

**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
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 PLEASE PRINT CLEARLY USING BLUE OR BLACK INK.

A. CLIENT IDENTIFICATION	
Last Name	
First Name	
Middle Name	
Nickname	
Social Security No.	
Email Address	
Homeless	<input type="checkbox"/> Yes <input type="checkbox"/> No
Receives Care from NFCSP Caregiver	<input type="checkbox"/> Yes <input type="checkbox"/> No
Requires Assistance in an Emergency	<input type="checkbox"/> Yes (Specify) <input type="checkbox"/> 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	<input type="checkbox"/> Male <input type="checkbox"/> Female
Disabled	<input type="checkbox"/> Yes (Specify Type) <input type="checkbox"/> No
Disability	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Not Applicable (N/A)
Physical Disability	(Specify) <input type="checkbox"/> N/A
Intellectual Disability	(Specify) <input type="checkbox"/> N/A
Mental Illness	(Specify) <input type="checkbox"/> N/A
Cerebral Palsy	(Specify) <input type="checkbox"/> N/A
If < 60 Reason for Service	<input type="checkbox"/> Caregiver <input type="checkbox"/> Other: _____ <input type="checkbox"/> Disabled <input type="checkbox"/> Meal Volunteer <input type="checkbox"/> Spouse <input type="checkbox"/> N/A
Citizenship	(Specify)
Race	(Specify) <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Multiple

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

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<i>Ethnicity</i>	<i>(Specify)</i>												
Primary Language	<i>(Specify)</i>												
English Fluency	<input type="checkbox"/> Needs Translation <input type="checkbox"/> Limited <input type="checkbox"/> Fluent		<input type="checkbox"/> Family <input type="checkbox"/> Friend/Neighbor <input type="checkbox"/> Paid Help <input type="checkbox"/> Has help but unsure who provides help <input type="checkbox"/> Unknown										
Literacy	<input type="checkbox"/> In English <input type="checkbox"/> In Main Language <input type="checkbox"/> In Both <input type="checkbox"/> Illiterate		Sources of Support <input type="checkbox"/> Yes <input type="checkbox"/> No										
<i>Relationship Status</i>	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single (Never Been Married) <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner		Assisted Transportation <input type="checkbox"/> Yes <input type="checkbox"/> No										
<i>Employment Status</i>	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> Un-Employed <input type="checkbox"/> Volunteer <input type="checkbox"/> Disabled		Needs an Escort <input type="checkbox"/> Yes <input type="checkbox"/> No										
Veteran Status	<input type="checkbox"/> Veteran <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> No		Primary Transportation <input type="checkbox"/> Owns Car <input type="checkbox"/> Aide <input type="checkbox"/> Friend <input type="checkbox"/> Public Transport <input type="checkbox"/> Senior Transport <input type="checkbox"/> Family <input type="checkbox"/> Other <input type="checkbox"/> None										
<i>Urban/Rural</i>	<input checked="" type="checkbox"/> Rural		Income Level Is your income less than										
Housing Type	<input type="checkbox"/> House/Own <input type="checkbox"/> House/Rent <input type="checkbox"/> Apartment/Duplex <input type="checkbox"/> Residential Care Facility <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Other <input type="checkbox"/> None		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Unit Size</th> <th>Per Month</th> <th>Per Year</th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>One (1)</td> <td>\$1,226.67</td> <td>\$14,720</td> <td></td> <td></td> </tr> </tbody> </table>	Unit Size	Per Month	Per Year	Yes	No	One (1)	\$1,226.67	\$14,720		
Unit Size	Per Month	Per Year	Yes	No									
One (1)	\$1,226.67	\$14,720											
<i>Lives With</i>	<input type="checkbox"/> Alone <input type="checkbox"/> Family <input type="checkbox"/> Spouse <input type="checkbox"/> Non-Relative <input type="checkbox"/> Other		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Unit Size</th> <th>Per Month</th> <th>Per Year</th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>Two (2)</td> <td>\$1,660.00</td> <td>\$19,920</td> <td></td> <td></td> </tr> </tbody> </table>	Unit Size	Per Month	Per Year	Yes	No	Two (2)	\$1,660.00	\$19,920		
Unit Size	Per Month	Per Year	Yes	No									
Two (2)	\$1,660.00	\$19,920											
Referral Source	<input type="checkbox"/> Self <input type="checkbox"/> Family/Friend <input type="checkbox"/> Agency: _____ <input type="checkbox"/> Other: _____		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Unit Size</th> <th>Per Month</th> <th>Per Year</th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>Three (3)</td> <td>\$2,0933.33</td> <td>\$25,120</td> <td></td> <td></td> </tr> </tbody> </table> <p> <input type="checkbox"/> Four (4) or more in the Unit Size, add \$433.33 per month or \$5,200 per year for each additional member. \$ _____ </p>	Unit Size	Per Month	Per Year	Yes	No	Three (3)	\$2,0933.33	\$25,120		
Unit Size	Per Month	Per Year	Yes	No									
Three (3)	\$2,0933.33	\$25,120											
		<i>Income Information</i> <input type="checkbox"/> Above 100% FPL <input type="checkbox"/> At or Below 100% FPL											
		Financial Assets <i>(Refer to FAS Scale)</i> <input type="checkbox"/> 29% to 49% below the poverty level <input type="checkbox"/> 50% to 74% below the poverty level <input type="checkbox"/> 75% or greater below the poverty level <input type="checkbox"/> N/A											

CLIENT'S NAME: _____ GETCARE ID: _____ PROGRAM ID: _____
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Receives Social Security	<input type="checkbox"/> None <input type="checkbox"/> Retirement <input type="checkbox"/> Disability <input type="checkbox"/> Dependent	<table border="1"> <tr> <th colspan="2">D. CLIENT FUNCTIONAL ASSESSMENT</th> </tr> <tr> <th colspan="2"><i>Activities of Daily Living (ADL) Choices</i></th> </tr> <tr> <td>Transfer Mobility</td> <td> <input type="checkbox"/> Unknown <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance <input type="checkbox"/> Dependent </td> </tr> <tr> <td>Bathing</td> <td> <input type="checkbox"/> Unknown <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance <input type="checkbox"/> Dependent </td> </tr> <tr> <td>Dressing</td> <td> <input type="checkbox"/> Unknown <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance <input type="checkbox"/> Dependent </td> </tr> <tr> <td>Toileting</td> <td> <input type="checkbox"/> Unknown <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance <input type="checkbox"/> Dependent </td> </tr> <tr> <td>Eating</td> <td> <input type="checkbox"/> Unknown <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance <input type="checkbox"/> Dependent </td> </tr> <tr> <td>Ambulating</td> <td> <input type="checkbox"/> Unknown <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance <input type="checkbox"/> Dependent </td> </tr> <tr> <td>Assistive Devices <i>(Specify)</i></td> <td></td> </tr> <tr> <td>Mobility Devices <i>(Specify)</i></td> <td></td> </tr> </table>	D. CLIENT FUNCTIONAL ASSESSMENT		<i>Activities of Daily Living (ADL) Choices</i>		Transfer Mobility	<input type="checkbox"/> Unknown <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance <input type="checkbox"/> Dependent	Bathing	<input type="checkbox"/> Unknown <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance <input type="checkbox"/> Dependent	Dressing	<input type="checkbox"/> Unknown <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance <input type="checkbox"/> Dependent	Toileting	<input type="checkbox"/> Unknown <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance <input type="checkbox"/> Dependent	Eating	<input type="checkbox"/> Unknown <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance <input type="checkbox"/> Dependent	Ambulating	<input type="checkbox"/> Unknown <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance <input type="checkbox"/> Dependent	Assistive Devices <i>(Specify)</i>		Mobility Devices <i>(Specify)</i>	
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Transfer Mobility	<input type="checkbox"/> Unknown <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance <input type="checkbox"/> Dependent																					
Bathing	<input type="checkbox"/> Unknown <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance <input type="checkbox"/> Dependent																					
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Ambulating	<input type="checkbox"/> Unknown <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance <input type="checkbox"/> Dependent																					
Assistive Devices <i>(Specify)</i>																						
Mobility Devices <i>(Specify)</i>																						
Receives Private Pension	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
Health Insurance	<i>(Specify)</i>																					
Medicare	<input type="checkbox"/> Part A <input type="checkbox"/> Part B Claim No. _____ <input type="checkbox"/> None <input type="checkbox"/> Part D Claim No. _____ <input type="checkbox"/> None <input type="checkbox"/> Medicare Supplemental Claim No. _____ <input type="checkbox"/> None																					
Medicaid	<input type="checkbox"/> Yes Claim No. _____ <input type="checkbox"/> None																					
Guardian/Conservator	<input type="checkbox"/> None <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary																					
Person/Organization Holding Guardianship/Conservatorship																						
Guardian Conservator Type	<input type="checkbox"/> Estate <input type="checkbox"/> Person <input type="checkbox"/> Both <input type="checkbox"/> Dementia Power <input type="checkbox"/> Medical Authority <input type="checkbox"/> None																					
Durable Power of Attorney	<input type="checkbox"/> Unknown <input type="checkbox"/> Limited <input type="checkbox"/> Health <input type="checkbox"/> Both <input type="checkbox"/> None																					
Supplemental Nutrition Assistance Program (SNAP)	<input type="checkbox"/> Yes <input type="checkbox"/> No																					

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

E. AGING SERVICES REQUESTED
<input type="checkbox"/> Adult Day Care Services <input type="checkbox"/> Elderly Nutrition Program: <ul style="list-style-type: none"> <input type="checkbox"/> Congregate Meals (Center/Day Care) <input type="checkbox"/> Home-Delivered Meals (Homebound) <p>Meal Type:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Regular <input type="checkbox"/> Mechanical/Chopped <input type="checkbox"/> Pureed/Blenderized <input type="checkbox"/> Special (<i>Provide document from physician or religious leader to certify special meal requirement.</i>)
<input type="checkbox"/> Case Management Services <input type="checkbox"/> In-Home Services <input type="checkbox"/> Legal Assistance Services <input type="checkbox"/> National Family Caregiver Support Program <input type="checkbox"/> Senior Center Operations <hr/> (Specify Center) <input type="checkbox"/> Transportation Services
COMMENTS:

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

F. HIGH RISK CLIENTS UNDER EMERGENCY DECLARATION
<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. Check all that apply.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bedridden. <input type="checkbox"/> Requires transportation and/or escort assistance for evacuation to shelter, e.g., those living alone. <input type="checkbox"/> Requires refrigeration of medication and/or is insulin dependent. <input type="checkbox"/> Requires oxygen. <input type="checkbox"/> Lives in substandard housing. <input type="checkbox"/> Not Applicable.
G. ELIGIBILITY AND CONSENT OF CLIENT
<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"> ◆ 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. <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	
H. INTAKE INFORMATION	
Intake Worker	
Signature of Intake Worker	
Date/Time of Intake	
Organization	
Phone Number	
IPR Forwarded To	
<ul style="list-style-type: none"> <input type="checkbox"/> Case Management Services Program <ul style="list-style-type: none"> <input type="checkbox"/> Adult Day Care Program <input type="checkbox"/> In-Home Services Program <input type="checkbox"/> Elderly Nutrition Program (Home-Delivered) <input type="checkbox"/> Elderly Nutrition Program (Congregate Meals) <input type="checkbox"/> Legal Assistance Services Program <input type="checkbox"/> Senior Center Operations Program <input type="checkbox"/> Transportation Services Program <input type="checkbox"/> 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	

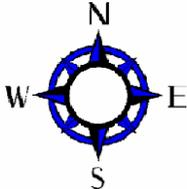
CLIENT'S NAME: _____ GETCARE ID: _____ PROGRAM ID: _____
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J. CLIENT'S HOME

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

Does the home have an accessible driveway?	<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

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.**



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