

Registered Client Intake Form
TITLE III B CASE MANAGEMENT – FY 2023-24

CONFIDENTIAL

CONTRACTOR:				DATE:					
CARE RECEIVER'S INFORMATION									
Last Name:						First Name: <i>(No nicknames)</i>			
Phone:						Birth Date: <i>(Required)</i>			
Street Address:				City:				ZIP:	
County:				Rural: (91307, 93066, 93040)				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing	
RACE – Please Choose (X) One:								Ethnicity:	
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black or African American <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese		<input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean		<input type="checkbox"/> Laotian <input type="checkbox"/> Multiple Race <input type="checkbox"/> Asian Indian <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other Race		<input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> White <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing		<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing	
MARITAL STATUS:		<input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Widowed <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing							
VETERAN STATUS: <input type="checkbox"/> I consent to this agency and the California Department of Aging transmitting my name, email address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for 12 months.		<input type="checkbox"/> Have you ever served in the United States military? <input type="checkbox"/> Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military? <input type="checkbox"/> No <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing		Preferred Language:					
Client Lives:		<input type="checkbox"/> Alone <input type="checkbox"/> Not Alone <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing		Number of Persons Living in Household:					
INDICATE CARE RECEIVER'S INCOME LEVEL (approximate):									
2-Person Household: <input type="checkbox"/> At or below Federal Poverty Level (\$19,720/year or less) <input type="checkbox"/> Above Federal Poverty Level (\$19,721/year or more) <input type="checkbox"/> Decline to State				1-Person Household: <input type="checkbox"/> At or below Federal Poverty Level (\$14,580/year or less) <input type="checkbox"/> Above Federal Poverty Level (\$14,581/year or more) <input type="checkbox"/> Decline to State					
The Gay Bisexual and Transgender Disparities Reduction Act of 2016 (AB 959)									
The State of CA requires that we ask you some demographic questions followed by three questions under the new CA State AB 959 Law, the Gay, Bisexual and Transgender Disparities Reduction Act of 2016. VCAA values your privacy and you have the option to decline to state.									
What was the Care Receiver's sex at birth?				<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing					
What is the Care Receiver's Gender?		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing <input type="checkbox"/> Not listed, please specify: _____							
How do you describe Care Receiver's sexual orientation or sexual identity?		<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"/> Decline to State <input type="checkbox"/> Missing <input type="checkbox"/> Not listed, please specify: _____							

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CALIFORNIA ACTIVITIES & INSTRUMENTAL ACTIVITIES (IADLS) OF DAILY LIVING (ADLS)							
Please Check (✓) One of the Columns for Each Activity							
TYPE OF ASSISTANCE CARE RECEIVER NEEDS TO PERFORM TASK →		1 INDEPENDENT Needs No Help	2 VERBAL QUE Needs verbal reminders	3 STAND BY Needs some human help	4 HANDS ON Needs lots of human help	5 DEPENDENT Cannot perform task	Decline to State
A D L S	Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I A D L S	Light Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Shopping/Errands	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Meal Prep/Cleanup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Using Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Managing Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Managing Money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Heavy Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care Receiver's Cognitive Impairment:		<input type="checkbox"/> None or Unknown <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe					

Narrative/Case Notes (Optional):			
Reviewed By:			Number of Hours:
Client Q Database/Unique Participant ID Number:			