

# HUALAPAI ELDERLY SERVICES

## CLIENT INTAKE AND SERVICE REQUEST FORM

(Items in **BOLD** must be completed)

**Client Rights & Responsibilities and Release of Information have been clearly explained to the client.**

**Date:** \_\_\_\_\_ **Client ID Number:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **First Name:** \_\_\_\_\_

**Gender:** Male  Female  **Birth Date:** \_\_\_\_\_ **Primary Language:** \_\_\_\_\_

**Home Address: Street/Apt. #:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_ **County:** \_\_\_\_\_

**Check if Mailing Address is Home Address**

**Mailing Address: Street/Apt. #:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_ **County:** \_\_\_\_\_

**Phone:** (\_\_\_\_\_) \_\_\_\_\_ **Home**  **Cell**  **Other**  (Check One)

**Eligibility Category:** 55 – 59 yrs. old  Under 60 with disability   
60 and over  Caregiver or eligible client

### DEMOGRAPHICS:

<b>Type of Disability:</b> (Provide medical note)	<b>Language:</b>	<b>Education:</b>
(1) Physical <input type="checkbox"/>	(1) English <input type="checkbox"/>	(1) Decline to state <input type="checkbox"/>
(2) Intellectual Disability/Disability <input type="checkbox"/>	(2) American Indian (w/English) <input type="checkbox"/>	(2) Some High School <input type="checkbox"/>
(3) Mental Illness <input type="checkbox"/>	(3) American Indian (w/o English) <input type="checkbox"/>	(3) High School Grad <input type="checkbox"/>
(4) Traumatic Brain Injury <input type="checkbox"/>	(4) Spanish (w English) <input type="checkbox"/>	(4) Some College <input type="checkbox"/>
(5) Dementia <input type="checkbox"/>	(5) Spanish (w/o English) <input type="checkbox"/>	(5) College Grad <input type="checkbox"/>
(6) Other <input type="checkbox"/>	(6) Decline to State <input type="checkbox"/>	(6) Grad School <input type="checkbox"/>
(7) None <input type="checkbox"/>	(7) Other ( <i>Specify</i> ) _____ <input type="checkbox"/>	

Ethnicity (Check One):	Race (Check all that apply):	Marital Status (Check One):
(1) Hispanic or Latino <input type="checkbox"/>	(1) Asian <input type="checkbox"/>	(1) Single <input type="checkbox"/>
(2) Not Hispanic or Latino <input type="checkbox"/>	(2) Black/African American <input type="checkbox"/>	(2) Married <input type="checkbox"/>
(3) Decline to state <input type="checkbox"/>	(3) American Indian/Alaska Native <input type="checkbox"/>	(3) Divorced <input type="checkbox"/>
	(4) Native Hawaiian or Pacific Islander <input type="checkbox"/>	(4) Separated <input type="checkbox"/>
	(5) White <input type="checkbox"/>	(5) Widowed <input type="checkbox"/>
	(6) Decline to state <input type="checkbox"/>	(6) Decline to state <input type="checkbox"/>
	(7) Other ( <i>Specify</i> ) _____ <input type="checkbox"/>	

<b>Residency Type:</b>	House <input type="checkbox"/>	<b>Living Arrangement:</b>	Rent <input type="checkbox"/>	<b>Legal Status:</b>	Independent <input type="checkbox"/>
	Mobile Home <input type="checkbox"/>		Own <input type="checkbox"/>		Conservator <input type="checkbox"/>
	Group Home <input type="checkbox"/>		N/A <input type="checkbox"/>		Guardian <input type="checkbox"/>
	Other: <input type="checkbox"/>		Other: <input type="checkbox"/>		LTC Payee <input type="checkbox"/>
	_____		_____		Other: <input type="checkbox"/>
					_____

Does the client live alone? Yes  No

If No, Please include the total number of Family Members in Household Including Client: \_\_\_\_\_

Is the client living in poverty (Low Income)? Yes  No

Monthly Household Income: \$ \_\_\_\_\_ Low Income  Moderate Income  High Income

{Use Current Year Federal Poverty Guideline Levels for Low Income/Poverty}

Monthly Income from:	Individual	Spouse
Job	_____	_____
Social Security	_____	_____
SSI	_____	_____
VA	_____	_____
Other Sources	_____	_____
Other Benefits (e.g., Food Stamps)	_____	_____

**EMERGENCY CONTACT INFORMATION: (PLEASE PROVIDE TWO)**

**1. Contact Name:** \_\_\_\_\_ **Phone:** (\_\_\_\_\_) \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**2. Contact Name:** \_\_\_\_\_ **Phone:** (\_\_\_\_\_) \_\_\_\_\_

**Relationship:** \_\_\_\_\_

Service(s) Requested: \_\_\_\_\_

Are you enrolled in?  Medicare - Medicare # \_\_\_\_\_  Medicaid - Medicaid # \_\_\_\_\_

Additional Information:

**NURTRITION INFORMATION:**

Does the client have a special diet? Yes  No  If yes, specify: \_\_\_\_\_

Does the client have a food allergy? Yes  No  If yes, specify: \_\_\_\_\_

<b>Nutrition Screening (Check all that apply and total the score shown for each selected responses):</b>	
<input type="checkbox"/> I have an illness or condition that changed the kind and/or amount of food I eat. (2)	<input type="checkbox"/> I don't always have enough money to buy the food I need. (4)
<input type="checkbox"/> I eat fewer than 2 meal per day. (3)	<input type="checkbox"/> I eat alone most of the time. (1)
<input type="checkbox"/> I eat few fruits or vegetables or milk products. (2)	<input type="checkbox"/> I take 3 or more different prescribed or over-the-counter drugs a day. (1)
<input type="checkbox"/> I have 3 or more drinks of beer, liquor or wine almost every day. (2)	<input type="checkbox"/> Without wanting to, I have lost or gained 10 pounds in the last 6 months. (2)
<input type="checkbox"/> I have tooth or mouth problems that make it hard for me to eat. (2)	<input type="checkbox"/> I am not always physically able to shop, cook and /or feed myself. (2)
<b>Total Score</b> (0-2 is good, 3-5 is moderate nutritional risk, 6 or greater is high nutritional risk):	
Comments:	

**Referred By:**  Community Organization  Indian Health Service  
 Human Services  Hospital

Health Department       Self  
 Family Member       Other: \_\_\_\_\_

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**Service Enrollment: (TO BE COMPLETED BY ELDERLY STAFF)**

Print name of Elderly Service staff completing Intake: \_\_\_\_\_

**Provider:** Hualapai Tribe

**Program:** \_\_\_\_\_ (Congregate Meals, Home Delivery, Disability, Caregiver, Spouse)

**Title Program:** \_\_\_\_\_ (Title VI, Title XX)

**Enrollment Status:**  Enrolled    Disenrolled    Waitlisted    Deceased

**Program Authorization** From: \_\_\_\_\_ Through: \_\_\_\_\_  
**Period:**

**Number of Meals:**

**Frequency:**  One time    Daily    Weekly    Monthly    Other: \_\_\_\_\_

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**Program:** \_\_\_\_\_ (Congregate Meals, Home Delivery, Disability, Caregiver, Spouse)

**Title Program:** \_\_\_\_\_ (Title III, Title VI, Title XX)

**Enrollment Status:**  Enrolled    Disenrolled    Waitlisted    Deceased

**Program Authorization** From: \_\_\_\_\_ Through: \_\_\_\_\_  
**Period:**

**Number of Meals:** 23 Meals Per Month      46 Meals Per Month

**Frequency:**  One time    Daily    Weekly    Monthly    Other: \_\_\_\_\_

**Nutrition Services: If participant is "other Older Americans Act(OAA) or Nutrition Service Incentive Program (NSIP) eligible participant under 60 years of age", check which of the following applies:**

- |  |                          |
|--|--------------------------|
| (1) Caregiver or Spouse                        | <input type="checkbox"/> |
| (2) Serves as volunteer at the nutrition site. | <input type="checkbox"/> |

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If anyone assisted the applicant with filling out this form please provide your name & relationship:**

\_\_\_\_\_