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

PART D: PROGRAM REGISTRATION

HOME DELIVERED MEALS ELIGIBILITY **If "Home Delivered Meals" Program is checked, please complete this section.**

Are you homebound due to an illness, disability, or isolation? ○ Yes ○ No

Are you a spouse of a home-delivered meal recipient? ○ Yes ○ No

Are you an individual with a disability who resides with a home-delivered meal recipient? ○ Yes ○ No

ADULT DAY CARE
- ☐ 5A Adult Day Care / Health - Counseling
- ☐ 5B Adult Day Care / Health - Medication Assistance
- ☐ 5C Adult Day Care / Health - Social & Rec. Activities

ASSESSMENT
- ☐ 1523 Comprehensive Assessment

CASE MANAGEMENT
- ☐ 6A Case Management
- ☐ 6B Case Mgmt - Care Planning
- ☐ 6D Case Mgmt - Case Monitoring
- ☐ 6E Case Mgmt - Money Mgmt
- ☐ 6C Case Mgmt - Service Auth/Arrangement

CHORE
- ☐ 3A Chore - Heavy Housework
- ☐ 3B Chore - Yard Work

CONGREGATE MEALS
- ☐ 7A Congregate Meals
- ☐ 1523 Congregate Meals (Non-Registered)

COUNSELING
- ☐ 50 Counseling (Number of Hours)
- ☐ 1535 Peer Counseling

EARS
- ☐ 302A EARS - One Unit Assigned

ELDER ABUSE - TITLE VII-B
- ☐ 1527 Elder Abuse Prevention Educational Materials
- ☐ 1526 Elder Abuse Prevention, Education, and Training

FCSP (CARE FOR ELDERLY)
- ☐ 1501 FCSP (Care for Elderly) Assistive Devices
- ☐ 131 FCSP (Care for Elderly) Caregiver Assessment
- ☐ 136 FCSP (Care for Elderly) Caregiver Case Management
- ☐ 132 FCSP (Care for Elderly) Caregiver Counseling
- ☐ 133 FCSP (Care for Elderly) Caregiver Peer Counseling
- ☐ 134 FCSP (Care for Elderly) Caregiver Support Groups
- ☐ 135 FCSP (Care for Elderly) Caregiver Training
- ☐ 112 FCSP (Care for Elderly) Community Education
- ☐ 1506 FCSP (Care for Elderly) Emgcy Cash/Material Aid
- ☐ 1502 FCSP (Care for Elderly) Home Adaptations
- ☐ 144 FCSP (Care for Elderly) Home Chore
- ☐ 142 FCSP (Care for Elderly) Homemaker Assistance

FCSP (CARE FOR ELDERLY)
- ☐ 121 FCSP (Care for Elderly) Information and Assistance
- ☐ 143 FCSP (Care for Elderly) In-Home Personal Care
- ☐ 141 FCSP (Care for Elderly) In-Home Supervision
- ☐ 123 FCSP (Care for Elderly) Interpretation/Translation
- ☐ 124 FCSP (Care for Elderly) Legal Resources
- ☐ 145 FCSP (Care for Elderly) Out-of-Home Day Care
- ☐ 146 FCSP (Care for Elderly) Out-of-Home Overnight Care
- ☐ 122 FCSP (Care for Elderly) Outreach
- ☐ 111 FCSP (Care for Elderly) Public Information
- ☐ 1503 FCSP (Care for Elderly) Services Registry

FCSP (CARE FOR CHILD)
- ☐ 1563 FCSP (Care for Child) Assistive Devices
- ☐ 1551 FCSP (Care for Child) Caregiver Assessment
- ☐ 1556 FCSP (Care for Child) Caregiver Case Management
- ☐ 1552 FCSP (Care for Child) Caregiver Counseling
- ☐ 1548 FCSP (Care for Child) Caregiver Outreach
- ☐ 1553 FCSP (Care for Child) Caregiver Peer Counseling
- ☐ 1554 FCSP (Care for Child) Caregiver Support Groups
- ☐ 1555 FCSP (Care for Child) Caregiver Training
- ☐ 1546 FCSP (Care for Child) Community Education
- ☐ 1566 FCSP (Care for Child) Emergency Cash/Material Aid
- ☐ 1564 FCSP (Care for Child) Home Applications
- ☐ 1560 FCSP (Care for Child) Home Chore
- ☐ 1558 FCSP (Care for Child) Homemaker Assistance
- ☐ 1559 FCSP (Care for Child) In-Home Personal Care
- ☐ 1557 FCSP (Care for Child) In-Home Supervision
- ☐ 1547 FCSP (Care for Child) Information and Assistance
- ☐ 1549 FCSP (Care for Child) Interpretation/Translation
- ☐ 1550 FCSP (Care for Child) Legal Resources

FCSP (CARE FOR CHILD)
- ☐ 1561 FCSP (Care for Child) Out-of-Home Day Care
- ☐ 1562 FCSP (Care for Child) Out-of-Home Overnight Care
- ☐ 1545 FCSP (Care for Child) Public Information
- ☐ 1565 FCSP (Care for Child) Services Registry

HOME DELIVERED MEALS
- ☐ 4A Home-Delivered Meal
- ☐ 1518 Home Delivered Meals (Non-Registered)

HOMEMAKER
- ☐ 19A Homemaker - Grocery/Pharmacy/Supply Delivery
- ☐ 2G Homemaker - Grocery/Pharmacy/Supply Delivery-3B
- ☐ 2H Homemaker - Grocery/Pharmacy/Supply Delivery-3D
- ☐ 2C HomeMaker - Light Housework-3B
- ☐ 2F HomeMaker - Light Housework-3D
- ☐ 2A Homemaker - Preparing Meals-3B
- ☐ 2D HomeMaker - Preparing Meals-3D
- ☐ 2B HomeMaker - Shopping Personal-3B
- ☐ 2E HomeMaker - Shopping Personal-3D

HOUSING
- ☐ 1530 Housing

NUTRITION
- ☐ 1583 Nutrition - C1

OUTREACH
- ☐ 14 Outreach
- ☐ 14A Outreach - 3C1
- ☐ 14B Outreach - 3C2

PERSONAL CARE
- ☐ 1B Personal Care-3B
- ☐ 1A Personal Care-IIID

RESPITE CARE
- ☐ 1541 Respite Care

TRANSPORTATION
- ☐ 10C Emergency Scrip - DOT (Prop A) - One booklet of 60
- ☐ 10D Taxi Coupons - DOT (MTA - Prop A) - One coupon
- ☐ 10B Transportation - 3B/One Bus Pass = one 1-way trip
- ☐ 10A Transportation - 3B/One Van Ride = one 1-way trip

VIC's Bernardi Senior Center Formulario de liberación de responsabilidad

Información del Participante:

- Nombre Completo: _____
- Fecha y Hora: _____
- Lugar: Bernardi Senior Center

Reconocimiento de Riesgos y Responsabilidades:

Yo, el participante abajo firmante, por la presente reconozco y entiendo que la participacion en la actividad/evento puede implicar ciertos riesgos y peligros, incluyendo pero no limitado a:

- Lesiones o daños físicos
- Daños materiales
- Enfermedad

Soy consciente de que estos riesgos y peligros son inherentes a la actividad/evento, y elijo voluntariamente participar a pesar de estos riesgos potenciales.

Exención de responsabilidad:

En consideración de ser permitido a participar en la actividad/evento, yo, en mi nombre, mis herederos, y representantes personales, por la presente libero, renuncio, descargo, y me comprometo a no demandar a VIC's Bernardi Senior Center, sus oficiales, empleados, agentes, y voluntarios, de cualquier y toda responsabilidad, reclamos, demandas, acciones, o derechos de acción, ya sean personales a mi o a terceros, que estén relacionados con mi participación en la actividad/evento. Esto incluye, pero no se limita a, cualquier y toda responsabilidad por cualquier pérdida, daño, lesión o gasto que pueda ocurrir.

Acepto los términos:

He leído este formulario de responsabilidad y entiendo sus términos. Lo firmo voluntariamente y por mi propia voluntad.

Firma del participante: _____

VIC's Bernardi Senior Center Liability Form

Participant Information:

- Full Name: _____
- Date and Time: _____
- Location: Bernardi Senior Center

Acknowledgment of Risks and Liabilities:

I, the undersigned participant, hereby acknowledge and understand that participation in the activity/event may involve certain risks and hazards, including but not limited to:

- Physical injury or harm
- Property damage
- Illness or disease

I am aware that these risks and hazards are inherent in the activity/event, and I voluntarily choose to participate in spite of these potential risks.

Release of Liability:

In consideration of being allowed to participate in the activity/event, I, on behalf of myself, my heirs, and personal representatives, hereby release, waive, discharge, and covenant not to sue VIC's Bernardi Senior Center, its officers, employees, agents, and volunteers, from any and all liability, claims, demands, actions, or rights of action, whether personal to me or to third parties, which are related to my participation in the activity/event. This includes, but is not limited to, any and all liability for any loss, damage, injury, or expense that may occur.

Agreement to Terms:

I have read this liability form, and I understand its terms. I am signing it voluntarily and of my own free will.

Participant's Signature: [redacted]