CITY OF LOS ANGELES - DEPARTMENT OF AGING (LADOA)
CLIENT INTAKE
CONFIDENTIAL

INTAKE DATE (mm/dd/yyyy) *	INTAKE PROVIDER	CASE MANAGER	SPOUSE ID

REFERRED BY *

○ 211	○ Channel 35 Aging in LA	○ Internet	○ LADOA Event	○ MPC	○ Walk In
○ 311	○ Family	○ LA City Depts/CD	○ LADOA Outreach	○ Self	○ Other
○ Adult Protective Services	○ FBO	○ LA County	○ LADOA Presentation/Education	○ Social Services	
○ Advertisement	○ Friend/Neighbor	○ LADOA Brochure	○ Med. Professional	○ SSA	

EMERGENCY VOLUNTARY REGISTRY	COVID-19 IMPACTED	SNAP-ED	CalFresh
○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

APPLICANT CLASSIFICATION *
○ Senior client ○ Non-senior client ○ Non-senior volunteer ○ Spouse of senior client ○ Qualified non-senior

ADDITIONAL CLASSIFICATIONS
☐ Caregiver ☐ Care Receiver ☐ Caring for someone with a disability ☐ Caring for a Veteran ☐ Caring for a person with Disability
☐ Kinship care

PART A: APPLICANT NAME AND ADDRESS

FIRST NAME *	MIDDLE INITIAL	LAST NAME *

EMAIL ADDRESS	PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER

LIVES ALONE * ○ Alone ○ Not Alone ○ Lives in Long Term Care (LTC) ○ Declined to State ○ Missing

RURAL DESIGNATION * ○ Rural ○ Urban ○ Declined to State ○ Missing

RESIDENT ADDRESS

STREET NUMBER	FRACTION	DIRECTION	NAME	TYPE	UNIT/SUITE

CITY	STATE	ZIP CODE *	COUNCIL DISTRICT

MAIL ADDRESS *(if different from Resident Address)*

STREET NUMBER	FRACTION	DIRECTION	NAME	TYPE	UNIT/SUITE

CITY	STATE	ZIP CODE

PART B: APPLICANT PERSONAL INFORMATION

BIRTHDATE (mm/dd/yyyy) *	STATE OF THE DRIVER'S LICENSE/STATE ID	DRIVER'S LICENSE NUMBER	STATE ID NUMBER

MARITAL STATUS *
○ Missing ○ Single (Never Married) ○ Married ○ Domestic partner ○ Separated ○ Divorced ○ Widowed ○ Declined to State

US CITIZEN ○ Yes ○ No **SPEAK ENGLISH *** ○ English Speaking ○ Need Interpreter ○ Non-English/Language

PRIMARY LANGUAGE SPOKEN *
○ Arabic ○ English ○ French ○ Hebrew ○ Hungarian ○ Italian ○ Korean ○ Mandarin Chinese ○ Portuguese ○ Spanish ○ Vietnames
○ Armenian ○ Farsi ○ German ○ Hindi ○ Indonesian ○ Japanese ○ Lithuanian ○ Polish ○ Russian ○ Tagalog ○ Missing

HAVE YOU EVER SERVED IN THE UNITED STATES MILITARY? *
○ Yes ○ No ○ Declined to state If the answer is "Yes", please enter the **VETERAN ID:** _____

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 to state

IF YOU IDENTIFY AS BEING MILITARY AFFILIATED, CHECK BELOW: *

"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 for 12 months."

○ Yes ○ No If the answer is "Yes", please enter the **DATE OF CONSENT: (mm/dd/yyyy)**_____

Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for service and supports at www.calvet.ca.gov or 1-800-952-5626.

WHAT WAS YOUR SEX AT BIRTH? *

○ Male ○ Female ○ Declined to State ○ Missing

WHAT IS YOUR GENDER? *

○ Male ○ Female ○ Transgender Male to Female ○ Transgender Female to Male ○ Gender Queer/Gender Non-Binary
○ Declined to State ○ Missing ○ Not listed, please specify _____

HOW DO YOU DESCRIBE YOUR SEXUAL ORIENTATION OR SEXUAL IDENTITY? *

○ Straight/Heterosexual ○ Bisexual ○ Gay/Lesbian/Same-Gender Loving ○ Questioning/Unsure
○ Declined to State ○ Missing ○ Not listed, please specify _____

MEDICARE/RRB NUMBER	HMO INSURANCE NAME	HMO INSURANCE NUMBER

SOCIAL SECURITY

☐ MEDI-CAL ☐ SOCIAL SECURITY ADMINISTRATION (SSA) ☐ SOCIAL SECURITY DISABILITY INSURANCE (SSDI)
☐ SOCIAL SECURITY SURVIVOR'S BENEFITS (SSB) ☐ SUPPLEMENTAL SECURITY INCOME (SSI)

ETHNICITY *

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

RACE * (Check all that apply)

☐ White ☐ Black/African American ☐ 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
☐ Missing ☐ Declined to State

EMPLOYMENT STATUS

○ Missing ○ Full-time ○ Part-time ○ Retired ○ Unemployed ○ Declined to State

EDUCATION LEVEL

○ College Graduate ○ Grade School ○ High School ○ None ○ Post Graduate ○ Some College ○ Some High School

NUMBER OF HOUSEHOLD MEMBERS * **TOTAL HOUSEHOLD INCOME *** $_____ ○ Yearly ○ Monthly ○ Declined to state

POVERTY LEVEL * Please go here to view the **HHS Poverty Guidelines** https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.

○ At or Below Federal Poverty Level ○ Above Federal Poverty Level ○ Declined to State ○ Missing

FUNCTIONALLY IMPAIRED

☐ Vision ☐ Mobility ☐ Hearing ☐ Mod. Cognitive ☐ Severe Cognitive Other:_____

TRANSPORTATION SERVICE NEEDS

○ Walks with no assistance (Non-Assisted) ○ Walks with assistance (Assisted) ○ Wheelchair ramp/lift

PART C: APPLICANT DOCTOR/EMERGENCY CONTACTS

DOCTOR INFORMATION

FULL NAME		PHONE NUMBER			
STREET NUMBER	FRACTION	DIRECTION	NAME	TYPE	UNIT/SUITE
CITY		STATE	ZIP CODE		

EMERGENCY CONTACT INFORMATION

1:	NAME	RELATIONSHIP	PHONE NUMBER
2:	NAME	RELATIONSHIP	PHONE NUMBER

PART E: DAILY LIVING & INSTRUMENTAL ACTIVITIES

ACTIVITIES OF DAILY LIVING (ADL) AND INSTRUMENTAL ACTIVITIES (IADL) are required if one of following Programs is checked:

- **Home Delivered Meals**
- **Personal Care, Homemaker, Chore, Adult Day Care, and Case Management**
- **Supportive Services, Respite Care, and Supplemental Services**

ACTIVITIES OF DAILY LIVING (ADL)

DESCRIPTION	1: INDEPENDENT	2: VERBAL ASSISTANCE	3: SOME HUMAN HELP	4: LOTS OF HUMAN HELP	5: DEPENDENT	DECLINED TO STATE	MISSING
Bathing	○	○	○	○	○	○	○
Dressing	○	○	○	○	○	○	○
Toileting	○	○	○	○	○	○	○
Eating	○	○	○	○	○	○	○
Transferring in/out of bed/chair	○	○	○	○	○	○	○
Walking	○	○	○	○	○	○	○
Grooming	○	○	○	○	○	○	○

INSTRUMENTAL ACTIVITIES (IADL)

DESCRIPTION	1: INDEPENDENT	2: VERBAL ASSISTANCE	3: SOME HUMAN HELP	4: LOTS OF HUMAN HELP	5: DEPENDENT	DECLINED TO STATE	MISSING
Use of Telephone	○	○	○	○	○	○	○
Preparing Meals	○	○	○	○	○	○	○
Stair Climbing	○	○	○	○	○	○	○
Laundry	○	○	○	○	○	○	○
Light Housework	○	○	○	○	○	○	○
Heavy Housework	○	○	○	○	○	○	○
Mobility Indoors	○	○	○	○	○	○	○
Mobility Outdoors	○	○	○	○	○	○	○
Shopping - Personal Items	○	○	○	○	○	○	○
Medication Management	○	○	○	○	○	○	○
Handling Finances	○	○	○	○	○	○	○
Transportation Ability	○	○	○	○	○	○	○

PART F: NUTRITION SCREENING

NUTRITIONAL RISK ASSESSMENT: Nutritional Risk Clients with nutritional screening total score of 6 or greater will be reported as 'at nutritional risk.'	SELECT	SCORE
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, vegetables, or milk products.	☐	2
I have 3 or more drinks of beer, wine, or liquor almost every day.	☐	2
I have tooth or mouth problems that make it hard for me to eat.	☐	2
I do not 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
None	☐	0
Declined to State	☐	0