SENIOR CITIZENS AGING SERVICES FY-2015
INTAKE, PROFILE AND REFERRAL (IPR) FORM

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 inputted and retained in a main registry.

- **SSN:** If a client does not provide a Social Security Number (SSN) then leave the space blank.

- **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.

- **PRIORITIZATION OF SERVICES:** Based on the need to activate prioritization of services, the number of persons to be served will be determined by the existing conditions of clients enrolled in a program and those on a wait list at the time of implementation. Information on mobility, support system, housing condition, activities of daily living, health status and financial assets is collected should prioritization of services be necessary.

- **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.

- **PROGRAM SPECIFIC INFORMATION:**

  - **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 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 prepared 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. Mechanical (chopped) or pureed (blenderized) meals are not classified as special meals and shall be provided to the client at their request.

FOR ADULT PROTECTIVE SERVICES (APS) REFERRALS, CALL 735-7421 / 7415
Monday - Friday, 8 a.m. to 5 p.m.
(Except on Recognized Holidays)

OR

EMERGENCY RECEIVING HOME
24-HOUR CRISIS INTERVENTION HOTLINE,
at 632-8853

SENIOR CITIZENS AGING SERVICES FY-2015
INTAKE, PROFILE AND REFERRAL (IPR) FORM
PLEASE PRINT CLEARLY USING BLUE OR BLACK INK.

PRINT DOWNLOAD CLEAR FORM

A. CLIENT IDENTIFICATION		
Last Name		
First Name		
Middle Name		
Nickname		
Social Security No.		
Email Address		
Homeless	☐ Yes ☐ No	
Receives Care from NFCSP Caregiver	☐ Yes ☐ No	
Requires Assistance in an Emergency	☐ Yes *(Specify)*	☐ No
Home Address		
Mailing Address		
Phone (1)		
Phone (2)		

B. CLIENT CONTACTS	
Primary Emergency Contact	
Relationship	
Address	
Phone	
Email	
Physician Contact	
Physician Type	
Address	
Phone	
Email	

Primary Caregiver	
Relationship	
Address	
Phone	
Email	
Personal Contact	
Relationship	
Address	
Phone	
Email	

C. CLIENT DEMOGRAPHICS			
Date of Birth		*Age*	
Gender	☐ Male ☐ Female		
Disabled	☐ Yes *(Specify Type)*	☐ No	
Disability	☐ Permanent ☐ Temporary ☐ Not Applicable (N/A)		
Physical Disability	*(Specify)*	☐ N/A	
Intellectual Disability	*(Specify)*	☐ N/A	
Mental Illness	*(Specify)*	☐ N/A	
Cerebral Palsy	*(Specify)*	☐ N/A	
If < 60 Reason for Service	☐ Caregiver ☐ Disabled ☐ Meal Volunteer	☐ Other: _____ ☐ Spouse ☐ N/A	
Citizenship *(Specify)*			
Race (Specify)	☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Multiple		

CLIENT'S NAME: _____ GETCARE ID: _____ PROGRAM ID: _____
(Last, First, Middle Name)

Ethnicity	*(Specify)*
Primary Language	*(Specify)*
English Fluency	☐ Needs Translation ☐ Limited ☐ Fluent
Literacy	☐ In English ☐ In Main Language ☐ In Both ☐ Illiterate
Relationship Status	☐ Married ☐ Divorced ☐ Separated ☐ Single (Never Been Married) ☐ Widowed ☐ Domestic Partner
Employment Status	☐ Full-Time ☐ Part-Time ☐ Retired ☐ Un-Employed ☐ Volunteer ☐ Disabled
Veteran Status	☐ Veteran ☐ Spouse ☐ Child ☐ No
Urban/Rural	■ Rural
Housing Type	☐ House/Own ☐ House/Rent ☐ Apartment/Duplex ☐ Residential Care Facility ☐ Nursing Facility ☐ Other ☐ None
Lives With	☐ Alone ☐ Family ☐ Spouse ☐ Non-Relative ☐ Other
Referral Source	☐ Self ☐ Family/Friend ☐ Agency:_____ ☐ Other:_____

Sources of Support	☐ Family ☐ Friend/Neighbor ☐ Paid Help ☐ Has help but unsure who provides help ☐ Unknown
Assisted Transportation	☐ Yes ☐ No
Needs an Escort	☐ Yes ☐ No
Primary Transportation	☐ Owns Car ☐ Aide ☐ Friend ☐ Public Transport ☐ Senior Transport ☐ Family ☐ Other ☐ None

Income Level

Is your income less than

Unit Size	Per Month	Per Year	Yes	No
One (1)	$1,226.67	$14,720		

Is your combined income less than

Unit Size	Per Month	Per Year	Yes	No
Two (2)	$1,660.00	$19,920		

Is your combined income less than

Unit Size	Per Month	Per Year	Yes	No
Three (3)	$2,0933.33	$25,120		

☐ Four (4) or more in the Unit Size, add $433.33 per month or $5,200 per year for each additional member.

$_____

Income Information	☐ Above 100% FPL ☐ At or Below 100% FPL
Financial Assets *(Refer to FAS Scale)*	☐ 29% to 49% below the poverty level ☐ 50% to 74% below the poverty level ☐ 75% or greater below the poverty level ☐ N/A

CLIENT'S NAME: _____ GETCARE ID: _____ PROGRAM ID: _____
(Last, First, Middle Name)

Receives Social Security	☐ None ☐ Retirement ☐ Disability ☐ Dependent
Receives Private Pension	☐ Yes ☐ No
Health Insurance	*(Specify)*
Medicare	☐ Part A ☐ Part B Claim No._____ ☐ None ☐ Part D Claim No._____ ☐ None ☐ Medicare Supplemental Claim No._____ ☐ None
Medicaid	☐ Yes Claim No._____ ☐ None
Guardian/ Conservator	☐ None ☐ Voluntary ☐ Involuntary
Person/ Organization Holding Guardianship/ Conservatorship	
Guardian Conservator Type	☐ Estate ☐ Person ☐ Both ☐ Dementia Power ☐ Medical Authority ☐ None
Durable Power of Attorney	☐ Unknown ☐ Limited ☐ Health ☐ Both ☐ None
Supplemental Nutrition Assistance Program (SNAP)	☐ Yes ☐ No

D. CLIENT FUNCTIONAL ASSESSMENT	
Activities of Daily Living (ADL) Choices	
Transfer Mobility	☐ Unknown ☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent
Bathing	☐ Unknown ☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent
Dressing	☐ Unknown ☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent
Toileting	☐ Unknown ☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent
Eating	☐ Unknown ☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent
Ambulating	☐ Unknown ☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent
Assistive Devices *(Specify)*	
Mobility Devices *(Specify)*	

CLIENT'S NAME: _____ GETCARE ID: _____ PROGRAM ID: _____
(Last, First, Middle Name)

Communication Skills Status	
Receptive	☐ Unknown ☐ Good ☐ Fair ☐ Poor ☐ Does Not Understand
Expressive	☐ Unknown ☐ Good ☐ Fair ☐ Poor ☐ Cannot Be Understood
Sensory Skills	
Vision	☐ Unknown ☐ Good ☐ Limited ☐ Legally Blind ☐ Blind
	☐ Glasses ☐ Other
Hearing	☐ Good ☐ Limited ☐ Deaf
	☐ Unknown ☐ Hearing Aid ☐ Other
Support System	☐ Unknown ☐ Support is Available ☐ Minimum Support ☐ No Support
Housing	☐ Unknown ☐ Full Concrete ☐ Semi Concrete ☐ Tin and Wood
Homebound	☐ Unknown ☐ Yes ☐ No
Bedridden	☐ Unknown ☐ Yes ☐ No

E. AGING SERVICES REQUESTED

☐ **Adult Day Care Services**

☐ **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.*)

☐ **Case Management Services**

☐ **In-Home Services**

☐ **Legal Assistance Services**

☐ **National Family Caregiver Support Program**

☐ **Senior Center Operations**

_____
(Specify Center)

☐ **Transportation Services**

COMMENTS:

CLIENT'S NAME: _____ GETCARE ID: _____ PROGRAM ID: _____
(Last, First, Middle Name)

F. HIGH RISK CLIENTS UNDER EMERGENCY DECLARATION

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. ***Check all that apply.***

- ☐ Bedridden.
- ☐ Requires transportation and/or escort assistance for evacuation to shelter, e.g., those living alone.
- ☐ Requires refrigeration of medication and/or is insulin dependent.
- ☐ Requires oxygen.
- ☐ Lives in substandard housing.
- ☐ Not Applicable.

G. ELIGIBILITY AND CONSENT OF CLIENT

Individuals age sixty (60) years and older are eligible for Title III programs under the Older Americans Act. This Act also prioritizes services for:

- ♦ Persons who are frail, homebound by reason of illness or incapacitating disability, or otherwise isolated; and
- ♦ 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.

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.

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.

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.

Signature of Client or Authorized Representative (AR)	
Date	
Relationship to Client, if AR	

H. INTAKE INFORMATION

Intake Worker	
Signature of Intake Worker	
Date/Time of Intake	
Organization	
Phone Number	

IPR Forwarded To

- ☐ Case Management Services Program
  - ☐ Adult Day Care Program
  - ☐ In-Home Services Program
  - ☐ Elderly Nutrition Program (Home-Delivered)
- ☐ Elderly Nutrition Program (Congregate Meals)
- ☐ Legal Assistance Services Program
- ☐ Senior Center Operations Program
- ☐ Transportation Services Program
- ☐ National Family Caregiver Support Program

Forwarded By	
Date Forwarded	
Time Forwarded	

I. RECEIVING ORGANIZATION INFORMATION

IPR Received By	
Date	
Time	
Date of Initial Contact with Client	
Time of Initial Contact with Client	
Time of Intake	
Organization	
Phone Number	

CLIENT'S NAME: _____ GETCARE ID: _____ PROGRAM ID: _____
(Last, First, Middle Name)

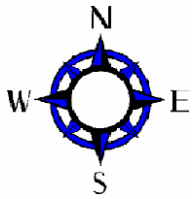
J. CLIENT'S HOME

IF MAP IS SENT SEPARATELY, INCLUDE THE CLIENT'S NAME AND SSN AT TOP OF MAP

Does the home have an accessible driveway?	☐ Yes	☐ No
If you use a wheelchair, is there an accessible ramp?	☐ Yes	☐ No

MAP TO THE CLIENT'S HOME

In the box below, draw a map to the client's residence marking the client's home with an "X". Indicate the house number, street name and the village where the client is from. Include 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. ***All pets at your home shall be controlled by leash, cage, etc. in accordance with P.L. 22-13 and 26-76.***



CLIENT'S NAME: _____ GETCARE ID: _____ PROGRAM ID: _____
(Last, First, Middle Name)