

# **Title III - Intake and Assessment Forms Guide**

**CALIFORNIA DEPARTMENT OF AGING  
LONG-TERM CARE AND AGING SERVICES DIVISION**

[www.aging.ca.gov](http://www.aging.ca.gov)

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# Title III - Intake & Assessment Forms Guide

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## Overview

### Introduction

Data and the information created from data elements contribute to valuable knowledge about service use and client demographics. It is a source for Area Agencies on Aging (AAA), California Department of Aging (CDA), and U.S. Administration for Community Living (ACL) performance measures.

### Background

AAA staff spends a large percentage of their time reading, completing, processing, and retrieving forms created or received by the agency.

Forms are an important part of the operations that aid in the collection and documentation of information. Well-designed and well-managed forms can reduce errors and save time and money.

### Purpose

The purpose of this guide is to help AAA staff identify the required ACL and CDA Title III data elements. This guide provides AAAs with guidance, resources, and sample layouts and forms to help AAAs evaluate and design agency intake forms.

**NOTE:** *This guide does not address Community Based Service Programs (CBSP), Health Insurance Counseling and Advocacy Program (HICAP), Long-Term Ombudsman Program, Senior Community Services Employment Program (Title V), or fiscal forms.*

## Data Performance Reporting Requirements

### Purpose

The Older Americans Act (OAA) requires a report of statistical data reflecting the number of service units provided and the number of registered clients or the estimated clients/audience reached.

### Process

#### Data Performance Management Process.

Entity	Role
Provider or AAA	<ul style="list-style-type: none"> <li>• collects and tracks client/user information and service units</li> <li>• reports service utilization units, consumer demographics and expenditures</li> <li>• maintains records</li> </ul>
AAA	<ul style="list-style-type: none"> <li>• plans and administers OAA data management system(s)</li> <li>• implements CDA data reporting requirements</li> <li>• develops and maintains written procedures</li> <li>• analyzes, corrects, and verifies data</li> <li>• monitors and evaluates local services</li> <li>• trains staff and provides technical assistance to the providers, clients, and caregivers</li> <li>• reports data to CDA via the statewide California Aging Reporting System (CARS)</li> </ul>
CDA	<ul style="list-style-type: none"> <li>• sets data reporting standards</li> <li>• monitors and evaluates AAA programs</li> <li>• plans and administers the CARS</li> <li>• provides AAAs with training and technical assistance as needed</li> <li>• reports data and program information to ACL and the California State Legislature</li> </ul>
ACL	<ul style="list-style-type: none"> <li>• provides Congress, states and other stakeholders with National Aging Program Information System (NAPIS) data</li> </ul>

### CARS Approval

AAAs shall assure that all data submitted is complete, accurate, timely, and verifiable.

AAA staff must approve CARS File Upload quarterly data and NAPISCare annual data within 10 days of notice of passed status. If the data cannot be corrected within 10 days, AAA staff must provide an explanation in the comments box in the report screen. CDA will be able to review the data after the 10-day approval period.

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## **Data Performance Reporting Requirements, Continued**

### **NAPIS Validation**

As part of the annual year-end performance reporting process, the AAA Director, or designee, will be required to validate the NAPIS data.

### **What is Reviewed**

CDA reviews the accuracy and completeness of the reported data on a regular basis. CDA reviews intake and assessment forms, reporting performance information, supporting documents, and reporting procedures during the CDA monitoring process.

AAAs shall keep complete records/documents on file to support all reports submitted to CDA. All paper and electronic client information records, data elements, and printouts collected are confidential and shall be secured and remain protected from unauthorized disclosure.

# Designing Forms that Work

## Introduction

The arrangement of the questions on the form will make it easier to enter, complete, and retrieve information.

## Group Data

Group related items with clearly defined sections to make the form easier to fill out. It can also eliminate the need for backtracking and reduces incomplete or missing data elements.

Databases may have separate data entry screens for

- Client Detail Identification
- Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), and/or
- Nutritional Risk Assessment

## Establish Item Sequence

Arrange questions in a sequence that will match the structure of the database configuration. This will allow for easier data entry from one section to the next without having to search the form for the correct entry area.

## Make Required Questions Clear

Make required data elements clear and visible. Design forms to clearly define form fields with bound boxes and headers.

## What is Reviewed

CDA reviews AAA forms to ensure all required data collection elements are integrated. See [Guidelines Chart](#).

## Required Title III B, C, and D (Clusters I & II), Registered Client Fields

### Chart Guidelines

Apply the following chart to determine if intake form(s) have required data collection and reporting elements for Title III B, C, and D (Clusters I and II) Programs. See [page 38](#) for Non-Registered fields.

**CARS Title III B, C, and D (Clusters I and II) Required Registered Client Fields**

Service Category	Service Units	Registered Client <sup>1</sup>	ADL & IADL <sup>2</sup>	Nutritional Risk <sup>3</sup>	Funding Source
Personal Care	X Hour	X	X		III B
Homemaker	X Hour	X	X		III B
Chore	X Hour	X	X		III B
Adult Day Care/Health	X Hour	X	X		III B
Case Management	X Hour	X	X		III B
Congregate Meals	X Meal	X		X	III C
Home-Delivered Meals	X Meal	X	X	X	III C
Nutritional Counseling	X Session per Participant	X		X	III C
Assisted Transportation	X One-way Trip	X			III B

**(X) Required Element**

#### <sup>1</sup> Registered Client Required Client Level Detail

- Participant ID to Determine Unduplicated Count
- Birth Date
- Zip Code
- Rural Designation
- Gender
- Sex at Birth
- Sexual Orientation or Sexual Identity
- Race
- Ethnicity
- Poverty Status
- Living Arrangement

*Continued on next page*

## Required Title III B, C, and D (Clusters I & II), Registered Client Fields, Continued

### <sup>2</sup> ADL/IADL Required Functional Rating Scale for each of the following:

- ADL: Eating
- ADL: Bathing
- ADL: Toileting
- ADL: Transferring in/out of bed/chair
- ADL: Walking
- ADL: Dressing
- IADL: Meal Preparation
- IADL: Shopping
- IADL: Medication Management
- IADL: Money Management
- IADL: Using Telephone
- IADL: Heavy Housework
- IADL: Light Housework
- IADL: Transportation

### ADL & IADL Functional Impairment Rating Scale

- (1) Independent: Can perform a task without human assistance.
  - (2) Verbal Assistance: Requires verbal prompting to begin or complete a task.
  - (3) Some Human Help: Requires some physical assistance to perform a task.
  - (4) Lots of Human Help: Requires substantial assistance to perform a task.
  - (5) Dependent: Totally dependent on another person to perform a task.
  - (6) Declined to State
  - (0) Missing
- Or as default, report only three levels: 1, 3, or 5 (and 6 – Declined to State).

### <sup>3</sup> Nutritional Risk - Required Score

- (1) Yes: High nutritional risk with score of 6 or higher.
  - (2) No: Nutritional score with 5 or lower.
  - (3) Declined to State
  - (0) Missing
- Scores are based on the *Determine Your Nutritional Health* checklist.

Refer to [CARS File Specifications](#) for file reporting structure and optional data elements.  
Documents are at [California Aging Reporting System \(CARS\)](#)

Refer to [Services Categories and Data Dictionary](#) for category definitions.



## Required Title III E, Registered Caregiver Fields (Group 1)

### Chart Guidelines

Apply the following chart to determine if intake form(s) have the required data collection and reporting elements for the Title III E Family Caregiver Support Program (FCSP) **Caring for Elderly** and **Caring for Child**. See [page 39](#) for Non-Registered fields.

#### CARS Title III E, FCSP Caring for Elderly/Caring for Child, Required Registered Caregiver Fields

Caring for Elderly/Child Service Category	Service Units	Registered Caregiver <sup>1</sup>
Assessment	X Hour	X
Counseling	X Hour	X
Peer Counseling	X Hour	X
Support Group	X Hour	X
Training	X Hour	X
Case Management	X Hour	X
In-Home Supervision	X Hour	X
Homemaker Assistance	X Hour	X
In-Home Personal Care	X Hour	X
Home Chore	X Hour	X
Out-of-Home Day Care	X Hour	X
Out-of-Home Overnight Care	X Hour	X
Assistive Devices	X Device/Occurrence	X
Home Adaptations	X Modification/Occurrence	X
Registry	X Hour/Occurrence	X
Emergency Cash/Material Aid	X Assistance/Occurrence	X

**(X) Required Element**

#### <sup>1</sup> Registered Caregiver Required Client Level Detail

- Participant ID to Determine Unduplicated Count
- Birth Date
- Zip Code
- Rural Designation
- Gender
- Sex at Birth
- Sexual Orientation or Sexual Identity
- Race
- Ethnicity
- Poverty Status
- Living Arrangement
- Relationship Status
- Employment Status
- Caregiver Relationship

Refer to [CARS File Specifications](#) for file reporting structure and optional data elements. Documents are at [California Aging Reporting System \(CARS\)](#)

Refer to [Services Categories and Data Dictionary](#) for category definitions.

## Required Title III E, Registered Care Receiver Fields (Group 1)

### Chart Guidelines

Apply the following chart to determine if intake form(s) have required data collection and reporting elements for the Care Receiver in the Title III E, Family Caregiver Support Program (FCSP), **Caring for Elderly**.

#### CARS Title III E, FCSP Caring for Elderly, Required Registered Care Receiver Fields

Caring for Elderly Service Category	Registered Care Receiver <sup>2</sup>	ADL & IADL <sup>3</sup>
Assessment	X	X
Counseling	X	X
Peer Counseling	X	X
Support Group	X	X
Training	X	X
Case Management	X	X
In-Home Supervision	X	X
Homemaker Assistance	X	X
In-Home Personal Care	X	X
Home Chore	X	X
Out-of-Home Day Care	X	X
Out-of-Home Overnight Care	X	X
Assistive Devices	X	X
Home Adaptations	X	X
Registry	X	X
Emergency Cash/Material Aid	X	X

**(X) Required Element**

#### <sup>2</sup> Registered Care Receiver Required Client Level Detail

- Participant ID to Determine Unduplicated Count
- Birth Date
- Zip Code
- Rural Designation
- Gender
- Sex at Birth
- Sexual Orientation or Sexual Identity
- Race
- Ethnicity
- Poverty Status
- Living Arrangement
- Relationship Status

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## Required Title III E, Registered Care Receiver Fields (Group 1), Continued

### <sup>3</sup> ADL/IADL Required Functional Rating Scale for each of the following:

- ADL: Eating
- ADL: Bathing
- ADL: Toileting
- ADL: Transferring in/out of bed/chair
- ADL: Walking
- ADL: Dressing
- IADL: Meal Preparation
- IADL: Shopping
- IADL: Medication Management
- IADL: Money Management
- IADL: Using Telephone
- IADL: Heavy Housework
- IADL: Light Housework
- IADL: Transportation

### ADL & IADL Functional Impairment Rating Scale

- (1) Independent: Can perform a task without human assistance.
- (2) Verbal Assistance: Requires verbal prompting to begin or complete a task.
- (3) Some Human Help: Requires some physical assistance to perform a task.
- (4) Lots of Human Help: Requires substantial assistance to perform a task.
- (5) Dependent: Totally dependent on another person to perform a task.
- (6) Declined to State
- (0) Missing

Or as default, report only three levels: 1, 3, or 5 (and 6 – Declined to State).

**Refer to [CARS File Specifications](#) for file reporting structure and optional data elements.  
Documents are at [California Aging Reporting System \(CARS\)](#)**

**Refer to [Services Categories and Data Dictionary](#) for category definitions.**

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## Required Title III E, Registered Care Receiver Fields (Group 1), Continued

### Chart Guidelines

Apply the following chart to determine if intake form(s) have required data collection and reporting elements for the Care Receiver in the Title III E FCSP **Caring for Child**.

#### CARS Title III E, FCSP Caring for Child Required Registered Care Receiver Fields

Caring for Child Service Category	Registered Care Receiver <sup>2</sup>
Assessment (Supportive Services)	X
Counseling (Supportive Services)	X
Peer Counseling (Supportive Services)	X
Support Group (Supportive Services)	X
Training (Supportive Services)	X
Case Management (Supportive Services)	X
In-Home Supervision (Respite Care)	X
Homemaker Assistance (Respite Care)	X
In-Home Personal Care (Respite Care)	X
Home Chore (Respite Care)	X
Out-of-Home Day Care (Respite Care)	
Out-of-Home Overnight Care (Respite Care)	X
Assistive Devices (Supplemental Services)	X
Home Adaptations (Supplemental Services)	X
Registry (Supplemental Services)	X
Emergency Cash/Material Aid (Supplemental Services)	X

**(X) Required Element**

#### <sup>2</sup> Registered Care Receiver Required Client Level Detail

- Participant ID to Determine Unduplicated Count
- Birth Date
- Zip Code
- Rural Designation
- Gender
- Sex at Birth
- Sexual Orientation or Sexual Identity
- Race
- Ethnicity
- Poverty Status
- Living Arrangement
- Relationship Status

**NOTE:** There are no ADL or IADL data collection requirements for Care Receivers in FCSP Caring for Child

Refer to [CARS File Specifications](#) for file reporting structure and optional data elements. Documents are at [California Aging Reporting System \(CARS\)](#)

Refer to [Services Categories and Data Dictionary](#) for category definitions.

# Required Registered Client Level Detail

## Introduction

OAA programs use client demographic elements for targeting and/or reporting purposes. The required registered client level details are birth date, zip code, rural designation, gender, sex at birth, sexual orientation or gender identity, race, ethnicity, poverty status, and living arrangement.

## Service Categories Required

The following are the programs that require collecting client level detail for registered clients, or FCSP caregivers *and* care receivers.

### Title III B, C, and D, Supportive and Nutrition Services

- Personal Care
- Homemaker
- Chore
- Home-Delivered Meals
- Adult Day Care/Health
- Case Management
- Congregate Meals
- Nutritional Counseling
- Assisted Transportation

### Title III E, FCSP Caregiver Caring for Elderly/Grandparent Caring for Child: Caregiver & Care Receiver

#### **SUPPLEMENTAL SERVICES**

- Assessment
- Counseling
- Peer Counseling
- Support Group
- Training
- Case Management
  
- Material Aid

#### **RESPIRE CARE**

- In-Home Supervision
- Homemaker Assistance
- In-Home Personal Care
- Home Chore
- Out-of-Home Day Care
- Out-of-Home Overnight Care

#### **SUPPLEMENTAL SERVICES**

- Assistive Devices
- Home Adaptations
- Registry
- Emergency Cash/

*Continued on next page*

## Required Registered Client Level Detail, Continued

### What is Reviewed

CDA reviews registered client level details for completeness. The client's information is self-reported and collected annually. If a client declines to provide information, document the action. Service **cannot** be denied to eligible clients declining to provide information.

All the listed data elements, except for birth date, include a "Declined to State" option which is calculated separately from "missing" information. Missing information occurs when a client is not asked to identify the required demographic data element or information was not entered into the AAA database.

### Birthday

Collect the month (##), day (##), and year (####) of birth.

### Elements Zip Code

Zip Code can be collected as ##### or ##### - ####.

### Sexual Orientation and Gender Identity (SOGI)

The following lists contain the various options available to report SOGI data to CARS:

#### ***GENDER CARS OPTIONS***

- Male
- Female
- Transgender Female to Male
- Transgender Male to Female
- Genderqueer/ Gender Non-binary
- Not listed. Please specify: \_\_\_\_\_
- Declined to State
- Missing

#### ***SEX AT BIRTH CARS OPTIONS***

- Male
- Female
- Declined to State
- Missing

#### ***SEXUAL ORIENTATION OR SEXUAL IDENTITY CARS OPTIONS***

- Straight/ Heterosexual
- Bisexual
- Gay/ Lesbian/ Same-Gender Loving
- Questioning/ Unsure
- Not listed. Please specify: \_\_\_\_\_
- Declined to State
- Missing

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## Required Registered Client Level Detail, Continued

### Rural Designation

According to the Census, a rural area encompasses all population, housing, and territory not included in an urban area. Often a client may not know how to declare their rural designation. A rural designation may be applied on behalf of the client. If applied, make sure areas, such as zip codes, are documented in AAA procedures.

To find Census information of rural and urban areas by zip code visit the [Census Bureau's Urban and Rural Classification](#).

#### Rural CARS Options

- Rural
- Urban
- Declined to State
- Missing

### Race

The following reflects the Office of Management and Budget's (OMB) reporting requirement for collecting race, and California's Government Code Section 8310.5 reporting requirement for collecting different Asian and Native Hawaiian/Other Pacific Islander groups.

#### Race CARS Options

- White
- American Indian or Alaska Native
- Black or African American
- Other Race
- Multiple Race
- Chinese
- Japanese
- Filipino
- Korean
- Vietnamese
- Asian Indian
- Laotian
- Cambodian
- Other Asian
- Guamanian
- Hawaiian
- Samoan
- Other Pacific Islander
- Declined to State
- Missing

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## **Required Registered Client Level Detail, Continued**

### **Ethnicity**

The following reflects the OMB's ethnicity reporting requirement. Hispanic or Latino origin is a **separate question from the race category**.

#### **Ethnicity CARS Options**

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

### **Living Arrangement**

ACL defines "living alone" as a one-person household (using the Census definition of household) where the householder lives by his or herself in an owned or rented place of residence in a non-institutional setting.

#### **Living Arrangement CARS Options**

- Alone
- Not Alone
- Declined to State
- Missing

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## Required Registered Client Level Detail, Continued

### Unique Participant ID

ACL requires that State Units on Aging (SUA) report the total unduplicated clients who were served in registered services. The most accurate method to avoid duplicating information is by assigning a unique participant identifier to a client (generally, each AAA data management system creates this identifier once the minimum data elements are entered into the system). All services received by the client can be tracked by tying them to the client's unique participant identifier.

When developing a unique identification number, AAAs must ensure that personal, sensitive, and confidential information is protected from inappropriate or unauthorized access or disclosure. AAAs must have written confidentiality procedures to ensure that no personal information is disclosed by the AAA or provider without informed consent of the client.

OAA services cannot be denied to eligible clients if they do not wish to disclose their information.

The unique "Participant ID" must be collected as an integer.

### Termination Date

This is the date on which the participant stopped receiving a service.

This date must be collected as YYYY-MM-DD.

### Termination Reason

This field identifies the reason for terminating services (i.e., deactivating a client).

#### Reason for Deactivation CARS Options

- Deceased
- No Longer MSSP Eligible
- Moved out of Service Area
- Won't Follow Care Plan
- No Longer Desires Services
- On Hold
- No Longer SNF Certifiable
- Service No Longer Needed
- No Longer Medi-Cal Eligible
- Past Active
- Institutionalization
- On Waiting List
- High Cost of Services
- Other Reason

# Federal Poverty Determination

## Introduction

While the OAA is concerned with the provision of services to all older persons, it requires assurance that preference is given to older individuals with greatest economic or social need, with particular attention to low-income minority individuals.

Under the OAA, “greatest economic need” means the need resulting from an income level at or below poverty levels established by OMB.

ACL uses the Federal Poverty Guidelines for targeting and reporting.

## Service Categories Required

The following are the programs that require collecting that require collecting poverty status for registered clients, or FCSP caregivers *and* care receivers.

### Title III B, C, and D, Supportive and Nutrition Services

- Personal Care
- Homemaker
- Chore
- Home-Delivered Meals
- Adult Day Care/Health
- Case Management
- Congregate Meals
- Nutritional Counseling
- Assisted Transportation

### Title III E, FCSP Caregiver Caring for Elderly/Grandparent Caring for Child (Caregiver and Care Receiver)

#### ***SUPPORTIVE SERVICES***

- Assessment
- Counseling
- Peer Counseling
- Support Group
- Training
- Case Management

#### ***RESPITE CARE***

- In-Home Supervision
- Homemaker Assistance
- In-Home Personal Care
- Home Chore
- Out-of-Home Day Care
- Out-of-Home Overnight Care

#### ***SUPPLEMENTAL SERVICES***

- Assistive Devices
- Home Adaptations
- Registry
- Emergency Cash/Material Aid

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## Federal Poverty Determination, Continued

### What to Include

Create a question to determine if the client, caregiver, or care receiver is at or below 100 percent of the federal poverty level.

Information is self-reported and collected annually.

### What is Reviewed

CDA will review demographic data to determine if AAAs are reaching individuals who are at or below the federal poverty line.

Use one of the examples below or create one. If the form does not list the federal poverty amounts, include an instructional sheet.

#### Example 1

- At or Below FPL (*Low Income*)
- Above FPL
- Declined to State

#### Example 2

- Total # Living in Household: \_\_\_\_  
Approx. Monthly Gross Income: \$ \_\_\_\_  
 Declined to State

#### Example 3

- # of Household Members (Circle One) **1**    **2**    **3**    **4**    **5**    **6**    **7**    **8+**  
What is Your Approximate Household Income? \$ \_\_\_\_ Per Month/ Per Year  
 Declined to State

#### Example 4

- Living Alone: Less than \$#,### Per Month
- Two Person Household: Less than \$#,### Per Month
- Other
- Declined to State

### Resources

The U.S. Department of Health and Human Services (HHS) updates information periodically. The Federal Register Poverty Guidelines are normally published in late January each year.

[2018 HHS Federal Poverty Guidelines](#)

[HSS Poverty Guidelines and Federal Register References](#)

# Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Functional Impairment Status

## Introduction

OAA programs use the Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) functional impairment scale to identify individuals with functional limitations. AAAs must also review functional limitations to determine eligibility for the provision of FCSP Caring for Elderly Respite Care and Supplemental Services.

The OAA preference is to give services to older individuals with greatest social need. The term “greatest social need” means the need caused by non-economic factors that include

- (A) physical and mental disabilities
- (B) language barriers
- (C) cultural, social, or geographical isolation, including isolation caused by racial or ethnic status that
  - (i) restricts an individuals’ ability to perform normal daily tasks
  - (ii) threatens such individuals’ capacity to live independently

ACL uses ADL and IADL characteristics for targeting frail older individuals and reporting purposes.

## Service Categories Required

The table below lists the programs that require ADL and IADL limitation status for registered clients.

### Title III B and C-2, Supportive and Nutrition Services

- Personal Care
- Homemaker
- Chore
- Home-Delivered Meals
- Adult Day Care/Health
- Case Management

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## **ADL and IADL Functional Impairment Status, Continued**

### **Service Categories Required, Continued**

The table below lists the programs that require ADL and IADL limitation status for registered care receivers in the FCSP Caring for Elderly.

#### **Title III E, FCSP Caregiver Caring for Elderly (Care Receiver)**

<b><i>SUPPORTIVE SERVICES</i></b>	<b><i>RESPIRE CARE</i></b>	<b><i>SUPPLEMENTAL SERVICES</i></b>
<ul style="list-style-type: none"><li>• Assessment</li><li>• Counseling</li><li>• Peer Counseling</li><li>• Support Group</li><li>• Training</li><li>• Case Management</li></ul>	<ul style="list-style-type: none"><li>• In-Home Supervision</li><li>• Homemaker Assistance</li><li>• In-Home Personal Care</li><li>• Home Chore</li><li>• Out-of-Home Day Care</li><li>• Out-of-Home Overnight Care</li></ul>	<ul style="list-style-type: none"><li>• Assistive Devices</li><li>• Home Adaptations</li><li>• Registry</li><li>• Emergency Cash/Material Aid</li></ul>

### **What to Include**

Create six (6) ADL and eight (8) IADL questions with the functional ability rating scale to determine the impairment level of the applicant or client.

Information is self-reported and collected annually. Conduct reassessment as needed, based on changes in the client's status within the year.

**NOTE:** Arrange questions to match database entry sequence.

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## ADL and IADL Functional Impairment Status, Continued

### How to Determine Score

ACL defines “impairment in Activities of Daily Living (ADL)” as the inability to perform one or more of the following six activities of daily living without personal assistance, stand-by assistance, supervision or cues: eating, dressing, bathing, toileting, transferring in and out of bed/chair, and walking.

ACL defines “impairment in Instrumental Activities of Daily Living (IADL)” as the inability to perform one or more of the following eight instrumental activities of daily living without personal assistance, or stand-by assistance, supervision or cues: preparing meals, shopping for personal items, medication management, managing money, using the telephone, doing heavy housework, doing light housework, and transportation ability (transportation ability refers to the individual's ability to make use of available transportation without assistance).

The ADL and IADL functional ability rating scale is applied to each question. The CARS system will count the number of ADLs and IADLs where verbal or human assistance is required. An applicant’s or client’s sum determines the overall level of functional impairment.

- If the Combined Total Number of ADLs & IADLs is **0**  
Then Client is **independent, has no functional limitations.**
- If the Combined Total Number of ADLs & IADLs is **1-2**  
Then Client is **frail, has minimal or mild functional impairments.**
- If the Combined Total Number of ADLs & IADLs is **3 or greater**  
Then Client is **severely disabled and vulnerable to loss of independence.**

To learn more about the data processing and output reports for ADLs and IADLs see the [CARS Overview and Guidance Appendix C](#)

### What is Reviewed

CDA will review demographic data to determine if the AAA is reaching individuals who are functionally impaired.

To qualify for Title III E, FCSP Caring for Elderly Respite Care and Supplemental Services care receivers must have two or more ADL limitations or a cognitive impairment.

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## ADL and IADL Functional Impairment Status, Continued

### Example 1:

Displays descriptive questions with ADL and IADL examples.

#### ADLs and IADLs - How would you rate your ability to perform the following daily activities?

*1=No Assistance Needs, 2=Requires Verbal Assistance, 3=Some Human Help,  
4=Lots of Human Help, 5=Cannot Do It At All*

##### **ACTIVITIES OF DAILY LIVING (RATE 1-5)**

- Can you manage eating without any help? \_\_\_\_\_
- Can you bathe or shower without any help? \_\_\_\_\_
- Can you use the toilet without any help? \_\_\_\_\_
- Can you get in and out of bed or chair without any help? \_\_\_\_\_
- Can you walk around inside without any help? \_\_\_\_\_
- Can you dress without any help? \_\_\_\_\_

##### **INSTRUMENTAL ACTIVITIES OF DAILY LIVING (RATE 1-5)**

- Can you prepare meals for yourself without help? \_\_\_\_\_
- Can you shop for food and other things you need without help? \_\_\_\_\_
- Can you take your medications without help? \_\_\_\_\_
- Can you handle your own money, like keeping track of bills without help? \_\_\_\_\_
- Can you answer the telephone or make a phone call without help? \_\_\_\_\_
- Can you do heavy housecleaning, like yard work and laundry, without any help? \_\_\_\_\_
- Can you do light housekeeping, like dusting or sweeping, without help? \_\_\_\_\_
- Can you use public transportation or drive beyond walking distances without help? \_\_\_\_\_

Notes: \_\_\_\_\_

Declined to State

### Example 2:

Displays a list of the ADLs and IADLs. Staff may provide description information.

#### ADLs and IADLs (Activities of Daily Living and Instrumental Activities of Daily Living)

*Please rate your functional abilities for the following activities.*

*RATING SCALE: 1 = Independent, 2 = Verbal Assistance, 3 = Some Human Help,  
4 = Lots of Human Help, 5 = Dependent, 6 = Declined to State*

##### **ADLs**

- Eating\_\_\_\_\_
- Dressing\_\_\_\_\_
- Bathing\_\_\_\_\_
- Transferring\_\_\_\_\_
- In/Out of Chair\_\_\_\_\_
- Walking\_\_\_\_\_
- Toileting\_\_\_\_\_

##### **IADLs**

- Meal Preparation\_\_\_\_\_
- Shopping\_\_\_\_\_
- Medication Management\_\_\_\_\_
- Money Management\_\_\_\_\_
- Using Telephone\_\_\_\_\_
- Transportation\_\_\_\_\_
- Light Housework\_\_\_\_\_
- Heavy Housework\_\_\_\_\_

Notes: \_\_\_\_\_

*Continued on next page*

## ADL and IADL Functional Impairment Status, Continued

### Example 3:

Displays all 5 functional ability rating scale options plus “Declined to State.” Staff may provide descriptive information.

#### Client ADL and IADL

#### (Activities of Daily Living and Instrumental Activities of Daily Living – Annual Assessment)

*Please check level of functional ability.*

ADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
Eating						
Bathing						
Toileting						
Transferring In/ Out of Bed/ Chair						
Walking						
Dressing						

Notes: \_\_\_\_\_

IADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
Meal Preparation						
Shopping						
Medication Management						
Money Management						
Using Telephone						
Heavy Housework						
Light Housework						
Transportation						

Notes: \_\_\_\_\_

*Continued on next page*



## ADL and IADL Functional Impairment Status, Continued

### Example 4:

Displays the minimum functional ability 3-option rating scale plus “Decline to State.”

<p><b>Activities of Daily Living (ADL):</b>  <i>Circle One For Each</i>  <i>1=No Assistance, 3=Some Human Help,</i>  <i>5=Cannot Perform (Dependent),</i></p> <p>Eating.....1 3 5          Bathing.....1 3 5          Toileting.....1 3 5          Transferring In/          Out of Bed/ Chair.....1 3 5          Walking.....1 3 5          Dressing.....1 3 5</p> <p><input type="checkbox"/> Declined to State</p>	<p><b>Instrumental of Daily Living (IADL):</b>  <i>Circle One For Each</i>  <i>1=No Assistance, 3=Some Human Help,</i>  <i>5=Cannot Perform (Dependent)</i></p> <p>Meal Preparation.....1 3 5          Shopping.....1 3 5          Medication Management.....1 3 5          Money Management.....1 3 5          Using Telephone.....1 3 5          Heavy Housework.....1 3 5          Light Housework.....1 3 5          Transportation.....1 3 5</p> <p><input type="checkbox"/> Declined to State</p>
---	---

### Example 5:

Displays ADL and IADLs with descriptive functional ability rating scales.

**ADLs and IADLs (Activities of Daily Living and Instrumental Activities of Daily Living)**  
*Please rate your functional ability for the following activities.*

#### **Client/Elderly Care Receiver Activities of Daily Living (ADL) Fields**

**Eating**(Rated Level \_\_\_\_\_)

*Reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth, chewing, swallowing food and liquids, manipulating food on plate. Cleaning face and hands as necessary following a meal.*

- (1)** Independent (able to feed self)
- (2)** Verbal assistance (able to feed self but needs verbal assistance such as reminding or encouragement to eat)
- (3)** Some human help (assistance needed during meal, e.g., to apply assistive device, get beverage or push more food to within reach, etc., but constant presence of another person not required)
- (4)** Lots of human help (able to feed self but cannot hold utensils, cups, glasses, etc., constant presence of another person is required)
- (5)** Dependent (unable to feed self at all)

*Continued on next page*

## **ADL and IADL Functional Impairment Status, Continued**

### **Example 5, Continued**

#### **Bathing**(Rated Level \_\_\_\_\_)

*Bathing means cleaning the body using a tub, shower, or sponge bath including getting a basin of water, managing faucets, getting in and out of a tub, reaching head and body parts for soaping, rinsing, and drying.*

- (1)** Independent (able to bathe self safely)
- (2)** Verbal assistance (able to bathe self with direction or intermittent monitoring; may need reminding to maintain personal hygiene)
- (3)** Some human help (generally able to bathe self, but needs assistance)
- (4)** Lots of human help (requires direct assistance with most aspects of bathing; would be at risk if left alone)
- (5)** Dependent (totally dependent on others for bathing)

#### **Toileting** (Rated Level \_\_\_\_\_)

*Able to move to and from, on and off toilet or commode, empty commode, manage clothing and wipe and clean body after toileting, use and empty bedpans, ostomy and/or catheter receptacles and urinals, apply diapers and disposable barrier pads. Menstrual care: able to apply external sanitary napkin and clean body.*

- (1)** Independent (no assistance needed)
- (2)** Verbal assistance (requires reminding and direction only)
- (3)** Some human help (requires minimal assistance with some activities, but the constant presence of the provider is not necessary)
- (4)** Lots of human help (unable to carry out most activities without assistance)
- (5)** Dependent (requires physical assistance in all areas of care)

#### **Transferring In/Out of Bed/Chair** (Rated Level \_\_\_\_\_)

*Moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or repositioning to prevent skin breakdown.*

- (1)** Independent (able to do all transfers safely)
- (2)** Verbal assistance (able to transfer but needs encouragement or direction)
- (3)** Some human help (requires some help from another person; e.g., routinely requires a boost or assistance with positioning)
- (4)** Lots of human help (unable to complete most transfers without physical assistance; would be at risk if unassisted)
- (5)** Dependent (totally dependent upon another person for all transfers)

*Continued on next page*

## ADL and IADL Functional Impairment Status, Continued

### Example 5, Continued

#### **Walking**(Rated Level \_\_\_\_\_)

*Walking or moving inside, moving from one area of indoor space to another without necessity of handrails. Can respond adequately to the presence of obstacles that must be stepped around. Includes ability to go from inside to outside and back.*

- (1)** Independent (no assistance needed)
- (2)** Verbal assistance (able to walk or move with encouragement, or reminders to watch for steps, or to use a cane or walker)
- (3)** Some human help (requires minimal assistance from another person to negotiate a wheelchair or to steady the person or guide them in the desired direction)
- (4)** Lots of human help (requires constant attention from another person, at risk of being lost or unsafe if not accompanied)
- (5)** Dependent (totally dependent upon another person, must be carried, lifted, or pushed in a wheelchair or on a gurney at all times)

#### **Dressing** (Rated Level \_\_\_\_\_)

*Putting on and taking off, fastening and unfastening garments and undergarments, special devices such as back braces, corsets, elastic stockings/garments and artificial limbs or splints.*

- (1)** Independent (able to put on, fasten and remove all clothing and devices without assistance; clothes self appropriately for health and safety)
- (2)** Verbal assistance (able to dress self, but requires reminding or directions with clothing selection)
- (3)** Some human help (unable to dress self completely, without the help of another person, e.g., tying shoes, buttoning, zipping, putting on hose or brace, etc.)
- (4)** Lots of human help (unable to put on most clothing items by self; without assistance would be inappropriately or inadequately clothed)
- (5)** Dependent (unable to dress self at all)

*Continued on next page*

## ADL and IADL Functional Impairment Status, Continued

### Example 5, Continued

#### ***Client/Elderly Care Receiver Instrumental Activities of Daily Living (IADL) Fields***

##### **Meal Preparation** (Rated Level \_\_\_\_\_)

*Planning menus. Washing, peeling, slicing vegetables, opening packages, cans, and bags, mixing ingredients, lifting pots and pans, re-heating food, cooking, safely operating stove, setting the table, serving the meal, cutting food into bite-sized pieces. Washing, drying, and putting away the dishes.*

- (1) Independent (no assistance needed)
- (2) Verbal assistance (needs only reminding or guidance in menu planning, meal preparation, and/or cleanup)
- (3) Some human help (requires another person to prepare and clean up main meals on less than a daily basis; e.g., can reheat food prepared by someone else, can prepare simple meals and/or needs help with cleanup on a less than daily basis)
- (4) Lots of human help (requires another person to prepare and clean up main meal(s) on a daily basis)
- (5) Dependent (totally dependent upon another person to prepare and clean up all meals)

##### **Shopping** (Rated Level \_\_\_\_\_)

*Compile list, bending, reaching, and lifting, managing cart, or basket, identifying items needed, transferring items to home, putting items away, ordering prescriptions over the phone and picking them up, and buying clothing.*

- (1) Independent (can perform all tasks without assistance)
- (2) Verbal assistance (able to perform tasks, but needs only reminding or direction, guidance or reminder)
- (3) Some human help (requires the help of another person for some tasks while shopping such as reaching and carrying items)
- (4) Lots of human help (unable to carry out most activities without assistance)
- (5) Dependent (unable to perform any tasks for self)

##### **Medication Management** (Rated Level \_\_\_\_\_)

*Physically and mentally able to identify, organize, schedule, handle, and consume (inject, instill or insert) the correct amount of the prescribed medication at the specified time according to a doctor's prescription.*

- (1) Independent (can identify, measure, organize, and self-administer prescribed medication)
- (2) Verbal assistance (able to perform tasks but needs verbal direction, guidance or reminder to do it, without risk to safety)
- (3) Some human help (requires some human help such as scheduling medications, opening the container, measuring the amount of medication)
- (4) Lots of human help (cannot perform some parts of this function; may require some human help with installing or injecting multiple medications)
- (5) Dependent (cannot perform any part of this function)

*Continued on next page*

## **ADL and IADL Functional Impairment Status, Continued**

### **Example 5, Continued**

#### **Money Management** (Rated Level \_\_\_\_\_)

*Physically and mentally handles the receipt of monies, expenditures, and receipt and payment of bills in a timely and primarily correct manner.*

- (1)** Independent (handles all financial matters)
- (2)** Verbal assistance (is able to perform all financial transactions but may need to be reminded to pay bills or obtain cash from bank)
- (3)** Some human help (for either physical or mental reasons may need assistance in doing banking, writing checks, etc.)
- (4)** Lots of human help (unable to carry out most activities without assistance)
- (5)** Dependent (unable to attend to any part of the necessary financial transactions to receive and disburse funds to meet daily needs)

#### **Using Telephone** (Rated Level \_\_\_\_\_)

Obtains number, dials, handles receiver, can speak and hear response, and terminates call, may include use of instrument with loudspeaker or hearing devices. Able to use telephone during emergency situations to call 911 or other help.

- (1)** Independent (can obtain and dial number without assistance)
- (2)** Verbal assistance (needs only reminder on how to use the phone)
- (3)** Some human help (needs human assistance to obtain number or dial)
- (4)** Lots of human help (currently not defined)
- (5)** Dependent (unable to use phone at all)

#### **Heavy Housework** (Rated Level \_\_\_\_\_)

*Cleaning oven and stove, cleaning and defrosting refrigerator, moving light furniture to clean under and behind, vacuuming upholstery and under cushions, providing deep cleaning activities such as washing and cleaning baseboards, window tracks, cabinets, doors, drapes/blinds, etc.*

- (1)** Independent (able to perform all domestic chores)
- (2)** Verbal Assistance (able to perform domestic chores but needs direction)
- (3)** Some human help (requires physical assistance from another person for some domestic chores)
- (4)** Lots of human help (unable to carry out most domestic chores without assistance)
- (5)** Dependent (totally dependent upon others for all domestic chores)

*Continued on next page*

## ADL and IADL Functional Impairment Status, Continued

### Example 5, Continued

#### Light Housework (Rated Level \_\_\_\_\_)

*Sweeping, vacuuming, mopping floors, washing kitchen counters and sinks, cleaning bathroom, taking out garbage, dusting and picking up.*

- (1) Independent (able to perform all light domestic chores)
- (2) Verbal assistance (able to perform domestic chores but needs direction)
- (3) Some human help (requires physical assistance from another person for some domestic chores)
- (4) Lots of human help (unable to carry out most domestic chores without assistance)
- (5) Dependent (totally dependent upon others for all domestic chores)

#### Transportation (Rated Level \_\_\_\_\_)

*Using private or public vehicles, cars, buses, trains, or other forms of transportation to get to medical appointments, purchase food, shop, pay bills, or arrange for services, to socialize and participate in entertainment or religious activities. Can arrange for getting and using public transportation; or get to, enter and operate a private vehicle.*

- (1) Independent (can arrange, get to, enter and travel in public or private vehicles)
- (2) Verbal assistance (can use public transportation or ride in a private vehicle when reminded to make arrangements)
- (3) Some human help (requires physical assistance to make transportation arrangements; i.e., calling, writing instructions about time and place, can ride with others if assisted into and out of the vehicle)
- (4) Lots of human help (unable to carry out most activities without assistance)
- (5) Dependent (unable to travel at all by self)

Check if Declined to State ADL and IADL Functional Abilities

### Resources

The [OAA](#) defines “frail” as an older individual that is functionally impaired because the individual “is unable to perform at least two ADLs without substantial human assistance, including verbal reminding, physical cueing, or supervision; or due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another person.” (Section 102(a) (22)).

# Nutritional Risk Assessment

## Introduction

Title III C Congregate and Home-Delivered Meal programs are required to perform a nutrition risk screening to identify individuals at high nutrition risk or at risk for malnutrition. NAPIS reporting requirements define a person at high nutrition risk as one who scores six or higher on the Determine Your Nutritional Risk Checklist (hereafter referred to as the “DETERMINE Checklist”) published by the Nutrition Screening Initiative (NSI).

## Service Categories Required

The following programs require collecting the nutritional risk scores for registered clients.

- Home-Delivered Meals
- Congregate Meals
- Nutritional Counseling

## What to Include

Title III C nutrition programs shall only use the DETERMINE Checklist to evaluate the client’s nutrition risk score.

The nutrition risk questionnaire must be filled out at initial intake or registration along with other client information then reported through the data collection system. After initial intake/registration, annually update and report nutrition risk information and other basic client data.

## How to Determine Score

Each question has a weighted point value. The sum total determines the reported nutritional risk score.

- If score is **0-2** Then client is **not at risk**
- If score is **3-5** Then client is **at moderate nutritional risk**
- If score is **6 or greater** Then client is **at high nutritional risk**

*Continued on next page*

## Nutritional Risk Assessment, Continued

### What is Reviewed

CDA will review data to determine if the AAA is serving individuals at high nutritional risk. CDA bases its target ranges on statewide analysis of the average number of participants at high nutritional risk. Target percentages may be adjusted on an annual basis.

Program	Target Percentage of all reported participants
For the Congregate Meals (C-1)	21% or higher at nutritional risk
Home-Delivered Meals (C-2)	65% or higher at nutritional risk

### DETERMINE Checklist

The following is the DETERMINE Checklist with weighted/scored values. The interviewer may need to provide additional clarification.

Determine Your Nutritional Health	Circle if yes
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 or vegetables or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't 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
<b>Total Score:</b> (If equal to or greater than 6, the client is at high nutritional risk)	
<b>Declined to State</b>	

*Continued on next page*



## Optional Client Level Detail

### Introduction

There may be other questions added to provide more helpful client information. Some common ones are listed below. These are **not** required CARS elements and must **not** be reported in CARS.

### Assessment Type

Assessment types (may be helpful) are as follows:

- New Client
- Annual Reassessment
- Significant Change in Condition

### Office Notes

Identification of intake/ assessment date and the staff reviewing the information is useful.

### Contact Information

To assign a unique identification number to each participant, data management systems may use any combination of name, address, phone number, or the last four digits of the participant's Social Security Number for record identification. This avoids duplicating information by recording client level detail for each participant and will enable tracking the client's services by provider and program.

- First Name:
- Middle Name:
- Last Name:
- Other name(s):
- Home Address:
- City:
- Mailing if Different:
- Telephone Number:
- Cell Number:
- Email Address:

### Social Security Number

The last four digits of the Social Security Number (SSN) may be useful in developing a unique participant identification number. If used, AAAs must ensure that this number is protected from inappropriate or unauthorized access or disclosure. AAAs cannot deny OAA services to eligible clients if they do not wish to disclose their information.

Last 4 Digits Social Security #:(*Optional*) \_ \_ \_ \_

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## Optional Client Level Detail, Continued

### Living Arrangement

This section can help to identify the following client living arrangements:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Lives Alone,     | <input type="checkbox"/> Lives W/ Relative, | <input type="checkbox"/> Senior Apartment, |
| <input type="checkbox"/> Lives W/ Spouse, | <input type="checkbox"/> Lives W/ Other(s), | Specify: _____                             |
| <input type="checkbox"/> Lives W/ Child,  |   |  |

### Source of Support

This section can help to identify the following various types of caregiving support:

- |                                 |  |                                    |                               |
|---------------------------------|--|------------------------------------|-------------------------------|
| <input type="checkbox"/> Family | <input type="checkbox"/> Friend/<br>Neighbor | <input type="checkbox"/> Paid Help | <input type="checkbox"/> None |
|                                 |  | <input type="checkbox"/> Unsure    |                               |

### LGBT

The Lesbian, Gay, Bisexual, and Transgender (LGBT) Disparities Reduction Act of 2016 (Chiu, Chapter 565, Statutes of 2015) requires CDA to begin collecting voluntarily self-identified information about Sexual Orientation and Gender Identity (SOGI) no later than July 1, 2018. This will require the 33 AAAs to update their perspective data management systems to collect the required SOGI data and submit it to CDA as part of their regular data submission process.

Each AAA shall ensure all older adults have equal access to programs and services, regardless of gender identity and sexual orientation. California law requires each AAA to include the needs of LGBT seniors in their needs assessment and area plans.

To determine if the LGBT population is being reached, adapt local data system to collect this information. The following questions will be included in CARS by July 1, 2018 to report the client's sexual orientation, sexual identity, and/or gender expression.

#### **GENDER**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Male                          | <input type="checkbox"/> Transgender Male to<br>Female     | <input type="checkbox"/> Not listed. Please<br>specify: _____ |
| <input type="checkbox"/> Female                        | <input type="checkbox"/> Genderqueer/ Gender<br>non-binary | <input type="checkbox"/> Declined to State                    |
| <input type="checkbox"/> Transgender Female to<br>Male |  |   |

#### **SEX AT BIRTH**

- |                               |                                 |  |
|-------------------------------|---------------------------------|--|
| <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> Declined to State |
|-------------------------------|---------------------------------|--|

#### **SEXUAL ORIENTATION OR SEXUAL IDENTITY**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Straight/ Heterosexual | <input type="checkbox"/> Gay/ Lesbian/ Same-<br>Gender Loving | <input type="checkbox"/> Not listed. Please<br>specify: _____ |
| <input type="checkbox"/> Bisexual               | <input type="checkbox"/> Questioning/Unsure                   | <input type="checkbox"/> Declined to State                    |

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## Optional Client Level Detail, Continued

### Transportation Services

The following options can help to identify type(s) of transportation assistance needed:

- Walks with No Assistance (Non-Assisted)
- Walks with Assistance (Assisted)
- Wheelchair ramp/lift

### Other Characteristics

The following options can help to identify if other conditions or assistance are needed.

#### **CHECK AIDS CURRENTLY USED:**

- |  |                                    |                                     |
|--|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Cane              | <input type="checkbox"/> Oxygen    | <input type="checkbox"/> Walker     |
| <input type="checkbox"/> Glasses/ Contacts | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Hearing Aid       | <input type="checkbox"/> TTY Phone | <input type="checkbox"/> Other:     |

#### **ABILITY TO SPEAK ENGLISH:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Speaks English | <input type="checkbox"/> Non-English<br>Language: _____ | <input type="checkbox"/> Need Interpreter |
|---|---|---|

#### **DO YOU RECEIVE HELP FROM OTHER ORGANIZATION(S)?**

- |                              |                                       |
|------------------------------|---------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> If so, which |
| <input type="checkbox"/> No  | one(s): _____                         |

### Emergency Identification

This section can allow the client to designate a contact person to call during or after an emergency event:

Emergency Contact Person Name:  
Address:  
Relationship to Client:  
Telephone number (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

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## **Optional Client Level Detail, Continued**

### **Disaster Registry**

In case of an emergency declaration, the following identification can help build a Disaster Registry to identify those high-risk clients that may need evacuation assistance.

A client is considered High Risk under Emergency Declaration if any of the following exists.

*Check all that apply.*

- Housebound seniors and people with physical disabilities that DO NOT have an existing network of support
- Significant mobility, vision, or hearing impairment
- Elderly or medically fragile
- Disabling mental illness or developmental disability
- Requires refrigeration of medication and/or is insulin dependent
- Reliance on life-support, oxygen, or dialysis
- Not Applicable

### **Eligibility for Title III B**

To determine eligibility for Supportive Services (Title III B) the following question can be asked:

Are you age 60 or over?

- Yes
- No

*Continued on next page*

## **Optional Client Level Detail**, Continued

### **Eligibility for Title III C-1 & C-2**

To determine eligibility for Congregate Meals (Title III C-1) and Home-Delivered Meals (Title III C-2) the following questions can be asked.

#### **QUESTIONS FOR THE CONGREGATE MEALS (C-1) ELIGIBILITY:**

- Are you over 60?
- Are you the spouse or domestic partner of an **Elderly Nutrition Program (ENP)** participant who is over the age of 60?
- Are you a person with a disability, who resides in housing where the congregate site is located?
- Are you a person with a disability who resides with and accompanies an ENP participant?
- Are you a volunteer under the age of 60? (May have a meal if it does not deprive a senior of a meal.)

#### **QUESTIONS FOR HOME-DELIVERED MEALS (C-2) ELIGIBILITY:**

- Are you homebound due to an illness, disability, or isolation?
- Are you a spouse of a person who is homebound?
- Are you an individual with a disability who resides with a homebound meal recipient?

#### **QUESTIONS TO DETERMINE EQUIPMENT CONDITIONS AND CLIENT ABILITIES:**

- Does the client have any dietary restrictions?
- Does the client have a working refrigerator?
- Does the client have a working microwave?
- Is client physically and mentally able to open the food containers?
- Is client physically and mentally able to reheat a meal?
- Are there pets inside or outside the home?

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## Optional Client Level Detail, Continued

### Eligibility for Title III E

To determine eligibility for Title III E, FCSP Caregivers Caring for Elderly or Grandparents Caring for a Child, the following questions may be asked.

#### **CAREGIVER CARING FOR ELDERLY ELIGIBILITY CRITERIA**

1. Is the **Care Receiver** an older individual (60 years of age or older) **or** an individual (of any age) with Alzheimer’s disease or related disorder with neurological and organic brain dysfunction?  
 Yes  No
2. Is the **Caregiver** an adult (18 years of age or older) family member or another individual (e.g., friend or neighbor) who is an informal (i.e., unpaid) provider of in-home or community care to an “elderly” Care Receiver?  
 Yes  No

*If answered “yes” to both questions above, the individual is qualified for “Family Caregiver Caring for Elderly.” If requesting “Respite Care” or “Supplemental Services,” the Care Receiver must also have two or more ADL deficiencies or a cognitive impairment.*

#### **GRANDPARENT/OLDER INDIVIDUALS CARING FOR CHILD ELIGIBILITY CRITERIA**

1. Is the **Care Receiver** an individual who is **not** more than 18 years of age **or** who is an individual (of any age) with a disability?  
 Yes  No
2. In the case of a **caregiver for a child**, is the Caregiver a grandparent, step-grandparent, or other older relative by blood, marriage, or adoption who is 55 years of age or older, living with the child, and identified as the primary caregiver through a legal or informal arrangement? Biological and adoptive parents are excluded.  
 Yes  No
3. In the case of a **caregiver for an individual with a disability**, is the Caregiver a parent, grandparent, or other relative by blood, marriage, or adoption who is 55 years of age or older, and living with the individual with a disability?  
 Yes  No

*If answered “yes” to either questions 1 and 2 **or** 1 and 3 above, the individual is qualified for “Grandparent/Older Caregiver Caring for Child.”*

*If the Care Receiver does not meet any of the criteria above, the Caregiver is ineligible to receive FCSP services, but may qualify to receive other services provided by the AAA.*

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## **Optional Client Level Detail, Continued**

### **Resources to Determine Eligibility**

The following links are to reference documents for the Title III E, Family Caregiver Support Program.

[\*\*CDA Statistical Fact Sheets and Program Narratives\*\*](#)

*Provide information on the program purpose, eligibility requirements, and history.*

[\*\*CDA Service Categories Data Dictionary\*\*](#)

*Provides category definitions.*

## Required Title III B, C, D and VII B (Cluster III), Non-Registered Client Fields

### Introduction

Some OAA programs do **not** require collecting any client-level demographic information. These programs target groups or provide sensitive services that may make client-level data collection difficult.

### What to Include

Report estimated total clients/audience by each service category for each quarter.

AAAs will be required to report at least:

- Legal Assistance
- Nutritional Education
- Information and Assistance
- Disease Prevention and Health Promotion
- Elder Abuse Prevention, and
- Other NAPIS Services

There are no required client fields in non-registered services. It is **optional** for AAAs to collect this information based on the guidelines described in the required client fields for Registered Services.

### What is Reviewed

CDA reviews the estimated enrollments and service units on a quarterly and annual basis.

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## Required Title III B, C, D and VII B (Cluster III), Non-Registered Client Fields, Continued

### Chart Guidelines

Apply the following chart to determine if form(s) or records have the required data collection and reporting elements for Title III B, C, D, and VII B Non-Registered services.

### CARS - Required Title III B, C, D, and VII Non-Registered Fields

Service Category	Service Units	Estimated Clients/ Audience	Funding Source
Transportation	X One-way Trip	X	III B
<b>Legal Assistance<sup>1</sup></b>	X Hour	X	III B
<b>Nutritional Education<sup>1</sup></b>	X Session per Participant	X	III C
<b>Information and Assistance<sup>1</sup></b>	X Contact	X	III B
Outreach	X Contact	X	III B
<b>Health Promotion<sup>1</sup></b>	X Contact	X	III D
Alzheimer's Day Care Services ("Other" NAPIS Services)	X Day of Attendance	X	III B
Cash/Material Aid ("Other" NAPIS Services)	X Assistance	X	III B
Community Education ("Other" NAPIS Services)	X Activity	X	III B
Comprehensive Assessment	X Hour	X	III B
Disaster Preparedness Materials ("Other" NAPIS Services)	X Product	X	III B
<b>Elder Abuse Prevention, Education and Training<sup>1</sup></b> ("Other" NAPIS Services)	X Session	X	VII
<b>Elder Abuse Prevention Educational Materials<sup>1</sup></b> ("Other" NAPIS Services)	X Product	X	VII
Employment ("Other" NAPIS Services)	X Activity	X	III B

**(X) Required Element**

<sup>1</sup>Required service categories. Elder Abuse Prevention requires at least one reported service category.

Refer to [CARS File Specifications](#) for file reporting structure and optional data elements. Documents are at [California Aging Reporting System \(CARS\)](#)

Refer to [Services Categories and Data Dictionary](#) for category definitions.

*Continued on next page*

## Required Title III B, C, D and VII B (Cluster III), Non-Registered Client Fields, Continued

### CARS Required Title III B, C, D, and VII Non-Registered Fields, Continued

Service Category	Service Units	Estimated Clients/ Audience	Funding Source
Health (“Other” NAPIS Services)	X Hour	X	III B
Housing (“Other” NAPIS Services)	X Hour	X	III B
Interpretation/ Translation (“Other” NAPIS Services)	X Contact	X	III B
Mobility Management Activities (“Other” NAPIS Services)	X Hour	X	III B
Mental Health (“Other” NAPIS Services)	X Hour	X	III B
Peer Counseling (“Other” NAPIS Services)	X Hour	X	III B
Personal Affairs Assistance (“Other” NAPIS Services)	X Contact	X	III B
Personal/Home Security (“Other” NAPIS Services)	X Product	X	III B
Public Information (“Other” NAPIS Services)	X Activity	X	III B
Registry (“Other” NAPIS Services)	X Hour	X	III B
Residential Repairs/Modifications (“Other” NAPIS Services)	X Modification	X	III B
Respite Care (“Other” NAPIS Services)	X Hour	X	III B
Senior Center Activities (“Other” NAPIS Services)	X Hour	X	III B
Telephone Reassurance (“Other” NAPIS Services)	X Contact	X	III B
Visiting (“Other” NAPIS Services)	X Hour	X	III B

**(X) Required Element**

<sup>1</sup>Required service categories. Elder Abuse Prevention requires at least one reported service category.

Refer to [CARS File Specifications](#) for file reporting structure and optional data elements. Documents are at [California Aging Reporting System \(CARS\)](#)

Refer to [Services Categories and Data Dictionary](#) for category definitions.

## Required Title III E, Non-Registered Client Fields

### Chart Guidelines

Apply the following chart to determine if form(s) or records have the required data collection and reporting elements for Title III E Non-Registered services.

### CARS Title III E, FCSP Caring for Elderly or Caring for Child Required Non-Registered Fields

Service Category	Service Units	Estimated Clients/Audience
Outreach (Access Assistance)	X Contact	X
Information and Assistance (Access Assistance)	X Contact	X
Interpretation/Translation (Access Assistance)	X Contact	X
Legal Resources (Access Assistance)	X Contact	X
Public Information (Information Services)	X Activity	X
Community Education (Information Services)	X Activity	X

(X) Required Element

Refer to [CARS File Specifications](#) for file reporting structure and optional data elements. Documents are at [California Aging Reporting System \(CARS\)](#)

Refer to [Services Categories and Data Dictionary](#) for category definitions.

## Data Performance References

The following lists applicable laws/regulations/policies.

- [Area Plan Contract](#)
- [CARS - CDA California Aging Reporting System Specification](#)
- [CCR - California Code of Regulations,](#)  
*Title 22 Division 1.8*
- [CFR - Code of Federal Regulations,](#)  
*Title 45 Part 1321*
- [OAA - Older Americans Act](#)
- [OCA - California Welfare and Institutions \(W&I\) Code,](#)  
*Division 8.5 Mello-Granlund Older Californians Act*
- [NAPIS SPR – ACL National Aging Program Information System State Program Reports](#)
- [PM - CDA Program Memoranda](#)

# Sample Forms Overview

## Introduction

Because each AAA has tailored programs to meet their community needs, CDA does **not** have required intake or assessment forms. CDA has designed these sample templates to help the AAAs evaluate and create their own forms for collecting and recording required performance data elements.

## What is Reviewed

CDA reviews the forms to ensure all required data collection elements are integrated. See [Guidelines Chart](#)

AAAs may use these forms, revise them, or create forms to meet local needs. AAAs do not have to use these sample templates.

## Forms Contents

This section contains the following templates:

### Sample 1 See Page [47](#)

- Title III B, C-1, C-2, and D (Cluster 1& 2, Registered)
- Personal Care, Homemaker, Chore, Home-Delivered Meals, Adult Day Care/Health, Case Management, Congregate Meals, Nutritional Counseling, Assisted Transportation, Other Non-Registered Services

### Sample 2 See Page [49](#)

- Title III B, C-2 (Cluster 1)
- Personal Care, Homemaker, Chore, Home-Delivered Meals, Adult Day Care/Health, Case Management

### Sample 3 See Page [51](#)

- Title III B, C1, and D (Cluster 2)
- Congregate Meals, Nutritional Counseling, Assisted Transportation

### Sample 4 See Page [53](#)

- Title III C-2
- Home-Delivered Meals

### Sample 5 See Page [55](#)

- Title III C-1
- Congregate Meals

*Continued on next page*

## Sample Forms Overview, Continued

### Forms Contents, Continued

#### Sample 6 See Page [57](#)

- Title III E (Group 1, Registered)
- Caring for Elderly, Caring for Child

#### Sample 7 See Page [61](#)

- Title III E (Group 1)
- Caring for Elderly

#### Sample 8 See Page [65](#)

- Title III E (Group 1)
- Caring for Child

#### Sample 9 See Page [68](#)

- Title III B (Cluster III, Non-Registered)
- Information and Assistance

**SAMPLE 1, Title III**

Provider Name:	*Unique Participant ID: _____
Region/Site Name:	Registration/Assessment Date: _____
*Termination Date: _____ *Reason: _____	
<b>Service Categories(Titles IIIB, IIIC and IIID):</b> <input type="checkbox"/> *Personal Care (IIIB) (A,I) <input type="checkbox"/> *Homemaker (IIIB) (A,I) <input type="checkbox"/> *Chore (IIIB) (A,I) <input type="checkbox"/> *Home-Delivered Meals (A,I,N) <input type="checkbox"/> *Adult Day Care/Health (IIIB) (A,I) <input type="checkbox"/> *Case Management (IIIB) (A,I) <input type="checkbox"/> *Assisted Transportation (IIIB) <input type="checkbox"/> *Congregate Meals (N) <input type="checkbox"/> *Nutrition Counseling (N) <input type="checkbox"/> Transportation (IIIB) <input type="checkbox"/> Nutrition Education <input type="checkbox"/> Other: _____	
<b>Notes:</b> Reference the Data Dictionary for allowable "Other" service categories; Requires: A-ADLs, I-IADLs, N-Nutritional Assessments on Page 2	

**SECTION 1 (Client)**

(\* Required for All Registered Programs)

Personal Data (Please Print):					
First Name:					
Middle Initial:					
Last Name:					
* What is your gender? (Check only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
* What was your sex at birth? (Check only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated				
* How do you describe your sexual orientation or sexual identity (Check only one)	<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
*Birth Date:					
Last 4 Digits Social Security # <i>Optional</i>	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> </tr> </table>				
Home Phone #:	(    )				
Residential Address:					
Street:					
City:					
* Zip Code:					

Mailing Address:	
Same as Residential? <input type="checkbox"/> Yes – Skip to Next Section	
Street:	
City:	
* Zip Code:	
Emergency Contact:	Name: Relationship: Phone #: (    )
*Ethnicity:	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State
*Federal Poverty Level (FPL)	<input type="checkbox"/> At or below FPL <input type="checkbox"/> Above FPL <input type="checkbox"/> Declined to State
*Lives Alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
*Rural?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
*Race: (Please Check ONE)	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race	
Asian:	
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Cambodian
<input type="checkbox"/> Filipino	<input type="checkbox"/> Japanese
<input type="checkbox"/> Laotian	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean
<input type="checkbox"/> Other Asian	<input type="checkbox"/> Other Asian
Hawaiian/Other Pacific Islander:	
<input type="checkbox"/> Guamanian	<input type="checkbox"/> Hawaiian
<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Samoan
<input type="checkbox"/> Declined to State	
Title IIIB Eligibility:	
Are you age 60 or over? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 2 –ADL and IADL (Activities of Daily Living and Instrumental Activities of Daily Living – Annual Assessment)

*\*Required for (III-C): Home-Delivered Meals; (III-B): Personal Care, Homemaker, Chore, Adult Day Care, Case Management*

ADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
*Eating						
*Bathing						
*Toileting						
*Transferring In/Out of Bed/Chair						
*Walking						
*Dressing						
Notes:						
IADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
*Meal Preparation						
*Shopping						
*Medication Management						
*Money Management						
*Using Telephone						
*Heavy Housework						
*Light Housework						
*Transportation						
Notes:						

SECTION 3 – Nutritional Assessment (Annual)

*\* Required for (IIIC): Home-Delivered Meals, Congregate Meals; Nutritional Counseling*

<b>*Nutritional Assessment:</b>	<b>Circle if yes</b>
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 or vegetables or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't 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 past 6 months?	2
I am not always physically able to shop, cook, and/or feed myself.	2
<b>Total Score:</b> (If equal to or greater than 6, the client is at high nutritional risk)	
<input type="checkbox"/> <b>Declined to State</b>	

[Page 2 of 2]

CDA Sample 1, Title III B, C-1, C-2, and D, Registration-Assessment Form (2018)



**SAMPLE 2, CLUSTER 1**

Provider Name:	*Unique Participant ID: _____
Region/Site Name:	Registration/Assessment Date: _____
*Termination Date: _____ *Reason: _____	
<b>Service Categories(Titles IIIB, IIIC and IIID):</b> <input type="checkbox"/> Personal Care (A,I) <input type="checkbox"/> Homemaker (A,I) <input type="checkbox"/> Chore (A,I) <input type="checkbox"/> Home-Delivered Meals (A,I,N) <input type="checkbox"/> Adult Day Care/Health (A,I) <input type="checkbox"/> Case Management (A,I)	
<b>Notes:</b> Reference the Data Dictionary for allowable "Other" service categories; Requires: A-ADLs, I-IADLs, N-Nutritional Assessments on Page 2	

**SECTION 1 (Client)**

(\* Required for All Registered Programs)

<b>Personal Data (Please Print):</b>					
First Name:					
Middle Initial:					
Last Name:					
* What is your gender? (Check only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
* What was your sex at birth? (Check only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated				
* How do you describe your sexual orientation or sexual identity (Check only one)	<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
*Birth Date:					
Last 4 Digits Social Security # <i>Optional</i>	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> </tr> </table>				
Home Phone #:	(    )				
<b>Residential Address:</b>					
Street:					
City:					
*Zip Code:					

<b>Mailing Address:</b>	
Same As Residential? <input type="checkbox"/> Yes – Skip to Next Section	
Street:	
City:	
* Zip Code:	
Emergency Contact:	Name: Relationship: Phone #: (    )
*Ethnicity:	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State
*Federal Poverty Level (FPL)	<input type="checkbox"/> At or below FPL <input type="checkbox"/> Above FPL <input type="checkbox"/> Declined to State
*Lives Alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
*Rural?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
<b>*Race: (Please Check ONE)</b>	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race	
Asian:	
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Cambodian
<input type="checkbox"/> Filipino	<input type="checkbox"/> Chinese
<input type="checkbox"/> Laotian	<input type="checkbox"/> Japanese
<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Korean
<input type="checkbox"/> Other Asian	<input type="checkbox"/> Other Asian
Hawaiian/Other Pacific Islander:	
<input type="checkbox"/> Guamanian	<input type="checkbox"/> Hawaiian
<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Samoan
<input type="checkbox"/> Declined to State	
<b>Title III B Eligibility:</b>	
Are you age 60 or over? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 2 – Client ADL and IADL

(Activities of Daily Living and Instrumental Activities of Daily Living Annual Assessment)

\* **Required for (III-C):** Home-Delivered Meals; **(III-B):** Personal Care, Homemaker, Chore, Adult Day Care, Case Management

ADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
*Eating						
*Bathing						
*Toileting						
*Transferring In/Out of Bed/Chair						
*Walking						
*Dressing						
Notes:						
IADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
*Meal Preparation						
*Shopping						
*Medication Management						
*Money Management						
*Using Telephone						
*Heavy Housework						
*Light Housework						
*Transportation						
Notes:						

SECTION 3 – Nutritional Assessment (Annual)

Required for (IIIC): Home-Delivered Meals

*Nutritional Assessment:	Circle if yes
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 or vegetables or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't 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 past 6 months?	2
I am not always physically able to shop, cook, and/or feed myself.	2
<b>Total Score:</b> (If equal to or greater than 6, the client is at high nutritional risk)	
<input type="checkbox"/> <b>Declined to State</b>	

**SAMPLE 3, CLUSTER 2**

Provider Name:	*Unique Participant ID: _____
Region/Site Name:	Registration/Assessment Date: _____
*Termination Date: _____ *Reason: _____	
Service Categories(Titles IIIB, IIIC and IIID):	
<input type="checkbox"/> *Assisted Transportation <input type="checkbox"/> *Congregate Meals (N) <input type="checkbox"/> *Nutrition Counseling (N)	
Notes: Requires N-Nutritional Assessments on Page 2	

**SECTION 1 (Client)**

(\* Required for All Registered Programs)

<b>Personal Data (Please Print):</b>					
First Name:					
Middle Initial:					
Last Name:					
* What is your gender? (Check only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
* What was your sex at birth? (Check only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated				
* How do you describe your sexual orientation or sexual identity (Check only one)	<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
*Birth Date:					
Last 4 Digits Social Security # <i>Optional</i>	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> </tr> </table>				
Home Phone #:	(    )				
<b>Residential Address:</b>					
Street:					
City:					
*Zip Code:					

<b>Mailing Address:</b>	
Same As Residential? <input type="checkbox"/> Yes – Skip to Next Section	
Street:	
City:	
* Zip Code:	
Emergency Contact:	Name: Relationship: Phone #: (    )
*Ethnicity:	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State
*Federal Poverty Level (FPL)	<input type="checkbox"/> At or below FPL <input type="checkbox"/> Above FPL <input type="checkbox"/> Declined to State
*Lives Alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
*Rural?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
<b>*Race: (Please Check ONE)</b>	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Hawaiian/Other Pacific Islander: <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to State	
<b>Title III B Eligibility:</b>	
Are you age 60 or over? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Transportation Service Needs:</b>	
<input type="checkbox"/> Walks with no assistance (Non-Assisted) <input type="checkbox"/> Walks with assistance (Assisted) <input type="checkbox"/> Wheelchair ramp/lift	

**SECTION 2 – Nutritional Assessment (Annual)**  
*Required for (IIIC): Congregate Meals; IIIC, D Nutritional Counseling*

<b>*Nutritional Assessment:</b>	<b>Circle if yes</b>
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 or vegetables or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't 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 past 6 months?	2
I am not always physically able to shop, cook, and/or feed myself.	2
<b>Total Score:</b> (If equal to or greater than 6, the client is at high nutritional risk)	
	<input type="checkbox"/> <b>Declined to State</b>

Notes:

**SAMPLE 4, C-2**

<b>Name of Home-Delivered Meals Provider</b> This form is designed to be completed by an intake staff. Items marked with asterisk (*) are required.		Route:	Intake Date: _____	Active Date: _____	Inactive Date: _____	
			Active Date: _____	Inactive Date: _____		
			Active Date: _____	Inactive Date: _____		
<b>*Unique Participant ID:</b>		<b>*Termination Date:</b>		<b>*Reason:</b>		
<b>*Date of Birth:</b> / /	Last 4 Digits Social Security # <i>Optional</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> New client <input type="checkbox"/> Annual reassessment <input type="checkbox"/> Change in information						
First Name:			Last Name			
Home Address:			City:		*Zip Code:	
Home Phone: ( )		Emergency Contact Name:				
Alternate Phone: ( )		Address:		Relationship:		
<b>*Living Arrangement # of household members</b> <input type="text"/> <input type="checkbox"/> Declined to State		<b>*What is your approximate household income?</b> \$_____ per <input type="checkbox"/> month <input type="checkbox"/> year <input type="checkbox"/> Declined to State		<b>*Rural Area?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State		
<b>* What is your gender? (Check only one)</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated		<b>* What was your sex at birth? (Check only one)</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated		<b>* How do you describe your sexual orientation or sexual identity (Check only one)</b> <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated		
<b>*Ethnicity (Check One)</b> Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State			Language: <input type="checkbox"/> English speaking <input type="checkbox"/> Need interpreter <input type="checkbox"/> Non-English/Language			
<b>*Race: (Check One)</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Multiple Race <input type="checkbox"/> Other Race <input type="checkbox"/> Declined to State						
<b>*ADLs and IADLs (Activities of Daily Living and Instrumental Activities of Daily Living)</b> Please rate your functional abilities for the following activities.						
ADLs	Rated Value	IADLs	Rated Value	IADLs	Rated Value	<b>RATING SCALE</b> 1 = Independent 2 = Verbal Assistance 3 = Some Human Help 4 = Lots of Human Help 5 = Dependent 6= Declined to State
Feeding		Meal Preparation		Light Housework		
Dressing		Shopping		Heavy Housework		
Bathing		Manage Medication		Notes:		
Transferring In/Out of Chair		Money Management				
Walking		Telephone				
Toileting		Transportation				

<b>Eligibility:</b> <input type="checkbox"/> Are you homebound due to an illness, disability, or isolation? <input type="checkbox"/> Are you a spouse of a person who is homebound? <input type="checkbox"/> Are you an individual with a disability who resides with a homebound meal recipient?	<b>Prioritization:</b>
--	------------------------

<b>*Nutritional Assessment:</b>	<b>Circle if yes</b>
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 or vegetables or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't 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 past 6 months?	2
I am not always physically able to shop, cook, and/or feed myself.	2
<b>Total Score:</b>	
(If equal to or greater than 6, the client is at high nutritional risk)	
	<input type="checkbox"/> <b>Declined to State</b>

	Yes	No	Comments
Do you have any dietary restrictions?			
Do you have a working refrigerator?			
Do you have a working microwave?			
Are you physically and mentally able to open the food containers?			
Are you physically and mentally able to reheat a meal?			
Are there pets?			
Have you recently been discharged from the hospital?			

<b>Referral(s) Made:</b> <input type="checkbox"/> Nutritional education/counseling for at risk client <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Notes:

\_\_\_\_\_  
Staff Completing Assessment

\_\_\_\_\_  
Date

[Page 2 of 2]

CDA Sample 4, Title III C-2, Home-Delivered Meals, Registration-Assessment Form (2018)

**SAMPLE 5, C-1**

<p><b>Name of Congregate Meals Provider {Site Name}</b></p> <p>Please complete this form to the best of your ability. Items Marked with asterisk (*) are required.</p>		<p>*Unique Participant ID: _____</p> <p>Referred by: _____</p> <p>Intake Date: _____</p> <p>Staff: _____</p> <p>Beginning Date: _____</p> <p>*Termination Date: _____</p> <p>*Reason: _____</p>		<p>Eligibility:</p> <p><input type="checkbox"/> Age 60+</p> <p><input type="checkbox"/> Spouse of ENP Participant</p> <p><input type="checkbox"/> Disabled person residing where the congregate site is located</p> <p><input type="checkbox"/> Disabled person who resides with and accompanies an ENP participant</p> <p><input type="checkbox"/> Volunteer</p>					
<p>Last 4 Digits Social Security # <i>Optional</i></p> <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> </tr> </table>									
<p>First Name: _____</p>		<p>Last Name _____</p>		<p>*Date of Birth: _____ / _____ / _____</p>					
<p>Home Address: _____</p>			<p>City: _____</p>		<p>*Zip Code: _____</p>				
<p>Mailing Address: Same As Residential? <input type="checkbox"/> Yes</p>			<p>City: _____</p>		<p>* Zip Code: _____</p>				
<p>Home Phone: ( ) _____</p> <p>Alternate Phone: ( ) _____</p>		<p>Emergency Contact Name: _____</p> <p>Phone: ( ) _____ Relationship: _____</p>							
<p>*Living Arrangement # of household members <input type="checkbox"/></p> <p><input type="checkbox"/> Declined to State</p>		<p>*What is your approximate household income?</p> <p>\$_____ per <input type="checkbox"/> month <input type="checkbox"/> year <input type="checkbox"/> Declined to State</p>		<p>*Rural Area?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Declined to State</p>					
<p>* What is your gender? (Check only one)</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female</p> <p><input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated</p>									
<p>* What was your sex at birth? (Check only one)</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p><input type="checkbox"/> Declined/not stated</p>			<p>* How do you describe your sexual orientation or sexual identity (Check only one)</p> <p><input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving</p> <p><input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not Listed, please specify: _____</p> <p><input type="checkbox"/> Declined/not stated</p>						
<p>*Ethnicity (Check One)</p> <p>Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Decline to State</p>			<p>Language:</p> <p><input type="checkbox"/> English speaking <input type="checkbox"/> Need interpreter</p> <p><input type="checkbox"/> Non-English/Language: _____</p>						
<p>*Race: (Check One) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native</p> <p><input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese</p> <p><input type="checkbox"/> Other Asian <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander</p> <p><input type="checkbox"/> Multiple Race <input type="checkbox"/> Other Race <input type="checkbox"/> Declined to State</p>									

Notes:

<b>*Nutritional Assessment:</b>	<b>Circle if yes</b>
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 or vegetables or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't 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 past 6 months?	2
I am not always physically able to shop, cook, and/or feed myself.	2
<b>Total Score:</b> (If equal to or greater than 6, the client is at high nutritional risk)	
<input type="checkbox"/> <b>Declined to State</b>	

I understand that the information I am providing on this form is for registration purposes. I understand it will be kept confidential and that the Area Agency on Aging and service providers may use it to help identify other services for which may benefit.

\_\_\_\_\_  
Signature of participant or person completing the form

\_\_\_\_\_  
Date



**SAMPLE 6, Title III E, Caring for Elderly, Caring for Child**

**SECTION 1 – Service Information**

Provider Name:	Registration/Assessment Date:	
Region/Site Name:	*Termination Date:	*Reason:
<b>Service Categories:</b> <input type="checkbox"/> Caregiver Caring for Elderly <input type="checkbox"/> Grandparent/Older Caregiver Caring for Child <b>Notes:</b> Check eligibility criteria below to determine for which program caregiver qualifies		

Title III E, Family Caregiver Support Program Services To Be Provided	
<b>Support Services:</b> <input type="checkbox"/> Caregiver Assessment <input type="checkbox"/> Caregiver Support <input type="checkbox"/> Caregiver Counseling <input type="checkbox"/> Caregiver Training <input type="checkbox"/> Caregiver Peer Counseling <input type="checkbox"/> Case Management	<b>Respite Care Services:</b> <input type="checkbox"/> In-Home Supervision <i>(Care Receiver has to have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/elder caregiver to qualify)</i> <input type="checkbox"/> Homemaker Assistance <input type="checkbox"/> In-Home Personal Care <input type="checkbox"/> Home Chore <input type="checkbox"/> Out of Home Day <input type="checkbox"/> Out of Home Overnight
<b>Supplemental Services:</b> <i>(Care Receiver has to have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/older caregiver to qualify)</i> <input type="checkbox"/> Assistive Devices <input type="checkbox"/> Home Adaptations for Caregiving <input type="checkbox"/> Caregiving Services Registry <input type="checkbox"/> Cash/Material Aid	
<b>Access Assistance:</b> <input type="checkbox"/> Information & Assistance <input type="checkbox"/> Caregiver Outreach <input type="checkbox"/> Interpretation/Translation <input type="checkbox"/> Caregiver Legal Resources	<b>Information Services:</b> <input type="checkbox"/> Public Information on Caregiving <input type="checkbox"/> Community Education on Caregiving

**SECTION 2 – Eligibility Criteria**

<p><b>Caregiver Caring for Elderly Eligibility Criteria</b></p> <p>1. Is the Care Receiver an older individual (60 years of age or older) <u>or</u> an individual (of any age) with Alzheimer’s disease or related disorder with neurological and organic brain dysfunction?      <input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p>2. Is the Caregiver an adult (18 years of age or older) family member or another individual (e.g., friend or neighbor) who is an informal (i.e., unpaid) provider of in-home or community care to an “elderly” Care Receiver?      <input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p><i>If answered “yes” to both questions above, check “Family Caregiver Caring for Elderly” box in Section 1. If answered “no” check to see if individual qualifies for “Grandparent/Older Caregiver Caring for Child” component below.</i></p>
<p><b>Grandparent/Older Caregiver Caring for Child Eligibility Criteria</b></p> <p>1. Is the Care Receiver an individual who is not more than 18 years of age <u>or</u> who is an individual (of any age) with a disability?      <input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p>2. Is the Caregiver a grandparent, step-grandparent, or other older relative of a child by blood, marriage, or adoption who is 55 years of age or older, living with the child, and identified as the primary caregiver through a legal or informal arrangement. Biological and adoptive parents are excluded.      <input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p><i>If answered “yes” to both questions above, check “Grandparent/Older Caregiver Caring for Child” box in Section 1.</i></p>
<p>If the Care Receiver does not meet any of the criteria above, the Caregiver is ineligible to receive FCSP services, but may qualify to receive other services provided by the Area Agency on Aging.</p>

**SECTION 3 (FCSP Caregiver)**  
 (\*) Required for Family Caregiver Support Program Services

<b>Caregiver Personal Data (Please Print):</b>					
<b>*Unique Participant ID</b>					
First Name:					
Middle Initial:					
Last Name:					
<b>* What is your gender? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
<b>* What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated				
<b>* How do you describe your sexual orientation or sexual identity (Check only one)</b>	<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
<b>*Birth Date:</b>					
Last 4 Digits Social Security # <i>Optional</i>	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table>				
Home Phone #:	(    )				
<b>Residential Address:</b>					
Street:					
City:					
*Zip Code:					

<b>Mailing Address:</b>	
Same As Residential? <input type="checkbox"/> Yes – Skip to Next Section ▯	
Street:	
City:	
* Zip Code:	
<b>*Ethnicity:</b>	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State
<b>*Federal Poverty Level (FPL)</b>	<input type="checkbox"/> At or below FPL <input type="checkbox"/> Above FPL <input type="checkbox"/> Declined to State
<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
<b>*Rural?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
<b>*Race: (Please Check ONE)</b>	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Hawaiian/Other Pacific Islander: <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to State	
<b>*Relationship to Care Receiver</b>	<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Grandparent <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other Relative <input type="checkbox"/> Daughter/Daughter-in-law <input type="checkbox"/> Son/Son-in-law <input type="checkbox"/> Non Relative <input type="checkbox"/> Declined to State
<b>*Relationship Status:</b>	<input type="checkbox"/> Single (never married) <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to State
<b>*Employment:</b>	<input type="checkbox"/> Full Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Part Time <input type="checkbox"/> Declined to State <input type="checkbox"/> Retired

**SECTION 4 (FCSP Care Receiver)**  
 (\*) Required for Family Caregiver Support Program Services

<b>Care Receiver Personal Data (Please Print):</b>					
*Unique Participant ID					
First Name:					
Middle Initial:					
Last Name:					
* What is your gender? (Check only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: <hr/> <input type="checkbox"/> Declined/not stated				
* What was your sex at birth? (Check only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated				
* How do you describe your sexual orientation or sexual identity (Check only one)	<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not Listed, please specify: <hr/> <input type="checkbox"/> Declined/not stated				
*Birth Date:					
Last 4 Digits Social Security # <i>Optional</i>	<table border="1" style="width: 100%; height: 30px;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table>				
Home Phone #:	(    )				
<b>Residential Address:</b>					
Street:					
City:					
*Zip Code:					

<b>Mailing Address:</b>	
Same As Residential? <input type="checkbox"/> Yes – Skip to Next Section <input type="checkbox"/>	
Street:	
City:	
* Zip Code:	
*Ethnicity:	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State
*Federal Poverty Level (FPL)	<input type="checkbox"/> Yes (At or below FPL) <input type="checkbox"/> No (Above FPL) <input type="checkbox"/> Declined to State
*Lives Alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
*Rural?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
<b>*Race: (Please Check ONE)</b>	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race	
Asian:	
<input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	
Hawaiian/Other Pacific Islander:	
<input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to State	
*Relationship Status:	<input type="checkbox"/> Single (never married) <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to State

**SECTION 5 (FCSP Care Receiver)**  
**ADL and IADL (Activities of Daily Living and Instrumental Activities of Daily Living)**

*\*Required for the Care Receiver only in Support Services, Respite Care, and Supplemental Services.*

*(Not required for Care Receivers in FCSP Grandparents/Older Caregiver Caring for Children)*

<b>ADLs:</b>	<b>1 – Independent</b>	<b>2 – Verbal Assistance</b>	<b>3 – Some Human Help</b>	<b>4 – Lots of Human Help</b>	<b>5 – Dependent</b>	<b>Declined to State</b>
*Eating						
*Bathing						
*Toileting						
*Transferring In/Out of Bed/Chair						
*Walking						
*Dressing						
Notes:						
<b>IADLs:</b>	<b>1 – Independent</b>	<b>2 – Verbal Assistance</b>	<b>3 – Some Human Help</b>	<b>4 – Lots of Human Help</b>	<b>5 – Dependent</b>	<b>Declined to State</b>
*Meal Preparation						
*Shopping						
*Medication Management						
*Money Management						
*Using Telephone						
*Heavy Housework						
*Light Housework						
*Transportation						
Notes:						

**SAMPLE 7, Title III E, Caring for Elderly**

**SECTION 1 – Service Information**

Provider Name:	Registration/Assessment Date:
Region/Site Name:	*Termination Date:                      *Reason:

Title III E, Family Caregiver Support Program Services To Be Provided	
<b>Support Services:</b> <input type="checkbox"/> Caregiver Assessment <input type="checkbox"/> Caregiver Support <input type="checkbox"/> Caregiver Counseling <input type="checkbox"/> Caregiver Training <input type="checkbox"/> Caregiver Peer Counseling <input type="checkbox"/> Case Management	<b>Respite Care Services:</b> <i>(Care Receiver has to have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/elder caregiver to qualify)</i> <input type="checkbox"/> In-Home Supervision <input type="checkbox"/> Homemaker Assistance <input type="checkbox"/> In-Home Personal Care <input type="checkbox"/> Home Chore <input type="checkbox"/> Out of Home Day <input type="checkbox"/> Out of Home Overnight
<b>Supplemental Services:</b> <i>(Care Receiver must have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/older caregiver to qualify)</i> <input type="checkbox"/> Assistive Devices <input type="checkbox"/> Home Adaptations for Caregiving <input type="checkbox"/> Caregiving Services Registry <input type="checkbox"/> Cash/Material Aid	
<b>Access Assistance:</b> <input type="checkbox"/> Information & Assistance <input type="checkbox"/> Caregiver Outreach <input type="checkbox"/> Interpretation/Translation <input type="checkbox"/> Caregiver Legal Resources	<b>Information Services:</b> <input type="checkbox"/> Public Information on Caregiving <input type="checkbox"/> Community Education on Caregiving

**SECTION 2 – Eligibility Criteria**

<b>Caregiver Caring for Elderly Eligibility Criteria</b> 1. Is the Care Receiver an older individual (60 years of age or older) <u>or</u> an individual (of any age) with Alzheimer’s disease or related disorder with neurological and organic brain dysfunction? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Is the Caregiver an adult (18 years of age or older) family member or another individual (e.g., friend or neighbor) who is an informal (i.e., unpaid) provider of in-home or community care to an “elderly” Care Receiver? <input type="checkbox"/> Yes <input type="checkbox"/> No
If the Care Receiver does not meet any of the criteria above, the Caregiver is ineligible to receive FCSP Caregiver Caring for Elderly services but may qualify to receive other services provided by the Area Agency on Aging.

<b>Notes:</b>
---------------

**SECTION 3 – (FCSP Caregiver)**  
 (\*) Required for Family Caregiver Support Program Services

<b>Caregiver Personal Data (Please Print):</b>					
<b>*Unique Participant ID</b>					
First Name:					
Middle Initial:					
Last Name:					
<b>* What is your gender? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
<b>* What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated				
<b>* How do you describe your sexual orientation or sexual identity (Check only one)</b>	<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
<b>*Birth Date:</b>					
Last 4 Digits Social Security # <i>Optional</i>	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table>				
Home Phone #:	(    )				
<b>Residential Address:</b>					
Street:					
City:					
*Zip Code:					

<b>Mailing Address:</b>	
Same As Residential? <input type="checkbox"/> Yes – Skip to Next Section ▯	
Street:	
City:	
* Zip Code:	
<b>*Ethnicity:</b>	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State
<b>*Federal Poverty Level (FPL)</b>	<input type="checkbox"/> At or below FPL <input type="checkbox"/> Above FPL <input type="checkbox"/> Declined to State
<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
<b>*Rural?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
<b>*Race: (Please Check ONE)</b>	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race	
Asian:	
<input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	
Hawaiian/Other Pacific Islander:	
<input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to State	
<b>*Relationship to Care Receiver</b>	<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Grandparent <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other Relative <input type="checkbox"/> Daughter/Daughter-in-law <input type="checkbox"/> Son/Son-in-law <input type="checkbox"/> Non Relative <input type="checkbox"/> Declined to State
<b>*Relationship Status:</b>	<input type="checkbox"/> Single (never married) <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to State
<b>*Employment:</b>	<input type="checkbox"/> Full Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Part Time <input type="checkbox"/> Declined to State <input type="checkbox"/> Retired

**SECTION 4 (Care Receiver)**  
 (\*) Required for Family Caregiver Support Program Services

<b>*Unique Participant ID:</b>					
<b>Care Receiver Personal Data (Please Print):</b>					
First Name:					
Middle Initial:					
Last Name:					
<b>* What is your gender? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
<b>* What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated				
<b>* How do you describe your sexual orientation or sexual identity (Check only one)</b>	<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
<b>*Birth Date:</b>					
Last 4 Digits Social Security # <i>Optional</i>	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table>				
Home Phone #:	(      )				
<b>Residential Address:</b>					
Street:					
City:					
*Zip Code:					

<b>Mailing Address:</b>	
Same As Residential? <input type="checkbox"/> Yes – Skip to Next Section <input type="checkbox"/>	
Street:	
City:	
* Zip Code:	
<b>*Ethnicity:</b>	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State
<b>*Federal Poverty Level (FPL)</b>	<input type="checkbox"/> Yes (At or below FPL) <input type="checkbox"/> No (Above FPL) <input type="checkbox"/> Declined to State
<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
<b>*Rural?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
<b>*Race: (Please Check ONE)</b>	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Hawaiian/Other Pacific Islander: <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to State	
<b>*Relationship Status:</b>	<input type="checkbox"/> Single (never married) <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to State

**SECTION 5 (Care Receiver)**

**\*ADLs & IADLs (Activities of Daily Living & Instrumental Activities of Daily Living)**

Required for Support Services, Respite Care, and Supplemental Services.

Please rate your functional abilities for the following activities.

ADLs	Rated Value	IADLs	Rated Value	IADLS	Rated Value	<b>RATING SCALE</b> 1 = Independent 2 = Verbal Assistance 3 = Some Human Help 4 = Lots of Human Help 5 = Dependent 6= Declined to State
Feeding		Meal Preparation		Light Housework		
Dressing		Shopping		Heavy Housework		
Bathing		Manage Medication		Notes:		
Transferring In/Out of Chair		Money Management				
Walking		Telephone				
Toileting		Transportation				



**SAMPLE 8, Title III E, Caring for Child**

**SECTION 1 – Service Information**

Provider Name:	Registration/Assessment Date:
Region/Site Name:	*Termination Date:                      *Reason:

**Title III E, Family Caregiver Support Program Services To Be Provided**

<b>Support Services:</b> <input type="checkbox"/> Caregiver Assessment <input type="checkbox"/> Caregiver Support <input type="checkbox"/> Caregiver Counseling <input type="checkbox"/> Caregiver Training <input type="checkbox"/> Caregiver Peer Counseling <input type="checkbox"/> Case Management	<b>Respite Care Services:</b> <input type="checkbox"/> In-Home Supervision <input type="checkbox"/> Home Chore <input type="checkbox"/> Homemaker Assistance <input type="checkbox"/> Out of Home Day <input type="checkbox"/> In-Home Personal Care <input type="checkbox"/> Out of Home Overnight
<b>Supplemental Services:</b> <input type="checkbox"/> Assistive Devices <input type="checkbox"/> Home Adaptations for Caregiving <input type="checkbox"/> Caregiving Services Registry <input type="checkbox"/> Cash/Material Aid	
<b>Access Assistance:</b> <input type="checkbox"/> Information & Assistance <input type="checkbox"/> Caregiver Outreach <input type="checkbox"/> Interpretation/Translation <input type="checkbox"/> Caregiver Legal Resources	<b>Information Services:</b> <input type="checkbox"/> Public Information on Caregiving <input type="checkbox"/> Community Education on Caregiving

**SECTION 2 – Eligibility Criteria**

<p><b>Grandparent/Older Caregiver Caring for Child Eligibility Criteria</b></p> <p>1. Is the Care Receiver an individual who is not more than 18 years of age <u>or</u> who is an individual (of any age) with a disability?                      <input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p>2. Is the Caregiver a grandparent, step-grandparent, or other older relative of a child by blood, marriage, or adoption who is 55 years of age or older, living with the child, and identified as the primary caregiver through a legal or informal arrangement. Biological and adoptive parents are excluded.                      <input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
<p>If the Care Receiver does not meet any of the criteria above, the Caregiver is ineligible to receive FCSP Grandparent Caring for Child services but may qualify to receive other services provided by the Area Agency on Aging.</p>

<p><b>Notes:</b></p>
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**SECTION 3 (Grandparent/Older Caregiver)**  
 (\*) Required for Family Caregiver Support Program Services

<b>Caregiver Personal Data (Please Print):</b>					
<b>*Unique Participant ID</b>					
First Name:					
Middle Initial:					
Last Name:					
<b>* What is your gender? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
<b>* What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated				
<b>* How do you describe your sexual orientation or sexual identity (Check only one)</b>	<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
<b>*Birth Date:</b>					
Last 4 Digits Social Security # <i>Optional</i>	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table>				
Home Phone #:	(      )				
<b>Residential Address:</b>					
Street:					
City:					
*Zip Code:					

<b>Mailing Address:</b>	
Same As Residential? <input type="checkbox"/> Yes – Skip to Next Section ▯	
Street:	
City:	
* Zip Code:	
<b>*Ethnicity:</b>	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State
<b>*Federal Poverty Level (FPL)</b>	<input type="checkbox"/> At or below FPL <input type="checkbox"/> Above FPL <input type="checkbox"/> Declined to State
<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
<b>*Rural?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
<b>*Race: (Please Check ONE)</b>	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race	
Asian:	
<input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	
Hawaiian/Other Pacific Islander:	
<input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to State	
<b>*Relationship to Care Receiver</b>	<input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Non Relative <input type="checkbox"/> Declined to State
<b>*Relationship Status:</b>	<input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to State
<b>*Employment:</b>	<input type="checkbox"/> Full Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Part Time <input type="checkbox"/> Declined to State <input type="checkbox"/> Retired

**SECTION 4 (Child)**  
 (\*) Required for Family Caregiver Support Program Services

Care Receiver Personal Data (Please Print):					
*Unique Participant ID					
First Name:					
Middle Initial:					
Last Name:					
* What is your gender? (Check only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
* What was your sex at birth? (Check only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated				
* How do you describe your sexual orientation or sexual identity (Check only one)	<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
*Birth Date:					
Last 4 Digits Social Security # <i>Optional</i>	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table>				
Home Phone #:	(    )				
Residential Address:					
Street:					
City:					
*Zip Code:					

Mailing Address:	
Same As Residential? <input type="checkbox"/> Yes – Skip to Next Section <input type="checkbox"/>	
Street:	
City:	
* Zip Code:	
*Ethnicity:	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State
*Federal Poverty Level (FPL)	<input type="checkbox"/> Yes (At or below FPL) <input type="checkbox"/> No (Above FPL) <input type="checkbox"/> Declined to State
*Lives Alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
*Rural?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
*Race: (Please Check ONE)	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race	
Asian:	
<input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	
Hawaiian/Other Pacific Islander:	
<input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to State	
*Relationship Status:	<input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to State

**SAMPLE 9, I&A**

Date: \_\_\_\_\_

Staff Completing Intake: \_\_\_\_\_

Personal Data (Please Print):					
Unique Participant ID					
Name:					
Birth Date:					
Last 4 Digits Social Security # <i>Optional</i>	<table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 25px;"></td><td style="width: 25px;"></td><td style="width: 25px;"></td><td style="width: 25px;"></td></tr></table>				
Home Phone #:	(     )				
Email:					
Address:					
* What is your gender? (Check only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
* What was your sex at birth? (Check only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated				
* How do you describe your sexual orientation or sexual identity (Check only one)	<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
Ethnicity:	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State				

Race:	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race	
	<b>Asian:</b> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	
	<b>Hawaiian/Other Pacific Islander:</b> <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to State	
	<b>Federal Poverty Level (FPL)</b> <input type="checkbox"/> Yes (At or below FPL) <input type="checkbox"/> No (Above FPL) <input type="checkbox"/> Declined to State	
	<b>Lives Alone?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State	
	<b>Rural?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State	
	<b>Service Requested:</b>	
	<b>Action Taken/Referral:</b>	
<b>Follow Up:</b>		
<b>Type of I &amp; A:</b>		
<input type="checkbox"/> IIIB If Requesting Services for an Older Individual <input type="checkbox"/> IIIE Elderly (If Requesting Services for a Caregiver) <input type="checkbox"/> IIIE Children (If Requesting Services for a Grandparent/Older Caregiver)		