ Walks with no assistance (non-assisted) ☐ Walks with assistance (Assisted) ☐ Wheelchair ramp/lift	

SECTION 2 – Nutritional Screening (Annual)

**** Required for (IIIC):*** *Congregate Meals, Nutritional Counseling*

***Nutritional Screening:**	**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:		
Is Nutrition Risk a total score 0-5 or 6+?	**0 - 5**	**6+**
☐ **Declined to State**		

Notes:

Sample Forms

SAMPLE 4, C-2

Name of Home-Delivered Meals Provider This form is designed to be completed by an intake staff. Items marked with an asterisk (*) are required.	Route:	Intake Date: _____ Active Date: _____ Inactive Date: _____ Active Date: _____ Inactive Date: _____ Active Date: _____ Inactive Date: _____

***Unique Participant ID:**	***Termination Date:** **Reason:**
***Date of Birth:** **/ /**	☐ New client ☐ Annual reassessment ☐ Change in information

First Name:	Last Name:

Home Address	City:	***Zip Code**

Home Phone: ( ) Alternate Phone: ( )	Emergency Contact Name: Address: Phone: ( ) Relationship:

***Living Arrangement** **# of household members** ☐ ☐ Declined/not stated	***What is your approximate household income?** $ _____ per ☐ month _____ ☐ year ☐ Declined/not stated	***Rural Area:** ☐ Yes ☐ No ☐ Declined/not stated

***What is your gender? (Check only one)** ☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ 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

***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 for12 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.

***Ethnicity:** (Check one) Hispanic ☐ Yes ☐ No ☐ Declined/not stated	Language: ☐ English Speaking ☐ Need interpreter ☐ Non-English/Language

***Race: (Check all that apply)**

☐ White ☐ Black ☐ American Indian/Alaska Native Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian
☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander ☐ Other Race ☐ Declined/not stated

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

Eligibility:
☐ Are you homebound due to an illness, disability, or isolation?
☐ Are you a spouse of a home-delivered meal recipient?
☐ Are you an individual with a disability who resides with a home-delivered meal recipient?

Prioritization:

***Nutritional Risk Checklist:**	**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:		
***Is Nutrition Risk Total Score 0-5 or 6+ ?**	**0-5**	**6+**
☐ **Declined to State**		

	Yes	No	Comments
Do you have any dietary restrictions?	☐	☐	
Do you have a working refrigerator?	☐	☐	

Do you have a working microwave?	☐	☐	
Are you physically and mentally able to open the food containers?	☐	☐	
Are you physically and mentally able to reheat a meal?	☐	☐	
Are there pets?	☐	☐	
Have you recently been discharged from the hospital?	☐	☐	

Referral(s) Made:

☐ Nutritional education/counseling for at risk clients

☐ Other:

☐ Other:

Notes:

_____ _____

Staff Completing Assessment Date

SAMPLE 5, C-1

Name of Congregate Meal Provider {Provider Name} Please complete this form to the best of your ability. Items marked with an asterisk (*) are required.	***Unique Participate ID:** ___ Referred by: _____ Intake Date: _____ Staff: _____ Beginning Date: _____ ***Termination Date:** _____ ***Reason:** _____	Eligibility: ☐ Age 60+ ☐ Spouse of congregate meal participant ☐ Disabled person residing where the congregate site is located ☐ Disabled person who resides with and accompanies a congregate meal participant ☐ Volunteer

First Name:	Last Name:	***Date of Birth:**
Home Address	City:	***Zip Code**
Mailing Address: Same As Residential? ☐ Yes	City:	***Zip Code**
Home Phone: ( ) Alternate Phone: ( )	Emergency Contact Name: Address: Phone: ( ) Relationship:	

***Living Arrangement** **# of household members** ☐ ☐ Declined/not stated	***What is your approximate household income?** $ _____ per ☐ month ☐ year ☐ Declined/not stated	***Rural Area:** ☐ Yes ☐ No ☐ Declined/not stated

***What is your gender? (Check only one)** ☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ 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

***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 for12 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.

***Ethnicity:** (Check one) Hispanic ☐ Yes ☐ No ☐ Declined/not stated	Language: ☐ English Speaking ☐ Need interpreter ☐ Non-English/Language

***Race: (Check all that apply)**

☐ White ☐ Black ☐ American Indian/Alaska Native Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian
☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander ☐ Other Race ☐ Declined/not stated

***Nutritional Risk Checklist:**	**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:		
Is Nutrition Risk a total score 0-5 or 6+ ?	**0 - 5**	**6+**
☐ **Declined to State**		

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 they may benefit.

_____ _____

Signature of participant or person completing the form Date

SAMPLE 6, TITLE III E CAREGIVERS OF OLDER ADULTS / OLDER RELATIVE CAREGIVERS

SECTION 1 – Service Information

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

Service Categories:
☐ **Caregivers of Older Adults** ☐ **Older Relative Caregivers**
Notes: Check the Eligibility criteria below to determine which program caregiver qualifies

Title III E, Family Caregiver Support Program Services to be Provided		
Support Services: ☐ Caregiver Training ☐ Caregiver Support Groups ☐ Caregiver Counseling	**Respite Care Services:** *(Care Receiver must have 2 or more ADL limitations, a cognitive impairment, or be grandparent/elder caregiver to qualify)*	☐ In-Home ☐ Other ☐ Out of Home Day ☐ Out of Home Overnight
Supplemental Services*: (Care Receiver must have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/older caregiver to qualify)* ☐ Assistive Tech. ☐ Home Modifications ☐ Caregiving Services Registry ☐ Consumable Supplies ☐ Caregiver Assessment ☐ Legal Consultation		
Access Assistance: ☐ Information & Assistance ☐ Caregiver Case Management	**Information Services:** ☐ Information Services	

SECTION 2 – Eligibility Criteria

Caregivers of Older Adults Eligibility Criteria
1. Is the Care Receiver an older individual (60 years of age or older) ***or*** an individual (of any age) with Alzheimer's disease or related disorder with neurological and organic brain dysfunction? ☐ Yes ☐ 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? ☐ Yes ☐ No

If answered "yes" to both questions above, check "Family Caregiver Caregivers of Older Adults" box in Section 1. If answered "no" check to see if individual qualifies for "Grandparent/Older Caregiver Older Relative Caregivers" component below.

Older Relative Caregivers Eligibility Criteria
1. Is the Care Receiver an individual who is not more than 18 years of age ***or*** who is an individual (of any age) with a disability? ☐ Yes ☐ No
2. Is the Caregiver a grandparent, step-grandparent, or other older relative of the Care Receiver by blood, marriage, or adoption who is 55 years of age or older, living with the Care Receiver, and identified as the primary caregiver through a legal or informal arrangement. Biological and adoptive parents are excluded. ☐ Yes ☐ No
If answered "yes" to both questions above, check "Older Relative Caregivers" box in Section 1.

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

SECTION 3 (FCSP Caregiver)

(*) Required for Family Caregiver Support Program Services

Personal Data (Please print):	
***Unique Participant ID**	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ 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
***Birth Date:**	
Home Phone:	( )
Residential Address:	
Street:	
City:	
***Zip Code:**	
Mailing Address: Same as Residential? ☐ Yes – Skip to Next Section	
Street:	

City:	
***Zip Code:**	
***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 for12 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.	
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated
***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated

***Race: (Check all that apply)**	☐ White ☐ Black ☐ American Indian/Alaska Native Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race ☐ Declined/not stated

***Relationship to Care Receiver:**	☐ Husband ☐ Wife ☐ Grandparent ☐ Domestic Partner ☐ Daughter/Daughter-in-law ☐ Son/Son-in-law ☐ Brother ☐ Sister ☐ Parents ☐ Other Relative ☐ Non-Relative ☐ Declined/not stated
***Relationship Status:**	☐ Single (never married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined/not stated
Employment:	☐ Full Time ☐ Unemployed ☐ Part Time ☐ Declined/not stated ☐ Retired

SECTION 4 (FCSP Care Receiver)

(*) Required for Family Caregiver Support Program Services

Personal Data (Please print):	
***Unique Participant ID**	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ 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
***Birth Date:**	
Home Phone:	( )
Residential Address:	
Street:	
City:	
***Zip Code:**	
***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 for12 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.	
Mailing Address: Same as Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
***Zip Code:**	
Demographics:	
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated

***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated
***Race: (Select all that apply)**	
☐ White ☐ Black ☐ American Indian/Alaska Native Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race ☐ Declined/not stated	
***Relationship Status:**	☐ Single (never married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined/not stated

SECTION 5 – (FCSP Care Receiver)

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

**Required for <u>the Care Receiver only</u> in Support Services, Respite Care, and Supplemental Services.*

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

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:						

SAMPLE 7, TITLE III E, CAREGIVERS OF OLDER ADULTS

SECTION 1 – Service Information

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

Title III E, Family Caregiver Support Program Services to be Provided		
Support Services: ☐ Caregiver Training ☐ Caregiver Support Groups ☐ Caregiver Counseling	**Respite Care Services:** *(Care Receiver must have 2 or more ADL limitations, a cognitive impairment, or be grandparent/elder caregiver to qualify)*	☐ In-Home ☐ Other ☐ Out of Home Day ☐ Out of Home Overnight
Supplemental Services*: (Care Receiver must have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/older caregiver to qualify)* ☐ Assistive Tech. ☐ Home Modifications ☐ Caregiving Services Registry ☐ Consumable Supplies ☐ Caregiver Assessment ☐ Legal Consultation		
Access Assistance: ☐ Information & Assistance ☐ Caregiver Case Management	**Information Services:** ☐ Information Services	

SECTION 2 – Eligibility Criteria

Caregivers of Older Adults Eligibility Criteria

1. Is the Care Receiver an older individual (60 years of age or older) ***or*** an individual (of any age) with Alzheimer's disease or related disorder with neurological and organic brain dysfunction? ☐ Yes ☐ 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? ☐ Yes ☐ 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.

Notes:

SECTION 3 (FCSP Caregiver)

(*) Required for Family Caregiver Support Program Services

Personal Data (Please print):	
***Unique Participant ID**	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ 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
***Birth Date:**	
Home Phone:	( )
Residential Address:	
Street:	
City:	
***Zip Code:**	
Mailing Address: Same as Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
***Zip Code:**	

***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 for12 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.

Demographics:	
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated
***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated

***Race: (Check all that apply)**

☐ White ☐ Black ☐ American Indian/Alaska Native
Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Vietnamese ☐ Other Asian
Hawaiian/Other Pacific Islander

☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race ☐ Declined/not stated	
***Relationship to Care Receiver:**	☐ Husband ☐ Wife ☐ Grandparent ☐ Domestic Partner ☐ Daughter/Daughter-in-law ☐ Son/Son-in-law ☐ Brother ☐ Sister ☐ Other Relative ☐ Non-Relative ☐ Declined/not stated

***Relationship Status:**	☐ Single (never married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined/not stated
Employment:	☐ Full Time ☐ Unemployed ☐ Part Time ☐ Declined/not stated ☐ Retired

SECTION 4 (FCSP Care Receiver)

(*) Required for Family Caregiver Support Program Services

Personal Data (Please print):	
***Unique Participant ID**	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ 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
***Birth Date:**	
Home Phone:	( )
Residential Address:	
Street:	
City:	
***Zip Code:**	
***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 for12 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.
Mailing Address: Same as Residential? ☐ Yes – Skip to Next Section

Street:	
City:	
***Zip Code:**	
Demographics:	
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated

***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated
***Race: (Check all that apply)**	
☐ White ☐ Black ☐ American Indian/Alaska Native Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race ☐ Declined/not stated	
***Relationship Status:**	☐ Single (never married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ 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 Car, and Supplemental Services.
Please rate your functional abilities for the following activities.

ADLs	Rated Value	IADLs	Rated Value	IADLs	Rated Value	RATING SCALE
Feeding		Meal Preparation		Heavy Housework		1 – Independent 2 – Verbal Assistance 3 – Some Human Help 4 – Lots of Human Help 5 – Dependent 6 - Declined to State
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 RELATIVE CAREGIVERS

SECTION 1- Service Information

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

Title III E, Family Caregiver Support Program Services to Be Provided		
Support Services: ☐ Caregiver Training ☐ Caregiver Support Groups ☐ Caregiver Counseling	**Respite Care Services:** *(Care Receiver must have 2 or more ADL limitations, a cognitive impairment, or be grandparent/elder caregiver to qualify)*	☐ In-Home ☐ Other ☐ Out of Home Day ☐ Out of Home Overnight
Supplemental Services*: (Care Receiver must have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/older caregiver to qualify)* ☐ Assistive Tech. ☐ Home Modifications ☐ Caregiving Services Registry ☐ Consumable Supplies ☐ Caregiver Assessment ☐ Legal Consultation		
Access Assistance: ☐ Information & Assistance ☐ Caregiver Case Management	**Information Services:** ☐ Information Services	

SECTION 2 – 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 the Care Receiver by blood, marriage, or adoption who is 55 years of age or older living with the Care Receiver, 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 Older Relative Caregivers services but may qualify to receive other services provided by the Area Agency on Aging.

Notes:

SECTION 3 (Older Caregiver)

(*) Required for Family Caregiver Support Program Services

Personal Data (Please print):	
***Unique Participant ID**	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ 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
***Birth Date:**	
Home Phone:	( )
Residential Address:	
Street:	
City:	
***Zip Code:**	
Mailing Address: Same as Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	

***Zip Code:**	
***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 for12 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.	
Demographics:	
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated
***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated
***Race: (Check all that apply)**	

☐ White ☐ Black ☐ American Indian/Alaska Native Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race ☐ Declined/not stated

***Relationship to Care Receiver:**	☐ Grandparent ☐ Parent ☐ Other Relative ☐ Non-Relative ☐ Declined/not stated
***Relationship Status:**	☐ Single (never married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined/not stated
Employment:	☐ Full Time ☐ Unemployed ☐ Part Time ☐ Declined/not stated ☐ Retired

SECTION 4 (Care Receiver)

(*) Required for Family Caregiver Support Program Services

Personal Data (Please print):	
***Unique Participant ID**	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ 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
***Birth Date:**	
Home Phone:	( )
Residential Address:	
Street:	
City:	
***Zip Code:**	
***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 for12 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.
Mailing Address: Same as Residential? ☐ Yes – Skip to Next Section

Street:	
City:	
***Zip Code:**	
Demographics:	
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated

***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated
***Race: (Check all that apply)**	
☐ White ☐ Black ☐ American Indian/Alaska Native Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race ☐ Declined/not stated	
***Relationship Status:**	☐ Single (never married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ 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	
***Unique Participant ID:**	
Name:	
***Birth Date:**	
Home Phone #:	( )
Email:	
Address:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ 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
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated

***Race: (Check all that apply)**	☐ White ☐ Black ☐ American Indian/Alaska Native Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race ☐ Declined/not stated
***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated
***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 for12 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.
Service Requested:
Action Taken/Referral:
Follow Up:
Type of I & A: ☐ III B (If Requesting Services for an Older Individual) ☐ III E Caregivers (If Requesting Services for an Older Individual) ☐ III E Relative (If Requesting Services for an Older Individual)

SAMPLE 10, III B LEGAL ASSISTANCE

Date: _____ **Staff Completing Intake:** _____

***Required Information**

PERSONAL DATA	
***Unique Participant ID:**	
Name:	
***Birth Date:**	
Phone #:	( )
Email:	
Address:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ 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
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated

***Race: (Check all that apply)**	☐ White ☐ Black ☐ American Indian/Alaska Native Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Race ☐ Other Pacific Islander ☐ Declined/not stated
***Federal Poverty Level (FPL):**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated
CASE INFORMATION	
***Unique Case ID:**	
***Case Opened Date:**	
***Case Closed Date:**	
***Service Level:**	☐ Advice ☐ Limited Representation ☐ Representation

***Case Type:**	☐ Income ☐ Health Care ☐ Long Term Care ☐ Nutrition ☐ Housing ☐ Utilities ☐ Abuse/Neglect ☐ Protective Services ☐ Age Discrimination ☐ Other/Miscellaneous
***Hours (Units):**	