Registered Client Intake Form
TITLE III E FAMILY CARE RECEIVER-CAREGIVER – FY 2017-18
CONFIDENTIAL

CONTRACTOR:		**DATE:**	

CARE RECEIVER'S INFORMATION

LAST NAME:		**FIRST NAME:** *(No nicknames)*	
Phone:		**Birth Date:** *(Required)*	
Street Address:			
City:		**ZIP:** *(Required)*	**RURAL:** (91307, 93066, 93040) ☐ Yes ☐ No ☐ Declined to State
COUNTY – *if NOT in Ventura County and in CA:*			
MARITAL STATUS:	☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Declined to State		

RACE – PLEASE CHOOSE (✓) ONE:

☐ American Indian or Alaska Native	☐ Chinese	☐ Korean	☐ OTHER RACE – Includes Hispanic /Latino
☐ Asian Indian	☐ Filipino	☐ Laotian	☐ Samoan
☐ Black or African American	☐ Guamanian	☐ Multiple Race	☐ Vietnamese
☐ Cambodian	☐ Hawaiian	☐ Other Asian	☐ White
	☐ Japanese	☐ Other Pacific Islander	☐ Declined to State

Ethnicity:	☐ Not Hispanic/Latino ☐ Hispanic/Latino	**Gender:**	☐ Female ☐ Male ☐ Transgender Woman ☐ Declined to State ☐ Transgender Man
Veteran Status:	☐ Yes ☐ No	**Client Lives:**	☐ Alone ☐ Not Alone
Preferred Language:		**Number of Persons Living in Household:**	

INDICATE CARE RECEIVER'S INCOME LEVEL (approximate):

2-Person Household:
- ☐ At or below Federal Poverty Level *(at or below $16,240/year)*
- ☐ Above Federal Poverty Level *(at or above $16,241/year)*
- ☐ Declined to State

1-Person Household:
- ☐ At or below Federal Poverty Level *(at (or below $12,060/year)*
- ☐ Above Federal Poverty Level *(at or above $12,061/year)*
- ☐ Declined to State

COGNITIVE IMPAIRMENT:
- ☐ None or Unknown
- ☐ Mild
- ☐ Moderate
- ☐ Severe

CALIFORNIA ACTIVITIES & INSTRUMENTAL ACTIVITIES (IADLS) OF DAILY LIVING (ADLS)
➔ PLEASE CHECK (✓) ONE OF THE COLUMNS FOR EACH ACTIVITY ➔

	TYPE OF ASSISTANCE NEEDED TO PERFORM TASK ➔	1 - INDEPENDENT Needs No Help	2- VERBAL QUE Needs verbal reminders	3 – STAND BY Needs some human help	4 – HANDS ON Needs lots of human help	5 – DEPENDENT Cannot perform task	Declined to State
ADLS	Eating						
ADLS	Dressing						
ADLS	Transferring						
ADLS	Bathing						
ADLS	Toileting						
ADLS	Walking						
IADLS	Light Housework						
IADLS	Shopping/Errands						
IADLS	Meal Prep/Cleanup						
IADLS	Transportation						
IADLS	Using Telephone						
IADLS	Managing Medications						
IADLS	Managing Money						
IADLS	Heavy Housework						

Registered Client Intake Form
TITLE III E FAMILY CARE RECEIVER-CAREGIVER – FY 2017-18
CONFIDENTIAL

CARE RECEIVER'S LIVING ARRANGEMENT: ☐ **With you** (caregiver) ☐ **Alone** in his/her home/apartment
☐ With spouse or partner ☐ In a board and care home, group home, assisted living facility or RCFE
☐ Nursing home ☐ Retirement community ☐ In home of other family member/friend ☐ Other ☐ Unknown

CAREGIVER'S INFORMATION

LAST NAME:		**FIRST NAME:** *(No nicknames)*	
Phone:		**Birth Date:** *(Required)*	
Street Address:			
City:		**ZIP:** *(Required)*	
COUNTY – *if NOT in Ventura County and in CA:*			

MARITAL STATUS: ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Declined to State

RACE - PLEASE CHOOSE (✓) ONE:

☐ American Indian or Alaska Native	☐ Chinese	☐ Korean	☐ OTHER RACE – Includes Hispanic /Latino
☐ Asian Indian	☐ Filipino	☐ Laotian	☐ Samoan
☐ Black or African American	☐ Guamanian	☐ Multiple Race	☐ Vietnamese
☐ Cambodian	☐ Hawaiian	☐ Other Asian	☐ White
	☐ Japanese	☐ Other Pacific Islander	☐ Declined to State

VETERAN STATUS: ☐ Yes ☐ No **Number of Persons Living in Household:**

ETHNICITY – CHOOSE ONE: ☐ Not Hispanic/Latino ☐ Hispanic/Latino

CLIENT LIVES: ☐ Alone ☐ Not Alone

Preferred Language Other than English:

Gender: ☐ Female ☐ Male ☐ Transgender Woman ☐ Declined to State ☐ Transgender Man

APPLICANT'S INCOME LEVEL (approximate):

2-Person Household:
☐ At or below Federal Poverty Level *(at or below $16,240/year)*
☐ Above Federal Poverty Level *(at or above $16,241/year)*
☐ Declined to State

1-Person Household:
☐ At or below Federal Poverty Level *(at (or below $12,060/year)*
☐ Above Federal Poverty Level *(at or above $12,061/year)*
☐ Declined to State

Caregiver's email address:

RELATIONSHIP WITH CARE RECEIVER:
☐ Daughter ☐ Son ☐ Spouse ☐ Domestic Partner ☐ Parent ☐ Grandparent
☐ Daughter-in-law ☐ Son-in- law ☐ Other Relative ☐ Non-Relative ☐ Declined to State

CAREGIVER'S EMPLOYMENT: ☐ FULL-TIME – 35+ hours per week ☐ PART-TIME – less than 35 hours per week
☐ On leave of absence ☐ Not employed (unemployed) ☐ Retired

NARRATIVE/CASE NOTES (OPTIONAL):