

# SENIOR CITIZENS AGING SERVICES FY-2010 INTAKE, PROFILE AND REFERRAL (IPR) FORM

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## INSTRUCTIONS

Title III reporting requirements provide statistical data for management and advocacy initiatives serving as indicators for new and continued funding of programs for seniors. The data collected is used for budget justifications, congressional inquiries, program development and mandated reports for federal, state and local agencies. Information must be accurate for it to be useful in supporting program services.

- ◆ **FORM:** This form is an Intake Profile and Referral (IPR) Form, and not an Assessment Form. Profile characteristics are used in developing new programs to meet the needs of the elderly. Each Service Provider may have their own Assessment Form for their specific programs.
- ◆ **DATA RETENTION:** Client data is retained in the main registry until a client remains on Inactive Status for over four (4) years or when a client is deceased.
- ◆ **SSN:** If a client does not yet have a Social Security Number (SSN), use 000 as the first three digits for their assigned number. The next two digits should be the month and the last four digits shall be the day and year the client was born. If a client was born on **March 21, 1911**, the SSN would be **000-03-2111**. If born on **November 9, 1933**, the SSN would be **000-11-0933**.
- ◆ **INCOME LEVEL:** The Income Level is based on the U.S. Department of Health and Human Services Poverty Guidelines and shall be completed before the Intake, Profile and Referral Form can be processed.
- ◆ **REFUSAL TO ANSWER:** Should a client refuse to answer a certain question, leave it blank. In the comments section, list the reason for not answering the question. This does not apply to Income Level.
- ◆ **SIGNATURE:** The signature of the client or responsible party is required before services can be provided.
- ◆ **SPECIAL ACCOMMODATIONS:** Clients requiring special accommodations shall inform the program in advance of their requirements.
- ◆ **SECTION B:**
  - **Case Management Services.** Case Management Services Program, at a minimum, conducts an assessment to individuals requesting Adult Day Care Services, In-Home Services and Home-Delivered Meals. Entry into these programs shall not be permitted before an assessment is made and eligibility established by Case Management Services.
  - **Transportation Services.** In order to meet demands, clients requesting transportation shall make reservations with the Transportation Services Program at least five (5) working days in advance for service. If the date requested cannot be accommodated, the Transportation Services Program shall recommend an alternate date. Requests for persons using wheelchairs or having a Personal Assistant/Personal Care Attendant shall be made in the same manner, whether for Center participation or to and from medical appointments, etc.
  - **Elderly Nutrition Program.** To the extent practicable, meals are adjusted to meet special dietary needs of eligible participants, and shall be supported by a statement from the client's doctor or religious leader stating the necessity for special meals, including nutrition supplements. Mechanical (chopped) or pureed (blended) meals are not classified as special meals and shall be provided to the client at their request.

FOR ADULT PROTECTIVE SERVICES (APS)  
REFERRALS PLEASE CONTACT 735-7384/86 OR  
EMERGENCY RECEIVING HOME  
AT 653-8855/56 TWENTY-FOUR HOURS A DAY  
SEVEN DAYS A WEEK.

**SENIOR CITIZENS AGING SERVICES FY-2010  
INTAKE, PROFILE AND REFERRAL (IPR) FORM**

*PLEASE PRINT CLEARLY USING BLUE OR BLACK INK.*

A. CLIENT INFORMATION	
Last Name	
First Name	
Middle Name	
Date of Birth	
Place of Birth	
SSN	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Village	
Home Address	
Mailing Address	
Ethnicity	
Citizenship	
Day Phone No.	
Night Phone No.	
<b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
<b>Living Arrangement</b> <input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with spouse <input type="checkbox"/> Lives with family <input type="checkbox"/> Lives with others <input type="checkbox"/> Lives in Group Home <input type="checkbox"/> Specify: _____ <input type="checkbox"/> Lives in Institution Specify: _____	

<b>Special Needs</b> <input type="checkbox"/> Language Interpreter Specify: _____ <input type="checkbox"/> Assistive Device(s) Specify: _____ <input type="checkbox"/> None identified at this time.	
<b>Mobility Status</b> ( <i>check all that apply</i> ) <input type="checkbox"/> Drives <input type="checkbox"/> Walks slowly <input type="checkbox"/> Walks with assistance <input type="checkbox"/> Climbs steps with assistance <input type="checkbox"/> Uses cane/crutches/walker <input type="checkbox"/> Uses a wheelchair <input type="checkbox"/> Bedridden <input type="checkbox"/> Other: _____	
<b>Health Status</b> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor	
<b>Allergies</b>	Specify: _____ _____ _____ _____ None known at this time.
<b>Undergoing Treatment</b> <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Cancer <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Other _____ <input type="checkbox"/> None at this time	
Health Insurance	
Policy No.	
Clinic Name	
Phone No.	
Primary Doctor	
Phone No.	

CLIENT'S NAME: \_\_\_\_\_ SSN: \_\_\_\_\_ CMS: \_\_\_\_\_ SCO: \_\_\_\_\_

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**Income Level Family Unit Size (FUS)**

Is your income less than

Unit Size	Per Month	Per Year	Yes	No
One (1)	\$1,127.50	\$13,530.00		

Is your combined income less than

Unit Size	Per Month	Per Year	Yes	No
Two (2)	\$1,517.50	\$18,210.00		

Is your combined income less than

Unit Size	Per Month	Per Year	Yes	No
Three (3)	\$1,907.50	\$22,890.00		

Four (4) or more in FUS, add \$390.00 per month or \$4,680.00 per year for each additional member.  
\$ \_\_\_\_\_

**B. SERVICES REQUESTED**

Case Management Services

Adult Day Care Services

In-Home Services

Legal Assistance Services

National Family Caregiver Support

Senior Center Operations: \_\_\_\_\_  
(Specify Center)

Transportation Services:

Walks with no assistance (Non-Assisted)

Walks with assistance (Assisted)

Elderly Nutrition Program:

Congregate Meals (Center/Day Care)

Home-Delivered Meals (Homebound)

**Meal Type:**

Regular

Mechanical/Chopped

Pureed/Blenderized

Special (Provide document from physician or religious leader to certify special meal requirement.)

Ombudsman Program

Guam Medicare Assistance Program

Senior Medicare Patrol Program

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

**C. CAREGIVER INFORMATION**

Not Applicable

Caregiver  
 Paid  
 Not Paid

Paid by: \_\_\_\_\_

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Day Phone No. \_\_\_\_\_

Night Phone No. \_\_\_\_\_

Relationship to Client \_\_\_\_\_

**D. GUARDIAN/AUTHORIZED REPRESENTATIVE INFORMATION**

Guardian

Authorized Representative

Not Applicable

Attach copy of Guardianship or Power of Attorney, as applicable.

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle Name \_\_\_\_\_

Day Phone No. \_\_\_\_\_

Night Phone No. \_\_\_\_\_

Relationship to Client \_\_\_\_\_

**E. EMERGENCY CONTACT NUMBER**

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle Name \_\_\_\_\_

Day Phone No. \_\_\_\_\_

Night Phone No. \_\_\_\_\_

Relationship to Client \_\_\_\_\_

CLIENT'S NAME: \_\_\_\_\_ SSN: \_\_\_\_\_ CMS: \_\_\_\_\_ SCO: \_\_\_\_\_

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<b>F. HIGH RISK CLIENTS UNDER EMERGENCY DECLARATION</b>
<p>A client is considered High Risk under Emergency Declaration if any of the following exists. This information shall be provided to the client's village Mayor in preparation for emergencies. <i>Check all that apply.</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bedridden</li> <li><input type="checkbox"/> Requires transportation and/or escort assistance for evacuation to shelter, e.g., those living alone.</li> <li><input type="checkbox"/> Requires refrigeration of medication and/or is insulin dependent.</li> <li><input type="checkbox"/> Requires oxygen.</li> <li><input type="checkbox"/> Lives in substandard housing.</li> <li><input type="checkbox"/> Not Applicable</li> </ul>
<b>G. ELIGIBILITY AND CONSENT OF CLIENT</b>
<p>Individuals age sixty (60) years and older are eligible for Title III programs under the Older Americans Act. This Act also prioritizes services for:</p> <ul style="list-style-type: none"> <li>◆ Persons who are frail, homebound by reason of illness or incapacitating disability, or otherwise isolated; and</li> <li>◆ Persons with greatest economic need with particular attention to low-income individuals; persons with greatest social need with particular attention to low-income minority individuals, and those who reside in rural areas.</li> </ul> <p>Voluntary contributions to Title III programs are encouraged and used to expand services. Services may not be denied because the client will not or cannot contribute to the cost of the program.</p> <p>I CERTIFY THE INFORMATION GIVEN BY ME IS TRUE TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND IT WILL BE KEPT CONFIDENTIAL AND USED ONLY TO HELP ME RECEIVE THE BENEFITS/SERVICES WHICH I MAY BE ENTITLED.</p> <p>I HEREBY AUTHORIZE THE DISCLOSURE AND RELEASE OF THIS INFORMATION ONLY FOR THE PURPOSES FOR WHICH IT IS INTENDED. THIS AUTHORIZATION MAY BE REVOKED BY THE UNDERSIGNED AT ANY TIME BY GIVING WRITTEN NOTICE TO THE PARTIES AUTHORIZED HEREIN.</p>

Signature of Client or Authorized Representative (AR)	
Date	
Relationship to Client, if AR	
<b>H. INTAKE INFORMATION</b>	
Intake Worker	
Signature of Intake Worker	
Date of Intake	
Time of Intake	
Organization	
Phone Number	
<p><b>IPR Forwarded To</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Adult Protective Services</li> <li><input type="checkbox"/> Case Management Services</li> <li><input type="checkbox"/> Elderly Nutrition Program (Congregate Meals)</li> <li><input type="checkbox"/> Guam Medicare Assistance Program</li> <li><input type="checkbox"/> Legal Assistance Services</li> <li><input type="checkbox"/> National Family Caregiver Support Program</li> <li><input type="checkbox"/> Ombudsman Services</li> <li><input type="checkbox"/> Senior Center Operations</li> <li><input type="checkbox"/> Senior Medicare Patrol</li> <li><input type="checkbox"/> Transportation Services</li> </ul>	
Forwarded By	
Date Forwarded	
Time Forwarded	
<b>I. RECEIVING ORGANIZATION INFORMATION</b>	
IPR Received By	
Date	
Time	

CLIENT'S NAME: \_\_\_\_\_ SSN: \_\_\_\_\_ CMS: \_\_\_\_\_ SCO: \_\_\_\_\_

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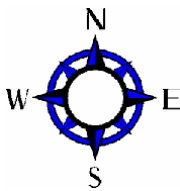
*PLEASE PRINT CLEARLY USING BLUE OR BLACK INK.*

**IPR Referred To**

- Adult Day Care Services
- Case Management Services
- Elderly Nutrition Program – Congregate Meals
- Elderly Nutrition Program – Home Delivered Meals
- Guam Medicare Assistance Program (MAP)
- In-Home Services
- Legal Assistance Services
- National Family Caregiver Support Program
- Senior Citizens Center Operations
- Senior Medicare Patrol Program
- Transportation Services
- Other: \_\_\_\_\_

Date of Initial Contact with Client	
Time of Initial Contact with Client	
Comments: _____ _____	
<b>J. CLIENT'S HOME</b>	
<b>IF MAP IS SENT SEPARATELY, INCLUDE THE CLIENT'S NAME AND SSN AT TOP OF MAP</b>	
Does the home have an accessible driveway?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you use a wheelchair, is there an accessible ramp?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>All pets at your home shall be controlled by leash, cage, etc. in accordance with P.L. 15-96 and 22-13.</i>	

**DRAW A MAP TO THE CLIENT'S HOME**  
(Indicate primary and secondary access roads, type and color of the house, if fenced, landmarks such as adjacent to or across from the village community center, store, bus stop, etc.)



CLIENT'S NAME: \_\_\_\_\_ SSN: \_\_\_\_\_ CMS: \_\_\_\_\_ SCO: \_\_\_\_\_