2018 STANISLAUS COUNTY AAA PROGRAM INTAKE

First Name:	MI:	Last Name:	
Address: Rural: ☐ Yes ☐ No ☐ Declined to state		City:	*Zip
Mail address if different:		City:	Zip
Home Phone:	Mobile:		Alternate:
Date registered:	Marital status: ☐ Declined to State		*Gender: ☐ Declined to State
*DOB:	Last 4 of SSN: ☐ Declined to State	Referred by:	
Emergency Contact name:	Relationship		Phone:

*Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State

*Race: Please check only one: ☐ Declined to State

☐ White ☐ Black / African American
☐ American Indian/Alaska Native
☐ Other Race
☐ Multiple Race
☐ Asian Select nationality if desired:
☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Vietnamese
☐ Other Asian
☐ Hawaiian/Other Pacific Islander
Select nationality if desired:
☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander

Income: Is the household income at or below the amount listed below for the number of people in the household? Circle one: YES or NO

Size of family	1	2	3	4
Monthly Income (2018 FPL)	$1005	$1,353	$1,702	2,050

*Federal Poverty Level (FPL) ☐ At or below FPL ☐ Above FPL ☐ Declined to State

*Live Alone? ☐ Yes ☐ No ☐ Declined to State Lives with:

AB 959 Circle only one response for the questions below:

1. What is your Gender? a. Male b. Female c Transgender female to male or d. male to female e. Genderqueer Non-binary f. Not listed: Specify _____ g. Declined to state

2. What was your sex at birth? a. Male b. Female c. Declined to state

3. How do you describe your sexual orientation or sexual identity?
a. Straight /Heterosexual b. Bisexual c. Gay/Lesbian/ same –Gender Loving
d. Questioning/Unsure e. Not listed Specify: _____ g. Declined to state

Nutritional Assessment: (Meal program participants only)	**No**	**Yes**
Do you have an illness or condition that made you change the kind/or amount of food you eat?	0	2
Do you eat fewer than 2 meals per day?	0	3
Do you eat few fruits, vegetables or milk products every day?	0	2
Do you have 3 or more drinks of beer, liquor or wine almost every day?	0	2
Do you have tooth or mouth problems that make it hard for you to eat?	0	2
Do you sometimes not have enough money to buy food?	0	4
Do you eat alone most of the time?	0	1
Do you take 3 or more different prescribed or over-the-counter drugs a day?	0	1
Without wanting to, have you lost or gained 10 pounds in the past 6 months?	0	2
Are you not always physically able to shop, cook, and/or feed yourself?	0	2
Add all "yes" responses - **Total Score Today:** *(If equal to or greater than 6, the client is at high nutritional risk.)*		
Declined to State (DTS):		

***ADLs and IADLs (Activities of Daily Living and Instrumental Activities of Daily Living)**
(Home delivered & Homemaker clients only) Please rate functional abilities for the following activities.

ADLs	Rated Value	IADLs	Rated Value	IADLs	Rated Value
Eating		Meal Preparation		Light Housework	
Bathing		Shopping		Transportation	
Toileting		Manage Medication		Notes:	
Transferring In/Out of Chair		Money Management			
Walking		Telephone			
Dressing		Heavy Housework			

RATING SCALE
1 = Independent
2 = Verbal Assistance
3 = Some Human Help
4 = Lots of Human Help
5 = Dependent
6= Declined to State

Meal Eligibility: ☐ 60 or older ☐ Spouse residing with eligible senior
☐ Disabled adult residing with eligible senior ☐ Volunteer
For Home Delivery: (Eligible senior) ☐ Homebound (does not drive)
Lives with: ☐ non-homebound person or has caregiver ☐ another homebound person
☐ Emergency short - term need Start date: _____ Stop date: _____

Custom Field:
☐ Wheelchair bound

Prioritization:

Participant ID #:_____
Notes:

*= NAPIS data shared with California Department on Aging –total numbers only. Reporting purposes only. Personal identifying information is kept confidential. DOB mandatory to verify program eligibility. Zip code automatically determines rural status. May decline to state sensitive information.

Completed by: Date: