



Funding provided by the Texas Health & Human Services

GOLDEN CRESCENT AREA AGENCY ON AGING  
 1908 N. LAURENT, SUITE 600 VICTORIA, TEXAS 77901  
 361-578-1587, EX 215, 1-800-252-9240,  
 FAX 361-578-8865

**CLIENT INTAKE AND SERVICE REQUEST FORM**

*FORMA DE ADMISIÓN Y SOLICITUD DE SERVICIOS PARA CLIENTES*

*The information on this form is required by your local service provider, the Area Agency on Aging (AAA), and the Texas Health & Human 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 individual client needs.*

*Esta solicitud contiene información que exigen el proveedor de servicios locales, la Agencia del Área para Adultos Mayores (AAA) y el Departamento de Servicios para Adultos Mayores y Personas Discapacitadas de Texas. Toda la información se mantendrá confidencial y protegida contra el uso no oficial. La información obtenida mediante el proceso de admisión o una valoración se puede divulgar para planear, organizar y prestar los servicios eficazmente para satisfacer las necesidades individuales del cliente.*



TEXAS  
 Health and Human  
 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 (office use only) \_\_\_\_\_

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)

**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

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Does client live alone? Yes  No

Client living in poverty (Low Income)? Yes  No

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

Are you enrolled in?  Medicare  Medicaid  Extra Help for Medicare Prescription Drug Plan

QMB & SLMB Would You Like More Information About these Programs? \_\_\_\_\_

To be completed by AAA/provider staff:

Print name of AAA/provider staff completing Intake: \_\_\_\_\_

**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) Spouse is eligible and participates in congregate or home delivered meal program.                                      | <input type="checkbox"/> |
| (2) Serves as volunteer at the nutrition site in accordance with OAA standards.  | <input type="checkbox"/> |
| (3) Disabled/resides in the housing facility and wants to participate in the congregate meal program provided at the site. | <input type="checkbox"/> |
| (4) Disabled and lives with a 60+ person who is eligible for congregate or home delivered meal program.                    | <input type="checkbox"/> |

Optional-Referred By \_\_\_\_\_

Referral Contact Information: \_\_\_\_\_ Phone \_\_\_\_\_ email \_\_\_\_\_

Additional Notes Regarding Referral:



## Area Agency on Aging of Golden Crescent

### Client Rights & Responsibilities for Older Americans Act Programs

The Area Agency on Aging of Golden Crescent welcomes you as a participant in programs for older individuals and family caregivers in our region. This program is mandated by the Older Americans Act of 1965, as amended, and provides access and assistance and other supportive services. The programs and services are administered by the Area Agency on Aging with funding provided through the Texas Department of Aging and Disability Services, client contributions and local funding.

Programs and services are designed for individuals age 60 or older and/or their family members and other caregivers. Our goal is to assist older individuals in leading independent, meaningful and dignified lives in their own homes and communities as long as possible through the provision of limited support services. Information will not be released to anyone, or any agency without your informed consent, with the exception of records subpoenaed by a court of law.

#### Client rights and responsibilities:

1. You have the right to be treated with respect and consideration. You have the right to have your property treated with respect.
2. You may not be denied services on the basis of race, religion, color, national origin, sex, disability, marital status, or inability and/or unwillingness to contribute.
3. You have the right to make a complaint/grievance or recommend changes to policy or service, without restraint, interference, coercion, discrimination or reprisal. To make a complaint or grievance contact the Area Agency on Aging. Contact information is identified below:

Service Provider Information	Area Agency on Aging Information
Victoria County Senior Citizens Centers	Cindy Cornish, AAA Director Golden Crescent AAA
603 E. Murray/S. Navarro	568 Big Bend Drive Victoria, Tx 77904
P.O. Box 1433	361-578-1587, 800-574-9745 <a href="mailto:cindyco@grpc.org">cindyco@grpc.org</a>
Victoria, Texas 77902	Joe E. Brannan, GRPC Executive Director Golden Crescent Regional Planning Commission
Phone 361-576-2189	568 BigBend Drive Victoria, Tx 77904 361-578-1587
Fax 361-578-8111	<a href="mailto:jbrannan@gcpr.org">jbrannan@gcpr.org</a>

4. You have the right to participate in the development of a care plan to address unmet needs.  N/A
5. You have the right to be informed in writing of available services and the applicable charges if the services are not covered or are unavailable by Medicare, Medicaid, health insurance, or Older Americans Act funding.  N/A
6. You have the right to make an independent choice of service providers from the list furnished by the Area Agency on Aging where multiple service providers are available and change service providers when desired.  N/A
7. You have the right to be informed of any change in service(s).  N/A
8. You have the right to make a voluntary, confidential, contribution for services received through the Area Agency on Aging. Services will not be denied if an eligible participant is unable or chooses not to make a contribution. All contributions will be kept confidential and will be utilized to expand or enhance the service(s) for which they were provided.
9. You have the responsibility to inform the Area Agency on Aging or its service provider(s) of your intent to withdraw from the program or any known periods of absenteeism when services will not be utilized.  N/A
10. You have the responsibility to provide the Area Agency on Aging or its services provider(s) with complete and accurate information.

I hold harmless this Area Agency on Aging program, its parent organization, funders, and the sponsoring state agencies for any liability arising out of the services provided in accordance with program guidelines.

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Client Signature

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Date

Victoria County Senior Citizens Association  
EMERGENCY CONTACT INFORMATION

Client Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Emergency Contact Name

Primary Contact Name \_\_\_\_\_

Relationship to \_\_\_\_\_

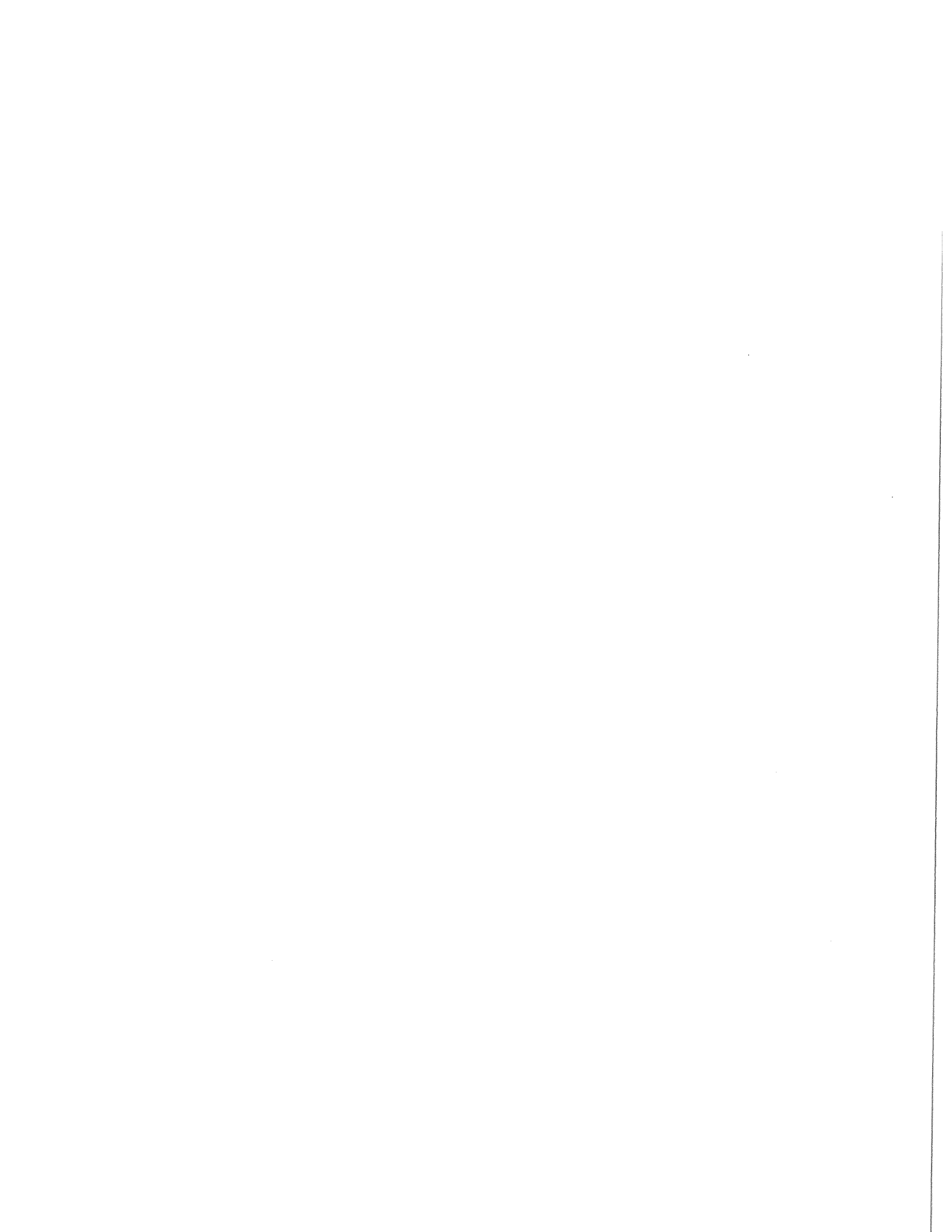
Primary Phone \_\_\_\_\_ Cellular Phone \_\_\_\_\_

Secondary Contact Name \_\_\_\_\_

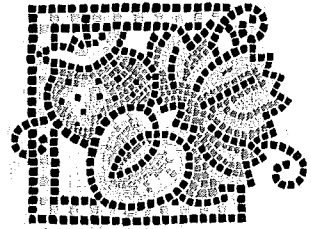
Relationship to \_\_\_\_\_

Primary Phone \_\_\_\_\_ Cellular Phone \_\_\_\_\_

Comments:



Provider/Center: Victoria County Senior Citizens Center  
 Consumer Name: \_\_\_\_\_  
 Consumer ID: XXXXX  
 Date: \_\_\_\_\_



*The Warning Signs of poor nutritional health are often overlooked. Use this checklist to find out if you are at nutritional risk.*

Read the statements below. Circle the number in the “Yes” column for those that apply to you. Add the circled numbers to get your total nutritional risk score.

	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 two meals a day.	3
I eat few fruits or vegetables, or milk products.	2
I have three 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 three or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained ten pounds in the last six month.	2
I am not always physically able to shop, cook and/or feed myself.	2
<b>SIGNATURE:</b>	<b>TOTAL</b>

Nutritional Health Score

- 0 – 2 Good
- 3 – 5 Moderate Nutritional Risk
- 6 or More High Nutritional Risk

Refer to the Determine Your Nutritional Health Handout to learn more about the warning signs of poor nutritional health.

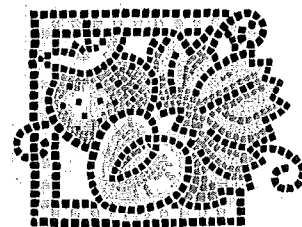
The Nutrition Screening Initiative • 1010 Wisconsin Avenue, NW • Suite 800 • Washington, DC 20007  
 The Nutrition Screening Initiative is funded in part by a grant from Ross Products Division of Abbott Laboratories, Inc.

Proveedor o centro: Victoria County Senior Citizens Center

Nombre del cliente: \_\_\_\_\_

Identificación del cliente: XXXXXXXX

Fecha: \_\_\_\_\_



*Las señales de advertencia de la mala salud nutricional muchas veces se pasan por alto. Use esta lista para enterarse si corre riesgo de tener mala nutrición.*

Lea las frases a continuación. Si la frase es pertinente a su situación, encierre en un círculo el número en la columna "Sí". Suma los números marcados para obtener su puntaje total de riesgo nutricional.

	<b>SÍ</b>
Tengo una enfermedad o un padecimiento que me hizo cambiar el tipo o la cantidad de comida que como.	2
Como menos de dos comidas al día.	3
Como pocas frutas o verduras, o pocos productos lácteos.	2
Tomo tres o más cervezas, cocteles o vinos casi todos los días.	2
Tengo problemas de los dientes o de la boca que me dificultan poder comer.	2
No siempre tengo suficiente dinero para comprar los alimentos que necesito.	4
Como solo la mayor parte del tiempo.	1
Tomo tres o más distintos medicamentos recetados o sin receta al día.	1
Sin querer hacerlo, he bajado o aumentado diez libras en los últimos seis meses.	2
No siempre me encuentro en condiciones físicas para ir de compras, cocinar o alimentarme.	2
<b>SIGNATURE/FIRMA:</b>	<b>TOTAL</b>

**Puntaje de salud nutricional**

- 0 - 2 Buena
- 3 - 5 Riesgo nutricional moderado
- 6 ó más Alto riesgo nutricional

Consulte la hoja informativa de Determinación de su salud nutricional para aprender sobre las señales de advertencia de la mala salud nutricional.

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