TEXAS Department of Aging and Disability Services

Form 2276
March 2014-E

Client Intake and Service Request

Area Agency on Aging of _____

The information on this form is required by your local service provider, the Area Agency on Aging (AAA), and the Texas Department of Aging and Disability Services. All information provided will be kept confidential and guarded against unofficial use. Information gathered through an intake or through an assessment may be shared to effectively plan, arrange and deliver services to meet an individual's needs.

☐ **Release of information has been clearly explained to the individual.**

Date	Individual's ID Number	Individual's Primary Language		
Last Name	First Name			MI
Street Address/Apt No.	City	State	ZIP Code	County
Area Code and Telephone No.	Birth Date	Gender ☐ Male ☐ Female		

Ethnicity (Check One):

- ☐ (1) Hispanic or Latino
- ☐ (2) Not Hispanic or Latino
- ☐ (3) Ethnicity Not Reported

Race (Check all that apply):

- ☐ (1) White – Non Hispanic
- ☐ (2) White – Hispanic
- ☐ (3) American Indian/Alaska Native
- ☐ (4) Asian
- ☐ (5) Black or African American
- ☐ (6) Native Hawaiian or Pacific Islander
- ☐ (7) Persons Reporting Some Other Race
- ☐ (8) Race Not Reported

Marital Status (Check One):

- ☐ (1) Married
- ☐ (2) Widowed
- ☐ (3) Divorced
- ☐ (4) Separated
- ☐ (5) Never Married
- ☐ (6) Not Reported

Does individual live alone? ☐ **Yes** ☐ **No**

Total Number of Family Members in Household Including Individual: _____

Monthly Household Income: _____ ☐ Low Income ☐ Moderate Income ☐ High Income

Low Income Levels for: Single person family unit – $ 11,490; Two person family unit – $15,510; Add $4,020 for each additional person

Monthly Income from:	**Individual**	**Spouse**
Job		
Social Security		
Supplemental Security Income		
Veterans Affairs		
Other Sources		
Other Benefits (e.g., Supplemental Nutritional Assistance Program (SNAP))		

Emergency Contact Information

Contact Name	Relationship	Area Code and Telephone No.
Primary Care Physician	Area Code and Telephone No.	
Service(s) Requested		

Are you enrolled in? ☐ Medicare Medicare No.: _____ ☐ Medicaid Medicaid No.: _____

Referred By

- ☐ Texas Department of Family and Protective Services (DFPS)
- ☐ Texas Department of Assistive and Rehabilitative Services (DARS)
- ☐ Texas Department of State Health Services (DSHS)
- ☐ Doctor ☐ Hospital ☐ Assisted Living Facility
- ☐ Home and Community Care Organization
- ☐ Family Member
- ☐ Other

_____ _____
Signature – AAA/Provider Staff Completing Intake Date

To be completed by AAA/Provider Staff

Nutrition Services: If participant is “other Older Americans Act (OAA) or NSIP eligible participant under 60 year of age," check which of the following applies:

- ☐ (1) Spouse is eligible and participates at the nutrition site
- ☐ (2) Serves as volunteer at the nutrition site in accordance with OAA standards.
- ☐ (3) Disabled/resides in the housing facility and wants to participate in the congregate meal program provided at the site.
- ☐ (4) Disabled and lives with the person participating in the congregate meal program.