**Center Name: Garland Senior Activity Center**

# AREA AGENCY ON AGING OF DALLAS COUNTY

## CLIENT INTAKE AND SERVICE REQUEST FORM

**The information on this form is required by your local service provider, the Area Agency on Aging (AAA), and the Texas Department of Aging and Disability Services. All information provided will be kept confidential and guarded against unofficial use. Information gathered through an intake or through an assessment may be shared to effectively plan, arrange and deliver services to meet individual client needs.**

*Client's Primary Language*: _____

**Release of information has been clearly explained to the client.** ☐

**Date**: _____ **Client ID Number**: _____

**Last Name**: _____ **MI**: _____ **First Name:** _____

**Street Address/Apt. #:** _____

**City**: _____ **State**: _____ **Zip Code:** _____ **County**: _____

**Phone**: (_____) _____ **Gender**: **Male** ☐ **Female** ☐ **Birth Date:** _____

---

**Ethnicity (Check One):**

- **(1) Hispanic or Latino** ☐
- **(2) Not Hispanic or Latino** ☐
- **(3) Ethnicity Not Reported** ☐

**Race (Check all that apply):**

- **(1) White – Non Hispanic** ☐
- **(2) White – Hispanic** ☐
- **(3) American Indian/Alaska Native** ☐
- **(4) Asian** ☐
- **(5) Black or African American** ☐
- **(6) Native Hawaiian or Pacific Islander** ☐
- **(7) Persons Reporting Some Other Race** ☐
- **(8) Race Not Reported** ☐

Marital Status (Check One):

- (1) Married ☐
- (2) Widowed ☐
- (3) Divorced ☐
- (4) Separated ☐
- (5) Never Married ☐
- (6) Not Reported ☐

---

**Does client live alone?** **Yes** ☐ **No** ☐

Total Number of Family Members in Household Including Client: _____

Monthly Household Income: $_____ **Low Income** ☐ **Moderate Income** ☐ **High Income** ☐

**{Low Income Levels for: Single person family unit – $ 11,490; Two person family unit – $15,510} Add $4,020 for each additional person**

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| Monthly Income from: | Individual | Spouse |
|---|---|---|
| Job | _____ | _____ |
| Social Security | _____ | _____ |
| SSI | _____ | _____ |
| VA | _____ | _____ |
| Other Sources | _____ | _____ |
| Other Benefits (e.g., Food Stamps) | _____ | _____ |

**Emergency Contact Information**

**Contact Name**: _____ **Phone**: (_____) _____

**Relationship**: _____

**Primary Care Physician**: _____ **Phone**: (_____) _____

Service(s) Requested: _____

Are you enrolled in? ☐ Medicare - Medicare # _____ ☐ Medicaid- Medicaid # _____

Referred By:

☐ Texas Department of Family & Protective Services (DFPS)

☐ Texas Department of Assistive & Rehabilitative Services (DARS)

☐ Texas Department of State Health Services (DSHS)

☐ Doctor ☐ Hospital ☐ Assisted Living Facility

☐ Home & Community Care Organization

☐ Family Member

☐ Other

_____ _____

**Signature of AAA/Provider Staff Completing Intake** **Date**

**To be completed by AAA/provider staff**

Nutrition Services: If participant is "other Older Americans Act or NSIP eligible participant under 60 year of age", check which of the following applies:

(1) Spouse is eligible and participates at the nutrition site. ☐

(2) Serves as volunteer at the nutrition site in accordance with OAA standards. ☐

(3) Disabled/resides in the housing facility and wants to participate in the congregate meal program provided at the site. ☐

(4) Disabled and lives with the person participating in congregate meal program. ☐

Name: _____/_____ Center: GSAC
Last First

## Area Agency on Aging of Dallas County
## Client Rights & Responsibilities for Older Americans Act Programs

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

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

**Client rights and responsibilities:**

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

| Service Provider Information | Area Agency on Aging Information |
|---|---|
| Dallas County Dept. of Health and Human | Dallas Area Agency on Aging |
| Services/Older Adult Services Program | 1349 Empire Central, Suite 400 |
| 2377 N. Stemmons Freeway, 2nd Floor | Dallas, TX 75247 |
| Dallas, TX 75207-2710 | Phone: 214-871-5065 |
| Phone: (214) 819-1860 | Fax: 214-871-7442 |
| Fax: (214) 819-1866 | |

4. You have the right to participate in the development of a care plan to address unmet needs. ☐ N/A
5. You have the right to be informed in writing of available services and the applicable charges if the services are not covered or are unavailable by Medicare, Medicaid, health insurance, or Older Americans Act funding. ☐ N/A



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July 2, 2007

6. You have the right to make an independent choice of service providers from the list furnished by the Area Agency on Aging where multiple service providers are available and change service providers when desired. ☐ N/A
7. You have the right to be informed of any change in service(s). ☐ N/A
8. You have the right to make a voluntary, confidential, contribution for services received through the Area Agency on Aging. Services will not be denied if an eligible participant is unable or chooses not to make a contribution. All contributions will be kept confidential and will be utilized to expand or enhance the service(s) for which they were provided.
9. You have the responsibility to inform the Area Agency on Aging or its service provider(s) of your intent to withdraw from the program or any known periods of absenteeism when services will not be utilized. ☐ N/A
10. You have the responsibility to provide the Area Agency on Aging or its services provider(s) with complete and accurate information.

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

**DALLAS COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**OLDER ADULT SERVICES PROGRAM**

**RELEASE OF RESPONSIBILITY**

**PLEASE READ CAREFULLY**

To be signed by the participant or a responsible adult member of the household before the participant engages in any trips or activities.

This release is in reference to all trips and activities participant will be engaged in along with other participants enrolled in the Dallas County Older Adult Services Program. In consideration of participant being permitted to make such trips and take part in such activities and the benefits participant will receive by reason thereof, I hereby relieve and release the County of Dallas, Participating Agencies, and Sponsoring Groups, together with all those persons assisting with any phase of such trips and activities, and hereby release all of said parties from all liability by reason of any accident or injury suffered by participant while on said trip, or participating in such activities, and I agree and hold all of said parties harmless from all claims hereafter made by or asserted on behalf of said participant.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date



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July 2, 2007

# Texas Department of Aging and Disability Services
# Access & Intake/Area Agencies on Aging

## Instructions for completing the Nutrition Risk Assessment (NRA)

## DETERMINE Your Nutritional Health
## Nutrition Screening Initiative (NSI)

**Background**

The Nutrition Screening Initiative (NSI) was developed in order to address the prevalence of malnutrition among older adults. This initiative represents the work of the American Academy of Family Physicians and the American Dietetic Association to create a coalition whose goal is to promote the integration of nutrition screening and intervention into healthcare for older adults. NSI helps to increase older adults' awareness about nutrition and health. It differentiates among adequate nutritional status, malnutrition risk and malnutrition.

The checklist is based on the following warning signs for poor nutrition:

**D**isease
**E**ating Poorly
**T**ooth Loss/Mouth Pain
**E**conomic Hardship
**R**educed Social Contact
**M**ultiple Medicines
**I**nvoluntary Weight Loss/Gain
**N**eeds Assistance in Self- Care
**E**lder Years Above Age 80

DETERMINE was designed by the American Academy of Family Physicians, the National Council on the Aging and others as part of the Nutrition Screening Initiative. This tool can be used by professionals working with elders in order to assess their risk for poor nutritional status or malnutrition. The DETERMINE questionnaire can also be used to measure an individual's change in level of nutritional risk over time. If DETERMINE scores taken prior to beginning a new nutrition program are compared with scores later in the program, a decrease in the resulting score would indicate a corresponding decrease in the elder's nutritional risk. In this way, the effectiveness of the program for the individual can be evaluated.

**Requirements**

The U.S. Administration on Aging (AoA) and the Texas Department of Aging and Disability Services (DADS) require nutrition programs funded by the Older Americans Act and Area Agencies on Aging (AAA) providing nutrition counseling to identify persons at high nutritional risk.

Individuals at high nutritional risk are defined by AoA as individuals who score "six (6) or higher on the DETERMINE Your Nutritional Health checklist published by the Nutrition Screen Initiative." This definition is included in the National Aging Program Information System (NAPIS) State Program Report.

The DETERMINE Your Nutritional Health checklist must be completed annually for all consumers receiving **congregate meals**, **home delivered meals** or **nutrition counseling**. The results of the completed checklist must be entered in the SAMS system for every consumer receiving one or more of these services. The content for this form is required and may not be altered by the AAA.

**Completing the Paper Form**

This form may be completed by the consumer or, when needed, it can be completed through an interview with the consumer. When this assessment is conducted by telephone by AAA staff the completed checklist and the "Determine Your Nutritional Health Handout" must both be provided to the consumer assessed and, as appropriate, documented in the consumer's file.

1. Enter the name of the provider or nutrition center. If the AAA is providing nutrition counseling directly, enter the name of the AAA.

2. Enter the consumer's name.

3. Enter the consumer's client identification number, if known. The consumer's Social Security Number should not be used for the client identification number.

4. Enter the date the DETERMINE Your Nutritional Health was completed. This assessment must be completed annually for all consumers receiving congregate meals, home delivered meals or nutrition counseling.

5. Circle the number in the "Yes" column if the statement applies to the consumer.

6. Total the score by summing only the numbers circled.

7. Enter the date and total score on the Handout for the DETERMINE Your Nutritional Health. The Handout should be given to the consumer for educational purposes and for future reference.

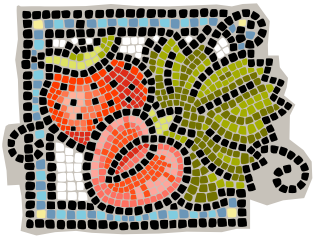
8. Enter the responses into SAMS. When the response is "Yes," SAMS will automatically apply the correct DETERMINE Your Nutritional Health score. The system will also automatically total the nutritional risk score and indicate the consumer's nutrition risk status in the SAMS client record.

Provider/Center: Garland Senior Activity Center

Consumer Name: _____

Consumer ID: _____

Date: _____



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

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

| | **YES** |
|---|---|
| I have an illness or condition that made me change the kind and/or amount of food I eat. | 2 |
| I eat fewer than two meals a day. | 3 |
| I eat few fruits or vegetables, or milk products. | 2 |
| I have three or more drinks of beer, liquor or wine almost every day. | 2 |
| I have tooth or mouth problems that make it hard for me to eat. | 2 |
| I don't always have enough money to buy the food I need. | 4 |
| I eat alone most of the time. | 1 |
| I take three or more different prescribed or over-the-counter drugs a day. | 1 |
| Without wanting to, I have lost or gained ten pounds in the last six month. | 2 |
| I am not always physically able to shop, cook and/or feed myself. | 2 |
| **TOTAL** | |

Nutritional Health Score

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

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

**The Nutrition Screening Initiative · 1010 Wisconsin Avenue, NW · Suite 800 · Washington, DC 2007**
The Nutrition Screening Initiative is funded in part by a grant from Ross Products Division of Abbott Laboratories, Inc.

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Proveedor o centro: _____

Nombre del cliente: _____

Identificación del cliente:_____

Fecha: _____

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

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

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

Puntaje de salud nutricional

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

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

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