Title III - Intake and Assessment Forms Guide

CALIFORNIA DEPARTMENT OF AGING

LONG-TERM CARE AND AGING SERVICES DIVISION

www.aging.ca.gov

July 2018

Title III - Intake & Assessment Forms Guide

Table of Contents

Overview

Introduction

Data and the information created from data elements contribute to valuable knowledge about service use and client demographics. It is a source for Area Agencies on Aging (AAA), California Department of Aging (CDA), and U.S. Administration for Community Living (ACL) performance measures.

Background

AAA staff spends a large percentage of their time reading, completing, processing, and retrieving forms created or received by the agency.

Forms are an important part of the operations that aid in the collection and documentation of information. Well-designed and well-managed forms can reduce errors and save time and money.

Purpose

The purpose of this guide is to help AAA staff identify the required ACL and CDA Title III data elements. This guide provides AAAs with guidance, resources, and sample layouts and forms to help AAAs evaluate and design agency intake forms.

NOTE: *This guide does not address Community Based Service Programs (CBSP), Health Insurance Counseling and Advocacy Program (HICAP), Long-Term Ombudsman Program, Senior Community Services Employment Program (Title V), or fiscal forms.*

Data Performance Reporting Requirements

Purpose

The Older Americans Act (OAA) requires a report of statistical data reflecting the number of service units provided and the number of registered clients or the estimated clients/audience reached.

Process

Data Performance Management Process.

Entity	Role
Provider or AAA	• collects and tracks client/user information and service units • reports service utilization units, consumer demographics and expenditures • maintains records
AAA	• plans and administers OAA data management system(s) • implements CDA data reporting requirements • develops and maintains written procedures • analyzes, corrects, and verifies data • monitors and evaluates local services • trains staff and provides technical assistance to the providers, clients, and caregivers • reports data to CDA via the statewide California Aging Reporting System (CARS)
CDA	• sets data reporting standards • monitors and evaluates AAA programs • plans and administers the CARS • provides AAAs with training and technical assistance as needed • reports data and program information to ACL and the California State Legislature
ACL	• provides Congress, states and other stakeholders with National Aging Program Information System (NAPIS) data

CARS Approval

AAAs shall assure that all data submitted is complete, accurate, timely, and verifiable.

AAA staff must approve CARS File Upload quarterly data and NAPISCare annual data within 10 days of notice of passed status. If the data cannot be corrected within 10 days, AAA staff must provide an explanation in the comments box in the report screen. CDA will be able to review the data after the 10-day approval period.

Continued on next page

Data Performance Reporting Requirements, Continued

NAPIS Validation

As part of the annual year-end performance reporting process, the AAA Director, or designee, will be required to validate the NAPIS data.

What is Reviewed

CDA reviews the accuracy and completeness of the reported data on a regular basis. CDA reviews intake and assessment forms, reporting performance information, supporting documents, and reporting procedures during the CDA monitoring process.

AAAs shall keep complete records/documents on file to support all reports submitted to CDA. All paper and electronic client information records, data elements, and printouts collected are confidential and shall be secured and remain protected from unauthorized disclosure.

Designing Forms that Work

Introduction

The arrangement of the questions on the form will make it easier to enter, complete, and retrieve information.

Group Data

Group related items with clearly defined sections to make the form easier to fill out. It can also eliminate the need for backtracking and reduces incomplete or missing data elements.

Databases may have separate data entry screens for

- Client Detail Identification
- Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), and/or
- Nutritional Risk Assessment

Establish Item Sequence

Arrange questions in a sequence that will match the structure of the database configuration. This will allow for easier data entry from one section to the next without having to search the form for the correct entry area.

Make Required Questions Clear

Make required data elements clear and visible. Design forms to clearly define form fields with bound boxes and headers.

What is Reviewed

CDA reviews AAA forms to ensure all required data collection elements are integrated. See Guidelines Chart.

Required Title III B, C, and D (Clusters I & II), Registered Client Fields

Chart Guidelines

Apply the following chart to determine if intake form(s) have required data collection and reporting elements for Title III B, C, and D (Clusters I and II) Programs. See **page 38** for Non-Registered fields.

CARS Title III B, C, and D (Clusters I and II) Required Registered Client Fields

Service Category	Service Units	Registered Client [1]	ADL & IADL [2]	Nutritional Risk [3]	Funding Source
Personal Care	**X** Hour	**X**	**X**		III B
Homemaker	**X** Hour	**X**	**X**		III B
Chore	**X** Hour	**X**	**X**		III B
Adult Day Care/Health	**X** Hour	**X**	**X**		III B
Case Management	**X** Hour	**X**	**X**		III B
Congregate Meals	**X** Meal	**X**		**X**	III C
Home-Delivered Meals	**X** Meal	**X**	**X**	**X**	III C
Nutritional Counseling	**X** Session per Participant	**X**		**X**	III C
Assisted Transportation	**X** One-way Trip	**X**			III B

(X) Required Element

[1] Registered Client
Required Client Level Detail

- Participant ID to Determine Unduplicated Count
- Birth Date
- Zip Code
- Rural Designation
- Gender
- Sex at Birth
- Sexual Orientation or Sexual Identity
- Race
- Ethnicity
- Poverty Status
- Living Arrangement

Continued on next page

Required Title III B, C, and D (Clusters I & II), Registered Client Fields, Continued

[2] ADL/IADL Required Functional Rating Scale for each of the following:

- ADL: Eating
- ADL: Bathing
- ADL: Toileting
- ADL: Transferring in/out of bed/chair
- ADL: Walking
- ADL: Dressing
- IADL: Meal Preparation
- IADL: Shopping
- IADL: Medication Management
- IADL: Money Management
- IADL: Using Telephone
- IADL: Heavy Housework
- IADL: Light Housework
- IADL: Transportation

ADL & IADL Functional Impairment Rating Scale

(1) Independent: Can perform a task without human assistance.
(2) Verbal Assistance: Requires verbal prompting to begin or complete a task.
(3) Some Human Help: Requires some physical assistance to perform a task.
(4) Lots of Human Help: Requires substantial assistance to perform a task.
(5) Dependent: Totally dependent on another person to perform a task.
(6) Declined to State
(0) Missing
Or as default, report only three levels: 1, 3, or 5 (and 6 – Declined to State).

[3] Nutritional Risk - Required Score

(1) Yes: High nutritional risk with score of 6 or higher.
(2) No: Nutritional score with 5 or lower.
(3) Declined to State
(0) Missing
Scores are based on the *Determine Your Nutritional Health* checklist.

Refer to CARS File Specifications for file reporting structure and optional data elements. Documents are at California Aging Reporting System (CARS)

Refer to Services Categories and Data Dictionary for category definitions.

Required Title III E, Registered Caregiver Fields (Group 1)

Chart Guidelines

Apply the following chart to determine if intake form(s) have the required data collection and reporting elements for the Title III E Family Caregiver Support Program (FCSP) **Caring for Elderly** and **Caring for Child**. See **page 39** for Non-Registered fields.

CARS Title III E, FCSP Caring for Elderly/Caring for Child, Required Registered Caregiver Fields

Caring for Elderly/Child Service Category	Service Units	Registered Caregiver [1]
Assessment	**X** Hour	**X**
Counseling	**X** Hour	**X**
Peer Counseling	**X** Hour	**X**
Support Group	**X** Hour	**X**
Training	**X** Hour	**X**
Case Management	**X** Hour	**X**
In-Home Supervision	**X** Hour	**X**
Homemaker Assistance	**X** Hour	**X**
In-Home Personal Care	**X** Hour	**X**
Home Chore	**X** Hour	**X**
Out-of-Home Day Care	**X** Hour	**X**
Out-of-Home Overnight Care	**X** Hour	**X**
Assistive Devices	**X** Device/Occurrence	**X**
Home Adaptations	**X** Modification/Occurrence	**X**
Registry	**X** Hour/Occurrence	**X**
Emergency Cash/Material Aid	**X** Assistance/Occurrence	**X**

(X) Required Element

[1] Registered Caregiver Required Client Level Detail

- Participant ID to Determine Unduplicated Count
- Birth Date
- Zip Code
- Rural Designation
- Gender
- Sex at Birth
- Sexual Orientation or Sexual Identity
- Race
- Ethnicity
- Poverty Status
- Living Arrangement
- Relationship Status
- Employment Status
- Caregiver Relationship

Refer to CARS File Specifications for file reporting structure and optional data elements. Documents are at California Aging Reporting System (CARS)

Refer to Services Categories and Data Dictionary for category definitions.

Required Title III E, Registered Care Receiver Fields (Group 1)

Chart Guidelines

Apply the following chart to determine if intake form(s) have required data collection and reporting elements for the Care Receiver in the Title III E, Family Caregiver Support Program (FCSP), **Caring for Elderly**.

CARS Title III E, FCSP Caring for Elderly, Required Registered Care Receiver Fields

Caring for Elderly Service Category	Registered Care Receiver [2]	ADL & IADL [3]
Assessment	**X**	**X**
Counseling	**X**	**X**
Peer Counseling	**X**	**X**
Support Group	**X**	**X**
Training	**X**	**X**
Case Management	**X**	**X**
In-Home Supervision	**X**	**X**
Homemaker Assistance	**X**	**X**
In-Home Personal Care	**X**	**X**
Home Chore	**X**	**X**
Out-of-Home Day Care	**X**	**X**
Out-of-Home Overnight Care	**X**	**X**
Assistive Devices	**X**	**X**
Home Adaptations	**X**	**X**
Registry	**X**	**X**
Emergency Cash/Material Aid	**X**	**X**

(X) Required Element

[2] Registered Care Receiver Required Client Level Detail

- Participant ID to Determine Unduplicated Count
- Birth Date
- Zip Code
- Rural Designation
- Gender
- Sex at Birth
- Sexual Orientation or Sexual Identity
- Race
- Ethnicity
- Poverty Status
- Living Arrangement
- Relationship Status

Continued on next page

Required Title III E, Registered Care Receiver Fields (Group 1), Continued

[3] ADL/IADL Required Functional Rating Scale for each of the following:

- ADL: Eating
- ADL: Bathing
- ADL: Toileting
- ADL: Transferring in/out of bed/chair
- ADL: Walking
- ADL: Dressing
- IADL: Meal Preparation
- IADL: Shopping
- IADL: Medication Management
- IADL: Money Management
- IADL: Using Telephone
- IADL: Heavy Housework
- IADL: Light Housework
- IADL: Transportation

ADL & IADL Functional Impairment Rating Scale

(1) Independent: Can perform a task without human assistance.
(2) Verbal Assistance: Requires verbal prompting to begin or complete a task.
(3) Some Human Help: Requires some physical assistance to perform a task.
(4) Lots of Human Help: Requires substantial assistance to perform a task.
(5) Dependent: Totally dependent on another person to perform a task.
(6) Declined to State
(0) Missing
Or as default, report only three levels: 1, 3, or 5 (and 6 – Declined to State).

Refer to CARS File Specifications for file reporting structure and optional data elements. Documents are at California Aging Reporting System (CARS)

Refer to Services Categories and Data Dictionary for category definitions.

Continued on next page

Required Title III E, Registered Care Receiver Fields (Group 1), Continued

Chart Guidelines

Apply the following chart to determine if intake form(s) have required data collection and reporting elements for the Care Receiver in the Title III E FCSP **Caring for Child**.

CARS Title III E, FCSP Caring for Child Required Registered Care Receiver Fields

Caring for Child Service Category	Registered Care Receiver [2]
Assessment (Supportive Services)	**X**
Counseling (Supportive Services)	**X**
Peer Counseling (Supportive Services)	**X**
Support Group (Supportive Services)	**X**
Training (Supportive Services)	**X**
Case Management (Supportive Services)	**X**
In-Home Supervision (Respite Care)	**X**
Homemaker Assistance (Respite Care)	**X**
In-Home Personal Care (Respite Care)	**X**
Home Chore (Respite Care)	**X**
Out-of-Home Day Care (Respite Care)	
Out-of-Home Overnight Care (Respite Care)	**X**
Assistive Devices (Supplemental Services)	**X**
Home Adaptations (Supplemental Services)	**X**
Registry (Supplemental Services)	**X**
Emergency Cash/Material Aid (Supplemental Services)	**X**

(X) Required Element

[2] Registered Care Receiver Required Client Level Detail

- Participant ID to Determine Unduplicated Count
- Birth Date
- Zip Code
- Rural Designation
- Gender
- Sex at Birth
- Sexual Orientation or Sexual Identity
- Race
- Ethnicity
- Poverty Status
- Living Arrangement
- Relationship Status

NOTE: *There are no ADL or IADL data collection requirements for Care Receivers in FCSP Caring for Child*

Refer to CARS File Specifications for file reporting structure and optional data elements. Documents are at California Aging Reporting System (CARS)

Refer to Services Categories and Data Dictionary for category definitions.

Required Registered Client Level Detail

Introduction

OAA programs use client demographic elements for targeting and/or reporting purposes. The required registered client level details are birth date, zip code, rural designation, gender, sex at birth, sexual orientation or gender identity, race, ethnicity, poverty status, and living arrangement.

Service Categories Required

The following are the programs that require collecting client level detail for registered clients, or FCSP caregivers *and* care receivers.

Title III B, C, and D, Supportive and Nutrition Services

- Personal Care
- Homemaker
- Chore
- Home-Delivered Meals
- Adult Day Care/Health
- Case Management
- Congregate Meals
- Nutritional Counseling
- Assisted Transportation

Title III E, FCSP Caregiver Caring for Elderly/Grandparent Caring for Child: Caregiver & Care Receiver

SUPPLEMENTAL SERVICES

- Assessment
- Counseling
- Peer Counseling
- Support Group
- Training
- Case Management
- Material Aid

RESPITE CARE

- In-Home Supervision
- Homemaker Assistance
- In-Home Personal Care
- Home Chore
- Out-of-Home Day Care
- Out-of-Home Overnight Care

SUPPLEMENTAL SERVICES

- Assistive Devices
- Home Adaptations
- Registry
- Emergency Cash/

Continued on next page

Required Registered Client Level Detail, Continued

What is Reviewed

CDA reviews registered client level details for completeness. The client's information is self-reported and collected annually. If a client declines to provide information, document the action. Service **cannot** be denied to eligible clients declining to provide information.

All the listed data elements, except for birth date, include a "Declined to State" option which is calculated separately from "missing" information. Missing information occurs when a client is not asked to identify the required demographic data element or information was not entered into the AAA database.

Birthday

Collect the month (##), day (##), and year (####) of birth.

Elements Zip Code

Zip Code can be collected as ##### or ##### - ####.

Sexual Orientation and Gender Identity (SOGI)

The following lists contain the various options available to report SOGI data to CARS:

GENDER CARS OPTIONS

- Male
- Female
- Transgender Female to Male
- Transgender Male to Female
- Genderqueer/ Gender Non-binary
- Not listed. Please specify: _____
- Declined to State
- Missing

SEX AT BIRTH CARS OPTIONS

- Male
- Female
- Declined to State
- Missing

SEXUAL ORIENTATION OR SEXUAL IDENTITY CARS OPTIONS

- Straight/ Heterosexual
- Bisexual
- Gay/ Lesbian/ Same-Gender Loving
- Questioning/ Unsure
- Not listed. Please specify: _____
- Declined to State
- Missing

Continued on next page

Required Registered Client Level Detail, Continued

Rural Designation

According to the Census, a rural area encompasses all population, housing, and territory not included in an urban area. Often a client may not know how to declare their rural designation. A rural designation may be applied on behalf of the client. If applied, make sure areas, such as zip codes, are documented in AAA procedures.

To find Census information of rural and urban areas by zip code visit the Census Bureau's Urban and Rural Classification.

Rural CARS Options

- Rural
- Urban
- Declined to State
- Missing

Race

The following reflects the Office of Management and Budget's (OMB) reporting requirement for collecting race, and California's Government Code Section 8310.5 reporting requirement for collecting different Asian and Native Hawaiian/Other Pacific Islander groups.

Race CARS Options

- White
- American Indian or Alaska Native
- Black or African American
- Other Race
- Multiple Race
- Chinese
- Japanese
- Filipino
- Korean
- Vietnamese
- Asian Indian
- Laotian
- Cambodian
- Other Asian
- Guamanian
- Hawaiian
- Samoan
- Other Pacific Islander
- Declined to State
- Missing

Continued on next page

Required Registered Client Level Detail, Continued

Ethnicity

The following reflects the OMB's ethnicity reporting requirement. Hispanic or Latino origin is a **separate question from the race category**.

Ethnicity CARS Options

- Not Hispanic/Latino
- Hispanic/Latino
- Declined to State
- Missing

Living Arrangement

ACL defines "living alone" as a one-person household (using the Census definition of household) where the householder lives by his or herself in an owned or rented place of residence in a non-institutional setting.

Living Arrangement CARS Options

- Alone
- Not Alone
- Declined to State
- Missing

Continued on next page

Required Registered Client Level Detail, Continued

Unique Participant ID

ACL requires that State Units on Aging (SUA) report the total unduplicated clients who were served in registered services. The most accurate method to avoid duplicating information is by assigning a unique participant identifier to a client (generally, each AAA data management system creates this identifier once the minimum data elements are entered into the system). All services received by the client can be tracked by tying them to the client's unique participant identifier.

When developing a unique identification number, AAAs must ensure that personal, sensitive, and confidential information is protected from inappropriate or unauthorized access or disclosure. AAAs must have written confidentiality procedures to ensure that no personal information is disclosed by the AAA or provider without informed consent of the client.

OAA services cannot be denied to eligible clients if they do not wish to disclose their information.

The unique "Participant ID" must be collected as an integer.

Termination Date

This is the date on which the participant stopped receiving a service.

This date must be collected as YYYY-MM-DD.

Termination Reason

This field identifies the reason for terminating services (i.e., deactivating a client).

Reason for Deactivation CARS Options

- Deceased
- No Longer MSSP Eligible
- Moved out of Service Area
- Won't Follow Care Plan
- No Longer Desires Services
- On Hold
- No Longer SNF Certifiable
- Service No Longer Needed
- No Longer Medi-Cal Eligible
- Past Active
- Institutionalization
- On Waiting List
- High Cost of Services
- Other Reason

Federal Poverty Determination

Introduction

While the OAA is concerned with the provision of services to all older persons, it requires assurance that preference is given to older individuals with greatest economic or social need, with particular attention to low-income minority individuals.

Under the OAA, "greatest economic need" means the need resulting from an income level at or below poverty levels established by OMB.

ACL uses the Federal Poverty Guidelines for targeting and reporting.

Service Categories Required

The following are the programs that require collecting that require collecting poverty status for registered clients, or FCSP caregivers *and* care receivers.

Title III B, C, and D, Supportive and Nutrition Services

- Personal Care
- Homemaker
- Chore
- Home-Delivered Meals
- Adult Day Care/Health
- Case Management
- Congregate Meals
- Nutritional Counseling
- Assisted Transportation

Title III E, FCSP Caregiver Caring for Elderly/Grandparent Caring for Child (Caregiver and Care Receiver)

SUPPORTIVE SERVICES

- Assessment
- Counseling
- Peer Counseling
- Support Group
- Training
- Case Management

RESPITE CARE

- In-Home Supervision
- Homemaker Assistance
- In-Home Personal Care
- Home Chore
- Out-of-Home Day Care
- Out-of-Home Overnight Care

SUPPLEMENTAL SERVICES

- Assistive Devices
- Home Adaptations
- Registry
- Emergency Cash/Material Aid

Continued on next page

Federal Poverty Determination, Continued

What to Include

Create a question to determine if the client, caregiver, or care receiver is at or below 100 percent of the federal poverty level.

Information is self-reported and collected annually.

What is Reviewed

CDA will review demographic data to determine if AAAs are reaching individuals who are at or below the federal poverty line.

Use one of the examples below or create one. If the form does not list the federal poverty amounts, include an instructional sheet.

Example 1
☐ At or Below FPL *(Low Income)*
☐ Above FPL
☐ Declined to State

Example 2
Total # Living in Household: ___
Approx. Monthly Gross Income: $___
☐ Declined to State

Example 3
# of Household Members (Circle One) **1 2 3 4 5 6 7 8+**
What is Your Approximate Household Income? $___ Per Month/ Per Year
☐ Declined to State

Example 4
☐ Living Alone: Less than $#,### Per Month
☐ Two Person Household: Less than $#,### Per Month
☐ Other
☐ Declined to State

Resources

The U.S. Department of Health and Human Services (HHS) updates information periodically. The Federal Register Poverty Guidelines are normally published in late January each year.

2018 HHS Federal Poverty Guidelines

HSS Poverty Guidelines and Federal Register References

Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Functional Impairment Status

Introduction

OAA programs use the Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) functional impairment scale to identify individuals with functional limitations. AAAs must also review functional limitations to determine eligibility for the provision of FCSP Caring for Elderly Respite Care and Supplemental Services.

The OAA preference is to give services to older individuals with greatest social need. The term "greatest social need" means the need caused by non-economic factors that include

(A) physical and mental disabilities
(B) language barriers
(C) cultural, social, or geographical isolation, including isolation caused by racial or ethnic status that
  (i) restricts an individuals' ability to perform normal daily tasks
  (ii) threatens such individuals' capacity to live independently

ACL uses ADL and IADL characteristics for targeting frail older individuals and reporting purposes.

Service Categories Required

The table below lists the programs that require ADL and IADL limitation status for registered clients.

Title III B and C-2, Supportive and Nutrition Services

- Personal Care
- Homemaker
- Chore
- Home-Delivered Meals
- Adult Day Care/Health
- Case Management

Continued on next page

ADL and IADL Functional Impairment Status, Continued

Service Categories Required, Continued

The table below lists the programs that require ADL and IADL limitation status for registered care receivers in the FCSP Caring for Elderly.

Title III E, FCSP Caregiver Caring for Elderly (Care Receiver)

SUPPORTIVE SERVICES	*RESPITE CARE*	*SUPPLEMENTAL SERVICES*
• Assessment	• In-Home Supervision	• Assistive Devices
• Counseling	• Homemaker Assistance	• Home Adaptations
• Peer Counseling	• In-Home Personal Care	• Registry
• Support Group	• Home Chore	• Emergency Cash/Material Aid
• Training	• Out-of-Home Day Care	
• Case Management	• Out-of-Home Overnight Care	

What to Include

Create six (6) ADL and eight (8) IADL questions with the functional ability rating scale to determine the impairment level of the applicant or client.

Information is self-reported and collected annually. Conduct reassessment as needed, based on changes in the client's status within the year.

***NOTE**: Arrange questions to match database entry sequence.*

Continued on next page

ADL and IADL Functional Impairment Status, Continued

How to Determine Score

ACL defines "impairment in Activities of Daily Living (ADL)" as the inability to perform one or more of the following six activities of daily living without personal assistance, stand-by assistance, supervision or cues: eating, dressing, bathing, toileting, transferring in and out of bed/chair, and walking.

ACL defines "impairment in Instrumental Activities of Daily Living (IADL)" as the inability to perform one or more of the following eight instrumental activities of daily living without personal assistance, or stand-by assistance, supervision or cues: preparing meals, shopping for personal items, medication management, managing money, using the telephone, doing heavy housework, doing light housework, and transportation ability (transportation ability refers to the individual's ability to make use of available transportation without assistance).

The ADL and IADL functional ability rating scale is applied to each question. The CARS system will count the number of ADLs and IADLs where verbal or human assistance is required. An applicant's or client's sum determines the overall level of functional impairment.

- If the Combined Total Number of ADLs & IADLs is **0**
  Then Client is **independent, has no functional limitations.**
- If the Combined Total Number of ADLs & IADLs is **1-2**
  Then Client is **frail, has minimal or mild functional impairments.**
- If the Combined Total Number of ADLs & IADLs is **3 or greater**
  Then Client is **severely disabled and vulnerable to loss of independence.**

To learn more about the data processing and output reports for ADLs and IADLs see the **CARS Overview and Guidance Appendix C**

What is Reviewed

CDA will review demographic data to determine if the AAA is reaching individuals who are functionally impaired.

To qualify for Title III E, FCSP Caring for Elderly Respite Care and Supplemental Services care receivers must have two or more ADL limitations or a cognitive impairment.

Continued on next page

ADL and IADL Functional Impairment Status, Continued

Example 1:

Displays descriptive questions with ADL and IADL examples.

ADLs and IADLs - How would you rate your ability to perform the following daily activities?

1=No Assistance Needs, 2=Requires Verbal Assistance, 3=Some Human Help, 4=Lots of Human Help, 5=Cannot Do It At All

ACTIVITIES OF DAILY LIVING (RATE 1-5)

Can you manage eating without any help? ____
Can you bathe or shower without any help? ____
Can you use the toilet without any help? ____
Can you get in and out of bed or chair without any help? ____
Can you walk around inside without any help? ____
Can you dress without any help? ____

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (RATE 1-5)

Can you prepare meals for yourself without help? ____
Can you shop for food and other things you need without help? ____
Can you take your medications without help? ____
Can you handle your own money, like keeping track of bills without help? ____
Can you answer the telephone or make a phone call without help? ____
Can you do heavy housecleaning, like yard work and laundry, without any help? ____
Can you do light housekeeping, like dusting or sweeping, without help? ____
Can you use public transportation or drive beyond walking distances without help? ____
Notes: _____

☐ Declined to State

Example 2:

Displays a list of the ADLs and IADLs. Staff may provide description information.

ADLs and IADLs (Activities of Daily Living and Instrumental Activities of Daily Living)

Please rate your functional abilities for the following activities.
RATING SCALE: 1 = Independent, 2 = Verbal Assistance, 3 = Some Human Help, 4 = Lots of Human Help, 5 = Dependent, 6 = Declined to State

ADLs	***IADLs***
Eating_____	Meal Preparation_____
Dressing_____	Shopping_____
Bathing_____	Medication Management_____
Transferring_____	Money Management_____
In/Out of Chair_____	Using Telephone_____
Walking_____	Transportation_____
Toileting_____	Light Housework_____
	Heavy Housework_____

Notes: _____

Continued on next page

ADL and IADL Functional Impairment Status, Continued

Example 3:

Displays all 5 functional ability rating scale options plus "Declined to State." Staff may provide descriptive information.

Client ADL and IADL
(Activities of Daily Living and Instrumental Activities of Daily Living – Annual Assessment)
Please check level of functional ability.

ADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
Eating						
Bathing						
Toileting						
Transferring In/ Out of Bed/ Chair						
Walking						
Dressing						

Notes: _____

IADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
Meal Preparation						
Shopping						
Medication Management						
Money Management						
Using Telephone						
Heavy Housework						
Light Housework						
Transportation						

Notes: _____

Continued on next page

ADL and IADL Functional Impairment Status, Continued

Example 4:

Displays the minimum functional ability 3-option rating scale plus "Decline to State."

Activities of Daily Living (ADL):
Circle One For Each
1=No Assistance, 3=Some Human Help, 5=Cannot Perform (Dependent),

Eating	1	3	5
Bathing	1	3	5
Toileting	1	3	5
Transferring In/ Out of Bed/ Chair	1	3	5
Walking	1	3	5
Dressing	1	3	5

☐ Declined to State

Instrumental of Daily Living (IADL):
Circle One For Each
1=No Assistance, 3=Some Human Help, 5=Cannot Perform (Dependent)

Meal Preparation	1	3	5
Shopping	1	3	5
Medication Management	1	3	5
Money Management	1	3	5
Using Telephone	1	3	5
Heavy Housework	1	3	5
Light Housework	1	3	5
Transportation	1	3	5

☐ Declined to State

Example 5:

Displays ADL and IADLs with descriptive functional ability rating scales.

ADLs and IADLs (Activities of Daily Living and Instrumental Activities of Daily Living)
Please rate your functional ability for the following activities.

Client/Elderly Care Receiver Activities of Daily Living (ADL) Fields

Eating(Rated Level_____)
Reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth, chewing, swallowing food and liquids, manipulating food on plate. Cleaning face and hands as necessary following a meal.

(1) Independent (able to feed self)
(2) Verbal assistance (able to feed self but needs verbal assistance such as reminding or encouragement to eat)
(3) Some human help (assistance needed during meal, e.g., to apply assistive device, get beverage or push more food to within reach, etc., but constant presence of another person not required)
(4) Lots of human help (able to feed self but cannot hold utensils, cups, glasses, etc., constant presence of another person is required)
(5) Dependent (unable to feed self at all)

Continued on next page

ADL and IADL Functional Impairment Status, Continued

Example 5, Continued

Bathing(Rated Level_____)
Bathing means cleaning the body using a tub, shower, or sponge bath including getting a basin of water, managing faucets, getting in and out of a tub, reaching head and body parts for soaping, rinsing, and drying.
(1) Independent (able to bathe self safely)
(2) Verbal assistance (able to bathe self with direction or intermittent monitoring; may need reminding to maintain personal hygiene)
(3) Some human help (generally able to bathe self, but needs assistance)
(4) Lots of human help (requires direct assistance with most aspects of bathing; would be at risk if left alone)
(5) Dependent (totally dependent on others for bathing)

Toileting (Rated Level_____)
Able to move to and from, on and off toilet or commode, empty commode, manage clothing and wipe and clean body after toileting, use and empty bedpans, ostomy and/or catheter receptacles and urinals, apply diapers and disposable barrier pads. Menstrual care: able to apply external sanitary napkin and clean body.
(1) Independent (no assistance needed)
(2) Verbal assistance (requires reminding and direction only)
(3) Some human help (requires minimal assistance with some activities, but the constant presence of the provider is not necessary)
(4) Lots of human help (unable to carry out most activities without assistance)
(5) Dependent (requires physical assistance in all areas of care)

Transferring In/Out of Bed/Chair (Rated Level_____)
Moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or repositioning to prevent skin breakdown.
(1) Independent (able to do all transfers safely)
(2) Verbal assistance (able to transfer but needs encouragement or direction)
(3) Some human help (requires some help from another person; e.g., routinely requires a boost or assistance with positioning)
(4) Lots of human help (unable to complete most transfers without physical assistance; would be at risk if unassisted)
(5) Dependent (totally dependent upon another person for all transfers)

Continued on next page

ADL and IADL Functional Impairment Status, Continued

Example 5, Continued

Walking(Rated Level_____)
Walking or moving inside, moving from one area of indoor space to another without necessity of handrails. Can respond adequately to the presence of obstacles that must be stepped around. Includes ability to go from inside to outside and back.

(1) Independent (no assistance needed)
(2) Verbal assistance (able to walk or move with encouragement, or reminders to watch for steps, or to use a cane or walker)
(3) Some human help (requires minimal assistance from another person to negotiate a wheelchair or to steady the person or guide them in the desired direction)
(4) Lots of human help (requires constant attention from another person, at risk of being lost or unsafe if not accompanied)
(5) Dependent (totally dependent upon another person, must be carried, lifted, or pushed in a wheelchair or on a gurney at all times)

Dressing (Rated Level_____)
Putting on and taking off, fastening and unfastening garments and undergarments, special devices such as back braces, corsets, elastic stockings/garments and artificial limbs or splints.

(1) Independent (able to put on, fasten and remove all clothing and devices without assistance; clothes self appropriately for health and safety)
(2) Verbal assistance (able to dress self, but requires reminding or directions with clothing selection)
(3) Some human help (unable to dress self completely, without the help of another person, e.g., tying shoes, buttoning, zipping, putting on hose or brace, etc.)
(4) Lots of human help (unable to put on most clothing items by self; without assistance would be inappropriately or inadequately clothed)
(5) Dependent (unable to dress self at all)

Continued on next page

ADL and IADL Functional Impairment Status, Continued

Example 5, Continued

Client/Elderly Care Receiver Instrumental Activities of Daily Living (IADL) Fields

Meal Preparation (Rated Level_____)
Planning menus. Washing, peeling, slicing vegetables, opening packages, cans, and bags, mixing ingredients, lifting pots and pans, re-heating food, cooking, safely operating stove, setting the table, serving the meal, cutting food into bite-sized pieces. Washing, drying, and putting away the dishes.

(1) Independent (no assistance needed)
(2) Verbal assistance (needs only reminding or guidance in menu planning, meal preparation, and/or cleanup)
(3) Some human help (requires another person to prepare and clean up main meals on less than a daily basis; e.g., can reheat food prepared by someone else, can prepare simple meals and/or needs help with cleanup on a less than daily basis)
(4) Lots of human help (requires another person to prepare and clean up main meal(s) on a daily basis)
(5) Dependent (totally dependent upon another person to prepare and clean up all meals)

Shopping (Rated Level_____)
Compile list, bending, reaching, and lifting, managing cart, or basket, identifying items needed, transferring items to home, putting items away, ordering prescriptions over the phone and picking them up, and buying clothing.

(1) Independent (can perform all tasks without assistance)
(2) Verbal assistance (able to perform tasks, but needs only reminding or direction, guidance or reminder)
(3) Some human help (requires the help of another person for some tasks while shopping such as reaching and carrying items)
(4) Lots of human help (unable to carry out most activities without assistance)
(5) Dependent (unable to perform any tasks for self)

Medication Management (Rated Level_____)
Physically and mentally able to identify, organize, schedule, handle, and consume (inject, instill or insert) the correct amount of the prescribed medication at the specified time according to a doctor's prescription.

(1) Independent (can identify, measure, organize, and self-administer prescribed medication)
(2) Verbal assistance (able to perform tasks but needs verbal direction, guidance or reminder to do it, without risk to safety)
(3) Some human help (requires some human help such as scheduling medications, opening the container, measuring the amount of medication)
(4) Lots of human help (cannot perform some parts of this function; may require some human help with installing or injecting multiple medications)
(5) Dependent (cannot perform any part of this function)

Continued on next page

ADL and IADL Functional Impairment Status, Continued

Example 5, Continued

Money Management (Rated Level_____)
Physically and mentally handles the receipt of monies, expenditures, and receipt and payment of bills in a timely and primarily correct manner.
(1) Independent (handles all financial matters)
(2) Verbal assistance (is able to perform all financial transactions but may need to be reminded to pay bills or obtain cash from bank)
(3) Some human help (for either physical or mental reasons may need assistance in doing banking, writing checks, etc.)
(4) Lots of human help (unable to carry out most activities without assistance)
(5) Dependent (unable to attend to any part of the necessary financial transactions to receive and disburse funds to meet daily needs)

Using Telephone (Rated Level_____)
Obtains number, dials, handles receiver, can speak and hear response, and terminates call, may include use of instrument with loudspeaker or hearing devices. Able to use telephone during emergency situations to call 911 or other help.
(1) Independent (can obtain and dial number without assistance)
(2) Verbal assistance (needs only reminder on how to use the phone)
(3) Some human help (needs human assistance to obtain number or dial)
(4) Lots of human help (currently not defined)
(5) Dependent (unable to use phone at all)

Heavy Housework (Rated Level_____)
Cleaning oven and stove, cleaning and defrosting refrigerator, moving light furniture to clean under and behind, vacuuming upholstery and under cushions, providing deep cleaning activities such as washing and cleaning baseboards, window tracks, cabinets, doors, drapes/blinds, etc.
(1) Independent (able to perform all domestic chores)
(2) Verbal Assistance (able to perform domestic chores but needs direction)
(3) Some human help (requires physical assistance from another person for some domestic chores)
(4) Lots of human help (unable to carry out most domestic chores without assistance)
(5) Dependent (totally dependent upon others for all domestic chores)

Continued on next page

ADL and IADL Functional Impairment Status, Continued

Example 5, Continued

Light Housework (Rated Level_____)
Sweeping, vacuuming, mopping floors, washing kitchen counters and sinks, cleaning bathroom, taking out garbage, dusting and picking up.
(1) Independent (able to perform all light domestic chores)
(2) Verbal assistance (able to perform domestic chores but needs direction)
(3) Some human help (requires physical assistance from another person for some domestic chores)
(4) Lots of human help (unable to carry out most domestic chores without assistance)
(5) Dependent (totally dependent upon others for all domestic chores)

Transportation (Rated Level_____)
Using private or public vehicles, cars, buses, trains, or other forms of transportation to get to medical appointments, purchase food, shop, pay bills, or arrange for services, to socialize and participate in entertainment or religious activities. Can arrange for getting and using public transportation; or get to, enter and operate a private vehicle.
(1) Independent (can arrange, get to, enter and travel in public or private vehicles)
(2) Verbal assistance (can use public transportation or ride in a private vehicle when reminded to make arrangements)
(3) Some human help (requires physical assistance to make transportation arrangements; i.e., calling, writing instructions about time and place, can ride with others if assisted into and out of the vehicle)
(4) Lots of human help (unable to carry out most activities without assistance)
(5) Dependent (unable to travel at all by self)

☐ Check if Declined to State ADL and IADL Functional Abilities

Resources

The OAA defines "frail" as an older individual that is functionally impaired because the individual "is unable to perform at least two ADLs without substantial human assistance, including verbal reminding, physical cueing, or supervision; or due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another person." (Section 102(a) (22)).

Nutritional Risk Assessment

Introduction

Title III C Congregate and Home-Delivered Meal programs are required to perform a nutrition risk screening to identify individuals at high nutrition risk or at risk for malnutrition. NAPIS reporting requirements define a person at high nutrition risk as one who scores six or higher on the Determine Your Nutritional Risk Checklist (hereafter referred to as the "DETERMINE Checklist") published by the Nutrition Screening Initiative (NSI).

Service Categories Required

The following programs require collecting the nutritional risk scores for registered clients.

- Home-Delivered Meals
- Congregate Meals
- Nutritional Counseling

What to Include

Title III C nutrition programs shall only use the DETERMINE Checklist to evaluate the client's nutrition risk score.

The nutrition risk questionnaire must be filled out at initial intake or registration along with other client information then reported through the data collection system. After initial intake/registration, annually update and report nutrition risk information and other basic client data.

How to Determine Score

Each question has a weighted point value. The sum total determines the reported nutritional risk score.

- If score is **0-2** Then client is **not at risk**
- If score is **3-5** Then client is **at moderate nutritional risk**
- If score is **6 or greater** Then client is **at high nutritional risk**

Continued on next page

Nutritional Risk Assessment, Continued

What is Reviewed

CDA will review data to determine if the AAA is serving individuals at high nutritional risk. CDA bases its target ranges on statewide analysis of the average number of participants at high nutritional risk. Target percentages may be adjusted on an annual basis.

Program	Target Percentage of all reported participants
For the Congregate Meals (C-1)	21% or higher at nutritional risk
Home-Delivered Meals (C-2)	65% or higher at nutritional risk

DETERMINE Checklist

The following is the DETERMINE Checklist with weighted/scored values. The interviewer may need to provide additional clarification.

Determine Your Nutritional Health	Circle if 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 2 meals per day.	**3**
I eat few fruits or vegetables or milk products.	**2**
I have 3 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 3 or more different prescribed or over-the-counter drugs a day.	**1**
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	**2**
I am not always physically able to shop, cook and/or feed myself.	**2**
Total Score: (If equal to or greater than 6, the client is at high nutritional risk)	
Declined to State	

Continued on next page

Optional Client Level Detail

Introduction

There may be other questions added to provide more helpful client information. Some common ones are listed below. These are **not** required CARS elements and must **not** be reported in CARS.

Assessment Type

Assessment types (may be helpful) are as follows:

- New Client
- Annual Reassessment
- Significant Change in Condition

Office Notes

Identification of intake/ assessment date and the staff reviewing the information is useful.

Contact Information

To assign a unique identification number to each participant, data management systems may use any combination of name, address, phone number, or the last four digits of the participant's Social Security Number for record identification. This avoids duplicating information by recording client level detail for each participant and will enable tracking the client's services by provider and program.

- First Name:
- Middle Name:
- Last Name:
- Other name(s):
- Home Address:
- City:
- Mailing if Different:
- Telephone Number:
- Cell Number:
- Email Address:

Social Security Number

The last four digits of the Social Security Number (SSN) may be useful in developing a unique participant identification number. If used, AAAs must ensure that this number is protected from inappropriate or unauthorized access or disclosure. AAAs cannot deny OAA services to eligible clients if they do not wish to disclose their information.

Last 4 Digits Social Security #:*(Optional)* __ __ __ __

Continued on next page

Optional Client Level Detail, Continued

Living Arrangement

This section can help to identify the following client living arrangements:

- ☐ Lives Alone,
- ☐ Lives W/ Spouse,
- ☐ Lives W/ Child,
- ☐ Lives W/ Relative,
- ☐ Lives W/ Other(s),
- ☐ Senior Apartment, Specify: _____

Source of Support

This section can help to identify the following various types of caregiving support:

- ☐ Family
- ☐ Friend/ Neighbor
- ☐ Paid Help
- ☐ Unsure
- ☐ None

LGBT

The Lesbian, Gay, Bisexual, and Transgender (LGBT) Disparities Reduction Act of 2016 (Chiu, Chapter 565, Statutes of 2015) requires CDA to begin collecting voluntarily self-identified information about Sexual Orientation and Gender Identity (SOGI) no later than July 1, 2018. This will require the 33 AAAs to update their perspective data management systems to collect the required SOGI data and submit it to CDA as part of their regular data submission process.

Each AAA shall ensure all older adults have equal access to programs and services, regardless of gender identity and sexual orientation. California law requires each AAA to include the needs of LGBT seniors in their needs assessment and area plans.

To determine if the LGBT population is being reached, adapt local data system to collect this information. The following questions will be included in CARS by July 1, 2018 to report the client's sexual orientation, sexual identity, and/or gender expression.

GENDER

- ☐ Male
- ☐ Female
- ☐ Transgender Female to Male
- ☐ Transgender Male to Female
- ☐ Genderqueer/ Gender non-binary
- ☐ Not listed. Please specify: _____
- ☐ Declined to State

SEX AT BIRTH

- ☐ Male
- ☐ Female
- ☐ Declined to State

SEXUAL ORIENTATION OR SEXUAL IDENTITY

- ☐ Straight/ Heterosexual
- ☐ Bisexual
- ☐ Gay/ Lesbian/ Same-Gender Loving
- ☐ Questioning/Unsure
- ☐ Not listed. Please specify: _____
- ☐ Declined to State

Continued on next page

Optional Client Level Detail, Continued

Transportation Services

The following options can help to identify type(s) of transportation assistance needed:

- ☐ Walks with No Assistance (Non-Assisted)
- ☐ Walks with Assistance (Assisted)
- ☐ Wheelchair ramp/lift

Other Characteristics

The following options can help to identify if other conditions or assistance are needed.

CHECK AIDS CURRENTLY USED:

- ☐ Cane
- ☐ Glasses/ Contacts
- ☐ Hearing Aid
- ☐ Oxygen
- ☐ Pacemaker
- ☐ TTY Phone
- ☐ Walker
- ☐ Wheelchair
- ☐ Other:

ABILITY TO SPEAK ENGLISH:

- ☐ Speaks English
- ☐ Non-English Language:_____
- ☐ Need Interpreter

DO YOU RECEIVE HELP FROM OTHER ORGANIZATION(S)?

- ☐ Yes
- ☐ No
- ☐ If so, which one(s):_____

Emergency Identification

This section can allow the client to designate a contact person to call during or after an emergency event:

Emergency Contact Person Name:
Address:
Relationship to Client:
Telephone number (___) ___-_____

Continued on next page

Optional Client Level Detail, Continued

Disaster Registry

In case of an emergency declaration, the following identification can help build a Disaster Registry to identify those high-risk clients that may need evacuation assistance.

A client is considered High Risk under Emergency Declaration if any of the following exists. *Check all that apply.*

- ☐ Housebound seniors and people with physical disabilities that DO NOT have an existing network of support
- ☐ Significant mobility, vision, or hearing impairment
- ☐ Elderly or medically fragile
- ☐ Disabling mental illness or developmental disability
- ☐ Requires refrigeration of medication and/or is insulin dependent
- ☐ Reliance on life-support, oxygen, or dialysis
- ☐ Not Applicable

Eligibility for Title III B

To determine eligibility for Supportive Services (Title III B) the following question can be asked: Are you age 60 or over?

- ☐ Yes
- ☐ No

Continued on next page

Optional Client Level Detail, Continued

Eligibility for Title III C-1 & C-2

To determine eligibility for Congregate Meals (Title III C-1) and Home-Delivered Meals (Title III C-2) the following questions can be asked.

QUESTIONS FOR THE CONGREGATE MEALS (C-1) ELIGIBILITY:

- ☐ Are you over 60?
- ☐ Are you the spouse or domestic partner of an **Elderly Nutrition Program (**ENP) participant who is over the age of 60?
- ☐ Are you a person with a disability, who resides in housing where the congregate site is located?
- ☐ Are you a person with a disability who resides with and accompanies an ENP participant?
- ☐ Are you a volunteer under the age of 60? (May have a meal if it does not deprive a senior of a meal.)

QUESTIONS FOR HOME-DELIVERED MEALS (C-2) ELIGIBILITY:

- ☐ Are you homebound due to an illness, disability, or isolation?
- ☐ Are you a spouse of a person who is homebound?
- ☐ Are you an individual with a disability who resides with a homebound meal recipient?

QUESTIONS TO DETERMINE EQUIPMENT CONDITIONS AND CLIENT ABILITIES:

- ☐ Does the client have any dietary restrictions?
- ☐ Does the client have a working refrigerator?
- ☐ Does the client have a working microwave?
- ☐ Is client physically and mentally able to open the food containers?
- ☐ Is client physically and mentally able to reheat a meal?
- ☐ Are there pets inside or outside the home?

Continued on next page

Optional Client Level Detail, Continued

Eligibility for Title III E

To determine eligibility for Title III E, FCSP Caregivers Caring for Elderly or Grandparents Caring for a Child, the following questions
may be asked.

CAREGIVER CARING FOR ELDERLY ELIGIBILITY CRITERIA

1. Is the **Care Receiver** an older individual (60 years of age or older) ***or*** an individual (of any age) with Alzheimer's disease or related disorder with neurological and organic brain dysfunction?
   ☐ Yes ☐ No

2. Is the **Caregiver** an adult (18 years of age or older) family member or another individual (e.g., friend or neighbor) who is an informal (i.e., unpaid) provider of in-home or community care to an "elderly" Care Receiver?
   ☐ Yes ☐ No

If answered "yes" to both questions above, the individual is qualified for "Family Caregiver Caring for Elderly." If requesting "Respite Care" or "Supplemental Services," the Care Receiver must also have two or more ADL deficiencies or a cognitive impairment.

GRANDPARENT/OLDER INDIVIDUALS CARING FOR CHILD ELIGIBILITY CRITERIA

1. Is the **Care Receiver** an individual who is **not** more than 18 years of age ***or*** who is an individual (of any age) with a disability?
   ☐ Yes ☐ No

2. In the case of a **caregiver for a child**, is the Caregiver a grandparent, step-grandparent, or other older relative by blood, marriage, or adoption who is 55 years of age or older, living with the child, and identified as the primary caregiver through a legal or informal arrangement? Biological and adoptive parents are excluded.
   ☐ Yes ☐ No

3. In the case of a **caregiver for an individual with a disability**, is the Caregiver a parent, grandparent, or other relative by blood, marriage, or adoption who is 55 years of age or older, and living with the individual with a disability?
   ☐ Yes ☐ No

If answered "yes" to either questions 1 and 2 ***or*** *1 and 3 above, the individual is qualified for "Grandparent/Older Caregiver Caring for Child."*
If the Care Receiver does not meet any of the criteria above, the Caregiver is ineligible to receive FCSP services, but may qualify to receive other services provided by the AAA.

Continued on next page

Optional Client Level Detail, Continued

Resources to Determine Eligibility

The following links are to reference documents for the Title III E, Family Caregiver Support Program.

CDA Statistical Fact Sheets and Program Narratives
Provide information on the program purpose, eligibility requirements, and history.

CDA Service Categories Data Dictionary
Provides category definitions.

Required Title III B, C, D and VII B (Cluster III), Non-Registered Client Fields

Introduction

Some OAA programs do **not** require collecting any client-level demographic information. These programs target groups or provide sensitive services that may make client-level data collection difficult.

What to Include

Report estimated total clients/audience by each service category for each quarter.

AAAs will be required to report at least:

- Legal Assistance
- Nutritional Education
- Information and Assistance
- Disease Prevention and Health Promotion
- Elder Abuse Prevention, and
- Other NAPIS Services

There are no required client fields in non-registered services. It is **optional** for AAAs to collect this information based on the guidelines described in the required client fields for Registered Services.

What is Reviewed

CDA reviews the estimated enrollments and service units on a quarterly and annual basis.

Continued on next page

Required Title III B, C, D and VII B (Cluster III), Non-Registered Client Fields, Continued

Chart Guidelines

Apply the following chart to determine if form(s) or records have the required data collection and reporting elements for Title III B, C, D, and VII B Non-Registered services.

CARS - Required Title III B, C, D, and VII Non-Registered Fields

Service Category	Service Units	Estimated Clients/ Audience	Funding Source
Transportation	**X** One-way Trip	**X**	III B
Legal Assistance[1]	**X** Hour	**X**	III B
Nutritional Education[1]	**X** Session per Participant	**X**	III C
Information and Assistance[1]	**X** Contact	**X**	III B
Outreach	**X** Contact	**X**	III B
Health Promotion[1]	**X** Contact	**X**	III D
Alzheimer's Day Care Services ("Other" NAPIS Services)	**X** Day of Attendance	**X**	III B
Cash/Material Aid ("Other" NAPIS Services)	**X** Assistance	**X**	III B
Community Education ("Other" NAPIS Services)	**X** Activity	**X**	III B
Comprehensive Assessment	**X** Hour	**X**	III B
Disaster Preparedness Materials ("Other" NAPIS Services)	**X** Product	**X**	III B
Elder Abuse Prevention, Education and Training [1] ("Other" NAPIS Services)	**X** Session	**X**	VII
Elder Abuse Prevention Educational Materials[1] ("Other" NAPIS Services)	**X** Product	**X**	VII
Employment ("Other" NAPIS Services)	**X** Activity	**X**	III B

(X) Required Element

[1]Required service categories. Elder Abuse Prevention requires at least one reported service category.

Refer to CARS File Specifications for file reporting structure and optional data elements. Documents are at California Aging Reporting System (CARS)

Refer to Services Categories and Data Dictionary for category definitions.

Continued on next page

Required Title III B, C, D and VII B (Cluster III), Non-Registered Client Fields, Continued

CARS Required Title III B, C, D, and VII Non-Registered Fields, Continued

Service Category	Service Units	Estimated Clients/ Audience	Funding Source
Health ("Other" NAPIS Services)	**X** Hour	**X**	III B
Housing ("Other" NAPIS Services)	**X** Hour	**X**	III B
Interpretation/ Translation ("Other" NAPIS Services)	**X** Contact	**X**	III B
Mobility Management Activities ("Other" NAPIS Services)	**X** Hour	**X**	III B
Mental Health ("Other" NAPIS Services)	**X** Hour	**X**	III B
Peer Counseling ("Other" NAPIS Services)	**X** Hour	**X**	III B
Personal Affairs Assistance ("Other" NAPIS Services)	**X** Contact	**X**	III B
Personal/Home Security ("Other" NAPIS Services)	**X** Product	**X**	III B
Public Information ("Other" NAPIS Services)	**X** Activity	**X**	III B
Registry ("Other" NAPIS Services)	**X** Hour	**X**	III B
Residential Repairs/Modifications ("Other" NAPIS Services)	**X** Modification	**X**	III B
Respite Care ("Other" NAPIS Services)	**X** Hour	**X**	III B
Senior Center Activities ("Other" NAPIS Services)	**X** Hour	**X**	III B
Telephone Reassurance ("Other" NAPIS Services)	**X** Contact	**X**	III B
Visiting ("Other" NAPIS Services)	**X** Hour	**X**	III B

(X) Required Element

[1]Required service categories. Elder Abuse Prevention requires at least one reported service category.

Refer to CARS File Specifications for file reporting structure and optional data elements. Documents are at California Aging Reporting System (CARS)

Refer to Services Categories and Data Dictionary for category definitions.

Required Title III E, Non-Registered Client Fields

Chart Guidelines

Apply the following chart to determine if form(s) or records have the required data collection and reporting elements for Title III E Non-Registered services.

CARS Title III E, FCSP Caring for Elderly or Caring for Child Required Non-Registered Fields

Service Category	Service Units	Estimated Clients/Audience
Outreach (Access Assistance)	**X** Contact	**X**
Information and Assistance (Access Assistance)	**X** Contact	**X**
Interpretation/Translation (Access Assistance)	**X** Contact	**X**
Legal Resources (Access Assistance)	**X** Contact	**X**
Public Information (Information Services)	**X** Activity	**X**
Community Education (Information Services)	**X** Activity	**X**

(X) Required Element

Refer to CARS File Specifications for file reporting structure and optional data elements. Documents are at California Aging Reporting System (CARS)

Refer to Services Categories and Data Dictionary for category definitions.

Data Performance References

The following lists applicable laws/regulations/policies.

- ***Area Plan Contract***
- ***CARS - CDA California Aging Reporting System Specification***
- ***CCR - California Code of Regulations*****,**
  Title 22 Division 1.8
- ***CFR - Code of Federal Regulations*****,**
  Title 45 Part 1321
- ***OAA - Older Americans Act***
- ***OCA - California Welfare and Institutions (W&I) Code*****,**
  Division 8.5 Mello-Granlund Older Californians Act
- ***NAPIS SPR – ACL National Aging Program Information System State Program Reports***
- ***PM - CDA Program Memoranda***

Sample Forms Overview

Introduction

Because each AAA has tailored programs to meet their community needs, CDA does **not** have required intake or assessment forms. CDA has designed these sample templates to help the AAAs evaluate and create their own forms for collecting and recording required performance data elements.

What is Reviewed

CDA reviews the forms to ensure all required data collection elements are integrated. See Guidelines Chart

AAAs may use these forms, revise them, or create forms to meet local needs.
AAAs do not have to use these sample templates.

Forms Contents

This section contains the following templates:

Continued on next page

Sample Forms Overview, Continued

Forms Contents, Continued

SAMPLE 1, Title III

Provider Name:	*Unique Participant ID: _____
Region/Site Name:	Registration/Assessment Date: _____ _____
	*Termination Date: *Reason:

Service Categories(Titles IIIB, IIIC and IIID):

☐ *Personal Care (IIIB) (A,I) ☐ *Homemaker (IIIB) (A,I) ☐ *Chore (IIIB) (A,I)
☐ *Home-Delivered Meals (A,I,N) ☐ *Adult Day Care/Health (IIIB) (A,I) ☐ *Case Management (IIIB) (A,I)
☐ *Assisted Transportation (IIIB) ☐ *Congregate Meals (N) ☐ *Nutrition Counseling (N)
☐ Transportation (IIIB) ☐ Nutrition Education ☐ Other: _____

Notes: *Reference the Data Dictionary for allowable "Other" service categories*; *Requires: A-ADLs, I-IADLs, N-Nutritional Assessments on Page 2*

SECTION 1 (Client)
(*) Required for All Registered Programs

Personal Data (Please Print):	
First Name:	
Middle Initial:	
Last Name:	
* What is your gender? (Check only one)	☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
* What was your sex at birth? (Check only one)	☐ Male ☐ Female ☐ Declined/not stated
* How do you describe your sexual orientation or sexual identity (Check only one)	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
*Birth Date:	
Last 4 Digits Social Security # *Optional*	☐☐☐☐
Home Phone #:	( )
Residential Address:	
Street:	
City:	
* Zip Code:	

Mailing Address: Same as Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
* Zip Code:	
Emergency Contact:	Name: Relationship: Phone #: ( )
*Ethnicity:	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State
*Federal Poverty Level (FPL)	☐ At or below FPL ☐ Above FPL ☐ Declined to State
*Lives Alone?	☐ Yes ☐ No ☐ Declined to State
*Rural?	☐ Yes ☐ No ☐ Declined to State

*Race: (Please Check ONE)

☐ White ☐ Black ☐ American Indian/Alaska Native
☐ Other Race ☐ Multiple Race

Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Vietnamese ☐ Other Asian

Hawaiian/Other Pacific Islander:
☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander
☐ Declined to State

Title IIIB Eligibility:
Are you age 60 or over? ☐ Yes ☐ No

SECTION 2 –ADL and IADL (Activities of Daily Living and Instrumental Activities of Daily Living – Annual Assessment)
***Required for (III-C)**: Home-Delivered Meals; **(III-B)**: Personal Care, Homemaker, Chore, Adult Day Care, Case Management*

ADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
*Eating						
*Bathing						
*Toileting						
*Transferring In/Out of Bed/Chair						
*Walking						
*Dressing						
Notes:						
IADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
*Meal Preparation						
*Shopping						
*Medication Management						
*Money Management						
*Using Telephone						
*Heavy Housework						
*Light Housework						
*Transportation						
Notes:						

SECTION 3 – Nutritional Assessment (Annual)
* *Required for (IIIC): Home-Delivered Meals, Congregate Meals; Nutritional Counseling*

***Nutritional Assessment:**	**Circle if 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 2 meals per day.	3
I eat few fruits or vegetables or milk products.	2
I have 3 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 3 or more different prescribed or over–the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the past 6 months?	2
I am not always physically able to shop, cook, and/or feed myself.	2
Total Score: (If equal to or greater than 6, the client is at high nutritional risk)	
☐ **Declined to State**	

SAMPLE 2, CLUSTER 1

Provider Name:	*Unique Participant ID: _____
Region/Site Name:	Registration/Assessment Date: _____
	*Termination Date: *Reason:

Service Categories(Titles IIIB, IIIC and IIID):

☐ Personal Care (A,I) ☐ Homemaker (A,I) ☐ Chore (A,I)

☐ Home-Delivered Meals (A,I,N) ☐ Adult Day Care/Health (A,I) ☐ Case Management (A,I)

Notes: *Reference the Data Dictionary for allowable "Other" service categories*; *Requires: A-ADLs, I-IADLs, N-Nutritional Assessments on Page 2*

SECTION 1 (Client)

(*) Required for All Registered Programs

Personal Data (Please Print):	
First Name:	
Middle Initial:	
Last Name:	
* What is your gender? (Check only one)	☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
* What was your sex at birth? (Check only one)	☐ Male ☐ Female ☐ Declined/not stated
* How do you describe your sexual orientation or sexual identity (Check only one)	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
*Birth Date:	
Last 4 Digits Social Security # *Optional*	☐☐☐☐
Home Phone #:	( )

Residential Address:	
Street:	
City:	
*Zip Code:	

Mailing Address: Same As Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
* Zip Code:	
Emergency Contact:	Name: Relationship: Phone #: ( )
*Ethnicity:	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State
*Federal Poverty Level (FPL)	☐ At or below FPL ☐ Above FPL ☐ Declined to State
*Lives Alone?	☐ Yes ☐ No ☐ Declined to State
*Rural?	☐ Yes ☐ No ☐ Declined to State

*Race: (Please Check ONE)

☐ White ☐ Black ☐ American Indian/Alaska Native
☐ Other Race ☐ Multiple Race

Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Vietnamese ☐ Other Asian

Hawaiian/Other Pacific Islander:
☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander
☐ Declined to State

Title III B Eligibility:
Are you age 60 or over? ☐ Yes ☐ No

SECTION 2 – Client ADL and IADL
(Activities of Daily Living and Instrumental Activities of Daily Living Annual Assessment)
**** Required for (III-C)**: Home-Delivered Meals; **(III-B)**: Personal Care, Homemaker, Chore, Adult Day Care, Case Management*

ADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 –Lots of Human Help	5 – Dependent	Declined to State
*Eating						
*Bathing						
*Toileting						
*Transferring In/Out of Bed/Chair						
*Walking						
*Dressing						
Notes:						

IADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
*Meal Preparation						
*Shopping						
*Medication Management						
*Money Management						
*Using Telephone						
*Heavy Housework						
*Light Housework						
*Transportation						
Notes:						

SECTION 3 – Nutritional Assessment (Annual)
Required for (IIIC): Home-Delivered Meals

***Nutritional Assessment:**	**Circle if 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 2 meals per day.	3
I eat few fruits or vegetables or milk products.	2
I have 3 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 3 or more different prescribed or over–the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the past 6 months?	2
I am not always physically able to shop, cook, and/or feed myself.	2
Total Score: (If equal to or greater than 6, the client is at high nutritional risk)	
☐ **Declined to State**	

SAMPLE 3, CLUSTER 2

Provider Name:	*Unique Participant ID: _____
Region/Site Name:	Registration/Assessment Date: _____
	*Termination Date: *Reason:

Service Categories(Titles IIIB, IIIC and IIID):

☐ *Assisted Transportation ☐ *Congregate Meals (N) ☐ *Nutrition Counseling (N)

Notes: *Requires N-Nutritional Assessments on Page 2*

SECTION 1 (Client)
(*) Required for All Registered Programs

Personal Data (Please Print):	
First Name:	
Middle Initial:	
Last Name:	
* What is your gender? (Check only one)	☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
* What was your sex at birth? (Check only one)	☐ Male ☐ Female ☐ Declined/not stated
* How do you describe your sexual orientation or sexual identity (Check only one)	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
*Birth Date:	
Last 4 Digits Social Security # *Optional*	☐☐☐☐
Home Phone #:	( )

Residential Address:	
Street:	
City:	
*Zip Code:	

Mailing Address: Same As Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
* Zip Code:	
Emergency Contact:	Name: Relationship: Phone #: ( )
*Ethnicity:	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State
*Federal Poverty Level (FPL)	☐ At or below FPL ☐ Above FPL ☐ Declined to State
*Lives Alone?	☐ Yes ☐ No ☐ Declined to State
*Rural?	☐ Yes ☐ No ☐ Declined to State

*Race: (Please Check ONE)

☐ White ☐ Black ☐ American Indian/Alaska Native
☐ Other Race ☐ Multiple Race

Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Vietnamese ☐ Other Asian

Hawaiian/Other Pacific Islander:
☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander
☐ Declined to State

Title III B Eligibility:
Are you age 60 or over? ☐ Yes ☐ No

Transportation Service Needs:
☐ Walks with no assistance (Non-Assisted)
☐ Walks with assistance (Assisted)
☐ Wheelchair ramp/lift

SECTION 2 – Nutritional Assessment (Annual)

Required for (IIIC): Congregate Meals; IIIC, D Nutritional Counseling

***Nutritional Assessment:**	**Circle if 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 2 meals per day.	3
I eat few fruits or vegetables or milk products.	2
I have 3 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 3 or more different prescribed or over–the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the past 6 months?	2
I am not always physically able to shop, cook, and/or feed myself.	2
Total Score: (If equal to or greater than 6, the client is at high nutritional risk)	
	☐ **Declined to State**

Notes:

SAMPLE 4, C-2

Name of Home-Delivered Meals Provider This form is designed to be completed by an intake staff. Items marked with asterisk (*) are required.	Route:	Intake Date: _____ Active Date:_____ Inactive Date:_____ Active Date:_____ Inactive Date:_____ Active Date:_____ Inactive Date:_____
*Unique Participant ID:	*Termination Date:	*Reason:

*Date of Birth: / /	Last 4 Digits Social Security # *Optional*	☐ New client ☐ Annual reassessment ☐ Change in information

First Name:	Last Name

Home Address:	City:	*Zip Code:

Home Phone: ( ) Alternate Phone: ( )	Emergency Contact Name: Address: Phone: ( ) Relationship:

*Living Arrangement # of household members ☐ ☐ Declined to State	*What is your approximate household income? $_____ per ☐ month ☐ year ☐ Declined to State	*Rural Area? ☐ Yes ☐ No ☐ Declined to State

* What is your gender? (Check only one) ☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated	* What was your sex at birth? (Check only one) ☐ Male ☐ Female ☐ Declined/not stated	* How do you describe your sexual orientation or sexual identity (Check only one) ☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated

*Ethnicity (Check One) Hispanic ☐ Yes ☐ No ☐ Decline to State	Language: ☐ English speaking ☐ Need interpreter ☐ Non-English/Language

*Race: (Check One) ☐ White ☐ Black ☐ American Indian/Alaska Native
☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese
☐ Other Asian ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander
☐ Multiple Race ☐ Other Race ☐ Declined to State

*ADLs and IADLs (Activities of Daily Living and Instrumental Activities of Daily Living)
Please rate your functional abilities for the following activities.

ADLs	Rated Value	IADLs	Rated Value	IADLs	Rated Value	RATING SCALE
Feeding		Meal Preparation		Light Housework		1 = Independent
Dressing		Shopping		Heavy Housework		2 = Verbal Assistance
Bathing		Manage Medication		Notes:		3 = Some Human Help
Transferring In/Out of Chair		Money Management				4 = Lots of Human Help
Walking		Telephone				5 = Dependent
Toileting		Transportation				6= Declined to State

Eligibility: ☐ Are you homebound due to an illness, disability, or isolation? ☐ Are you a spouse of a person who is homebound? ☐ Are you an individual with a disability who resides with a homebound meal recipient?	Prioritization:

***Nutritional Assessment:**	**Circle if 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 2 meals per day.	3
I eat few fruits or vegetables or milk products.	2
I have 3 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 3 or more different prescribed or over–the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the past 6 months?	2
I am not always physically able to shop, cook, and/or feed myself.	2
Total Score: (If equal to or greater than 6, the client is at high nutritional risk)	
	☐ **Declined to State**

	Yes	No	Comments
Do you have any dietary restrictions?			
Do you have a working refrigerator?			
Do you have a working microwave?			
Are you physically and mentally able to open the food containers?			
Are you physically and mentally able to reheat a meal?			
Are there pets?			
Have you recently been discharged from the hospital?			

Referral(s) Made: ☐ Nutritional education/counseling for at risk client ☐ ☐ ☐
Notes:

_____ _____

Staff Completing Assessment Date

SAMPLE 5, C-1

Name of Congregate Meals Provider {Site Name}

Please complete this form to the best of your ability.
Items Marked with asterisk (*) are required.

*Unique Participant ID:_____
Referred by:_____
Intake Date: _____
Staff: _____
Beginning Date: _____
*Termination Date: _____
*Reason:_____

Eligibility:
☐ Age 60+
☐ Spouse of ENP Participant
☐ Disabled person residing where the congregate site is located
☐ Disabled person who resides with and accompanies an ENP participant
☐ Volunteer

Last 4 Digits Social Security # *Optional* | | | | |

First Name: | Last Name | *Date of Birth: / /

Home Address: | City: | *Zip Code:

Mailing Address: Same As Residential? ☐ Yes | City: | * Zip Code:

Home Phone: ( )
Alternate Phone: ( )

Emergency Contact Name:
Phone: ( ) Relationship:

*Living Arrangement
# of household members
☐ Declined to State

*What is your approximate household income?
$_____ per ☐ month ☐ year ☐ Declined to State

*Rural Area?
☐ Yes ☐ No
☐ Declined to State

* What is your gender? (Check only one)
☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female
☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated

* What was your sex at birth? (Check only one)
☐ Male ☐ Female
☐ Declined/not stated

* How do you describe your sexual orientation or sexual identity (Check only one)
☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving
☐ Questioning/Unsure ☐ Not Listed, please specify: _____
☐ Declined/not stated

*Ethnicity (Check One)
Hispanic ☐ Yes ☐ No
☐ Decline to State

Language:
☐ English speaking ☐ Need interpreter
☐ Non-English/Language:

*Race: (Check One) ☐ White ☐ Black ☐ American Indian/Alaska Native
☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese
☐ Other Asian ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander
☐ Multiple Race ☐ Other Race ☐ Declined to State

Notes:

*Nutritional Assessment:	Circle if 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 2 meals per day.	3
I eat few fruits or vegetables or milk products.	2
I have 3 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 3 or more different prescribed or over–the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the past 6 months?	2
I am not always physically able to shop, cook, and/or feed myself.	2
Total Score: (If equal to or greater than 6, the client is at high nutritional risk)	
☐ **Declined to State**	

I understand that the information I am providing on this form is for registration purposes. I understand it will be kept confidential and that the Area Agency on Aging and service providers may use it to help identify other services for which may benefit.

_____ _____

Signature of participant or person completing the form Date

SAMPLE 6, Title III E, Caring for Elderly, Caring for Child

SECTION 1 – Service Information

Provider Name:	Registration/Assessment Date:
Region/Site Name:	*Termination Date: *Reason:

Service Categories:
☐ Caregiver Caring for Elderly ☐ Grandparent/Older Caregiver Caring for Child
Notes: Check eligibility criteria below to determine for which program caregiver qualifies

Title III E, Family Caregiver Support Program Services To Be Provided			
Support Services: ☐ Caregiver Assessment ☐ Caregiver Counseling ☐ Caregiver Peer Counseling	☐ Caregiver Support ☐ Caregiver Training ☐ Case Management	Respite Care Services: *(Care Receiver has to have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/elder caregiver to qualify)*	☐ In-Home Supervision ☐ Homemaker Assistance ☐ In-Home Personal Care ☐ Home Chore ☐ Out of Home Day ☐ Out of Home Overnight
Supplemental Services: *(Care Receiver has to have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/older caregiver to qualify)* ☐ Assistive Devices ☐ Home Adaptations for Caregiving ☐ Caregiving Services Registry ☐ Cash/Material Aid			
Access Assistance: ☐ Information & Assistance ☐ Caregiver Outreach ☐ Interpretation/Translation ☐ Caregiver Legal Resources		Information Services: ☐ Public Information on Caregiving ☐ Community Education on Caregiving	

SECTION 2 – Eligibility Criteria

Caregiver Caring for Elderly Eligibility Criteria
1. Is the Care Receiver an older individual (60 years of age or older) ***or*** an individual (of any age) with Alzheimer's disease or related disorder with neurological and organic brain dysfunction? ☐ Yes ☐ No
2. Is the Caregiver an adult (18 years of age or older) family member or another individual (e.g., friend or neighbor) who is an informal (i.e., unpaid) provider of in-home or community care to an "elderly" Care Receiver? ☐ Yes ☐ No

If answered "yes" to both questions above, check "Family Caregiver Caring for Elderly" box in Section 1. If answered "no" check to see if individual qualifies for "Grandparent/Older Caregiver Caring for Child" component below.

Grandparent/Older Caregiver Caring for Child Eligibility Criteria
1. Is the Care Receiver an individual who is not more than 18 years of age ***or*** who is an individual (of any age) with a disability? ☐ Yes ☐ No
2. Is the Caregiver a grandparent, step-grandparent, or other older relative of a child by blood, marriage, or adoption who is 55 years of age or older, living with the child, and identified as the primary caregiver through a legal or informal arrangement. Biological and adoptive parents are excluded. ☐ Yes ☐ No

If answered "yes" to both questions above, check "Grandparent/Older Caregiver Caring for Child" box in Section 1.

If the Care Receiver does not meet any of the criteria above, the Caregiver is ineligible to receive FCSP services, but may qualify to receive other services provided by the Area Agency on Aging.

SECTION 3 (FCSP Caregiver)
(*) Required for Family Caregiver Support Program Services

Caregiver Personal Data (Please Print):	
*Unique Participant ID	
First Name:	
Middle Initial:	
Last Name:	
* What is your gender? (Check only one)	☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
* What was your sex at birth? (Check only one)	☐ Male ☐ Female ☐ Declined/not stated
* How do you describe your sexual orientation or sexual identity (Check only one)	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
*Birth Date:	
Last 4 Digits Social Security # *Optional*	☐☐☐☐
Home Phone #:	( )

Residential Address:	
Street:	
City:	
*Zip Code:	

Mailing Address: Same As Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
* Zip Code:	
*Ethnicity:	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State
*Federal Poverty Level (FPL)	☐ At or below FPL ☐ Above FPL ☐ Declined to State
*Lives Alone?	☐ Yes ☐ No ☐ Declined to State
*Rural?	☐ Yes ☐ No ☐ Declined to State

*Race: (Please Check ONE)

☐ White ☐ Black ☐ American Indian/Alaska Native
☐ Other Race ☐ Multiple Race

Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Vietnamese ☐ Other Asian

Hawaiian/Other Pacific Islander:
☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander
☐ Declined to State

*Relationship to Care Receiver	☐ Husband ☐ Wife ☐ Grandparent ☐ Domestic Partner ☐ Other Relative ☐ Daughter/Daughter- in-law ☐ Son/Son-in-law ☐ Non Relative ☐ Declined to State
*Relationship Status:	☐ Single (never married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined to State
*Employment:	☐ Full Time ☐ Unemployed ☐ Part Time ☐ Declined to State ☐ Retired

SECTION 4 (FCSP Care Receiver)
(*) Required for Family Caregiver Support Program Services

Care Receiver Personal Data (Please Print):	
*Unique Participant ID	
First Name:	
Middle Initial:	
Last Name:	
* What is your gender? (Check only one)	☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
* What was your sex at birth? (Check only one)	☐ Male ☐ Female ☐ Declined/not stated
* How do you describe your sexual orientation or sexual identity (Check only one)	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
*Birth Date:	
Last 4 Digits Social Security # *Optional*	☐☐☐☐
Home Phone #:	( )

Residential Address:	
Street:	
City:	
*Zip Code:	

Mailing Address: Same As Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
* Zip Code:	
*Ethnicity:	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State
*Federal Poverty Level (FPL)	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined to State
*Lives Alone?	☐ Yes ☐ No ☐ Declined to State
*Rural?	☐ Yes ☐ No ☐ Declined to State

*Race: (Please Check ONE)

☐ White ☐ Black ☐ American Indian/Alaska Native
☐ Other Race ☐ Multiple Race

Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Vietnamese ☐ Other Asian

Hawaiian/Other Pacific Islander:
☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander
☐ Declined to State

*Relationship Status:	☐ Single (never married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined to State

SECTION 5 (FCSP Care Receiver)
ADL and IADL (Activities of Daily Living and Instrumental Activities of Daily Living)

**Required for <u>the Care Receiver only</u> in Support Services, Respite Care, and Supplemental Services.*

(Not required for Care Receivers in FCSP Grandparents/Older Caregiver Caring for Children)

ADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
*Eating						
*Bathing						
*Toileting						
*Transferring In/Out of Bed/Chair						
*Walking						
*Dressing						
Notes:						
IADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
*Meal Preparation						
*Shopping						
*Medication Management						
*Money Management						
*Using Telephone						
*Heavy Housework						
*Light Housework						
*Transportation						
Notes:						

SAMPLE 7, Title III E, Caring for Elderly

SECTION 1 – Service Information

Provider Name:	Registration/Assessment Date:
Region/Site Name:	*Termination Date: *Reason:

Title III E, Family Caregiver Support Program Services To Be Provided			
Support Services: ☐ Caregiver Assessment ☐ Caregiver Counseling ☐ Caregiver Peer Counseling ☐ Caregiver Support ☐ Caregiver Training ☐ Case Management		Respite Care Services: *(Care Receiver has to have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/elder caregiver to qualify)*	☐ In-Home Supervision ☐ Homemaker Assistance ☐ In-Home Personal Care ☐ Home Chore ☐ Out of Home Day ☐ Out of Home Overnight
Supplemental Services: *(Care Receiver must have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/older caregiver to qualify)* ☐ Assistive Devices ☐ Home Adaptations for Caregiving ☐ Caregiving Services Registry ☐ Cash/Material Aid			
Access Assistance: ☐ Information & Assistance ☐ Caregiver Outreach ☐ Interpretation/Translation ☐ Caregiver Legal Resources		Information Services: ☐ Public Information on Caregiving ☐ Community Education on Caregiving	

SECTION 2 – Eligibility Criteria

Caregiver Caring for Elderly Eligibility Criteria

1. Is the Care Receiver an older individual (60 years of age or older) ***or*** an individual (of any age) with Alzheimer's disease or related disorder with neurological and organic brain dysfunction? ☐ Yes ☐ No
2. Is the Caregiver an adult (18 years of age or older) family member or another individual (e.g., friend or neighbor) who is an informal (i.e., unpaid) provider of in-home or community care to an "elderly" Care Receiver? ☐ Yes ☐ No

If the Care Receiver does not meet any of the criteria above, the Caregiver is ineligible to receive FCSP Caregiver Caring for Elderly services but may qualify to receive other services provided by the Area Agency on Aging.

Notes:

SECTION 3 – (FCSP Caregiver)

(*) Required for Family Caregiver Support Program Services

Caregiver Personal Data (Please Print):	
*Unique Participant ID	
First Name:	
Middle Initial:	
Last Name:	
* What is your gender? (Check only one)	☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
* What was your sex at birth? (Check only one)	☐ Male ☐ Female ☐ Declined/not stated
* How do you describe your sexual orientation or sexual identity (Check only one)	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
*Birth Date:	
Last 4 Digits Social Security # *Optional*	☐☐☐☐
Home Phone #:	( )

Residential Address:	
Street:	
City:	
*Zip Code:	

Mailing Address: Same As Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
* Zip Code:	
*Ethnicity:	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State
*Federal Poverty Level (FPL)	☐ At or below FPL ☐ Above FPL ☐ Declined to State
*Lives Alone?	☐ Yes ☐ No ☐ Declined to State
*Rural?	☐ Yes ☐ No ☐ Declined to State

*Race: (Please Check ONE)

☐ White ☐ Black ☐ American Indian/Alaska Native
☐ Other Race ☐ Multiple Race

Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Vietnamese ☐ Other Asian

Hawaiian/Other Pacific Islander:
☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander
☐ Declined to State

*Relationship to Care Receiver	☐ Husband ☐ Wife ☐ Grandparent ☐ Domestic Partner ☐ Other Relative ☐ Daughter/Daughter- in-law ☐ Son/Son-in-law ☐ Non Relative ☐ Declined to State
*Relationship Status:	☐ Single (never married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined to State
*Employment:	☐ Full Time ☐ Unemployed ☐ Part Time ☐ Declined to State ☐ Retired

SECTION 4 (Care Receiver)

(*) Required for Family Caregiver Support Program Services

*Unique Participant ID:	
Care Receiver Personal Data (Please Print):	
First Name:	
Middle Initial:	
Last Name:	
* What is your gender? (Check only one)	☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
* What was your sex at birth? (Check only one)	☐ Male ☐ Female ☐ Declined/not stated
* How do you describe your sexual orientation or sexual identity (Check only one)	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
*Birth Date:	
Last 4 Digits Social Security # *Optional*	☐☐☐☐
Home Phone #:	( )
Residential Address:	
Street:	
City:	
*Zip Code:	

Mailing Address: Same As Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
* Zip Code:	
*Ethnicity:	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State
*Federal Poverty Level (FPL)	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined to State
*Lives Alone?	☐ Yes ☐ No ☐ Declined to State
*Rural?	☐ Yes ☐ No ☐ Declined to State

*Race: (Please Check ONE)

☐ White ☐ Black
☐ American Indian/Alaska Native
☐ Other Race
☐ Multiple Race

Asian:

☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Vietnamese ☐ Other Asian

Hawaiian/Other Pacific Islander:

☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander
☐ Declined to State

*Relationship Status:	☐ Single (never married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined to State

SECTION 5 (Care Receiver)

*ADLs & IADLs (Activities of Daily Living & Instrumental Activities of Daily Living)
Required for Support Services, Respite Care, and Supplemental Services.
Please rate your functional abilities for the following activities.

ADLs	Rated Value	IADLs	Rated Value	IADLS	Rated Value	RATING SCALE
Feeding		Meal Preparation		Light Housework		1 = Independent
Dressing		Shopping		Heavy Housework		2 = Verbal Assistance
Bathing		Manage Medication		Notes:		3 = Some Human Help
Transferring In/Out of Chair		Money Management				4 = Lots of Human Help
Walking		Telephone				5 = Dependent
Toileting		Transportation				6= Declined to State

SAMPLE 8, Title III E, Caring for Child

SECTION 1 – Service Information

Provider Name:	Registration/Assessment Date:
Region/Site Name:	*Termination Date: *Reason:

Title III E, Family Caregiver Support Program Services To Be Provided	
Support Services: ☐ Caregiver Assessment ☐ Caregiver Support ☐ Caregiver Counseling ☐ Caregiver Training ☐ Caregiver Peer Counseling ☐ Case Management	Respite Care Services: ☐ In-Home Supervision ☐ Home Chore ☐ Homemaker Assistance ☐ Out of Home Day ☐ In-Home Personal Care ☐ Out of Home Overnight
Supplemental Services: ☐ Assistive Devices ☐ Home Adaptations for Caregiving ☐ Caregiving Services Registry ☐ Cash/Material Aid	
Access Assistance: ☐ Information & Assistance ☐ Caregiver Outreach ☐ Interpretation/Translation ☐ Caregiver Legal Resources	Information Services: ☐ Public Information on Caregiving ☐ Community Education on Caregiving

SECTION 2 – Eligibility Criteria

Grandparent/Older Caregiver Caring for Child Eligibility Criteria

1. Is the Care Receiver an individual who is not more than 18 years of age ***or*** who is an individual (of any age) with a disability? ☐ Yes ☐ No
2. Is the Caregiver a grandparent, step-grandparent, or other older relative of a child by blood, marriage, or adoption who is 55 years of age or older, living with the child, and identified as the primary caregiver through a legal or informal arrangement. Biological and adoptive parents are excluded. ☐ Yes ☐ No

If the Care Receiver does not meet any of the criteria above, the Caregiver is ineligible to receive FCSP Grandparent Caring for Child services but may qualify to receive other services provided by the Area Agency on Aging.

Notes:

SECTION 3 (Grandparent/Older Caregiver)

(*) Required for Family Caregiver Support Program Services

Caregiver Personal Data (Please Print):	
*Unique Participant ID	
First Name:	
Middle Initial:	
Last Name:	
* What is your gender? (Check only one)	☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
* What was your sex at birth? (Check only one)	☐ Male ☐ Female ☐ Declined/not stated
* How do you describe your sexual orientation or sexual identity (Check only one)	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
*Birth Date:	
Last 4 Digits Social Security # *Optional*	☐☐☐☐
Home Phone #:	( )

Residential Address:	
Street:	
City:	
*Zip Code:	

Mailing Address: Same As Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
* Zip Code:	
*Ethnicity:	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State
*Federal Poverty Level (FPL)	☐ At or below FPL ☐ Above FPL ☐ Declined to State
*Lives Alone?	☐ Yes ☐ No ☐ Declined to State
*Rural?	☐ Yes ☐ No ☐ Declined to State

*Race: (Please Check ONE)

☐ White ☐ Black ☐ American Indian/Alaska Native
☐ Other Race ☐ Multiple Race

Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Vietnamese ☐ Other Asian

Hawaiian/Other Pacific Islander:
☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander
☐ Declined to State

*Relationship to Care Receiver	☐ Grandparent ☐ Other Relative ☐ Non Relative ☐ Declined to State
*Relationship Status:	☐ Single (Never Married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined to State
*Employment:	☐ Full Time ☐ Unemployed ☐ Part Time ☐ Declined to State ☐ Retired

SECTION 4 (Child)

(*) Required for Family Caregiver Support Program Services

Care Receiver Personal Data (Please Print):	
*Unique Participant ID	
First Name:	
Middle Initial:	
Last Name:	
* What is your gender? (Check only one)	☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
* What was your sex at birth? (Check only one)	☐ Male ☐ Female ☐ Declined/not stated
* How do you describe your sexual orientation or sexual identity (Check only one)	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
*Birth Date:	
Last 4 Digits Social Security # *Optional*	☐☐☐☐
Home Phone #:	( )

Residential Address:	
Street:	
City:	
*Zip Code:	

Mailing Address: Same As Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
* Zip Code:	
*Ethnicity:	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State
*Federal Poverty Level (FPL)	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined to State
*Lives Alone?	☐ Yes ☐ No ☐ Declined to State
*Rural?	☐ Yes ☐ No ☐ Declined to State

*Race: (Please Check ONE)

☐ White ☐ Black ☐ American Indian/Alaska Native
☐ Other Race ☐ Multiple Race

Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Vietnamese ☐ Other Asian

Hawaiian/Other Pacific Islander:
☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander
☐ Declined to State

*Relationship Status:	☐ Single (Never Married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined to State

SAMPLE 9, I&A

Date: _____ Staff Completing Intake: _____

Personal Data (Please Print):	
Unique Participant ID	
Name:	
Birth Date:	
Last 4 Digits Social Security # *Optional*	☐☐☐☐
Home Phone #:	( )
Email:	
Address:	
* What is your gender? (Check only one)	☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
* What was your sex at birth? (Check only one)	☐ Male ☐ Female ☐ Declined/not stated
* How do you describe your sexual orientation or sexual identity (Check only one)	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
Ethnicity:	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State

Race:	☐ White ☐ Black ☐ American Indian/Alaska Native ☐ Other Race ☐ Multiple Race Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander: ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Declined to State
Federal Poverty Level (FPL)	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined to State
Lives Alone?	☐ Yes ☐ No ☐ Declined to State
Rural?	☐ Yes ☐ No ☐ Declined to State
Service Requested:	
Action Taken/Referral:	
Follow Up:	
Type of I & A: ☐ IIIB If Requesting Services for an Older Individual) ☐ IIIE Elderly (If Requesting Services for a Caregiver) ☐ IIIE Children (If Requesting Services for a Grandparent/Older Caregiver)	