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:

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

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

Residency Type:
House ☐
Mobile Home ☐
Group Home ☐
Other: ☐
_____

Living Arrangement:
Rent ☐
Own ☐
N/A ☐
Other: ☐
_____

Legal Status:
Independent ☐
Conservator ☐
Guardian ☐
LTC Payee ☐
Other: ☐
_____

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: _____

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

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 Period: **From: _____ Through:_____**

Number of Meals:

Frequency: ☐ **One time** ☐ **Daily** ☐ **Weekly** ☐ **Monthly** ☐ **Other:_____**

Provider: **Hualapai Tribe**

Program: _____ (Congregate Meals, Home Delivery, Disability, Caregiver, Spouse)

Title Program: _____ (Title III, Title VI, Title XX)

Enrollment Status: ☐ **Enrolled** ☐ **Disenrolled** ☐ **Waitlisted** ☐ **Deceased**

Program Authorization Period: **From: _____ Through:_____**

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 ☐

(2) Serves as volunteer at the nutrition site. ☐

Applicant Signature: _____ **Date:** _____

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

_____