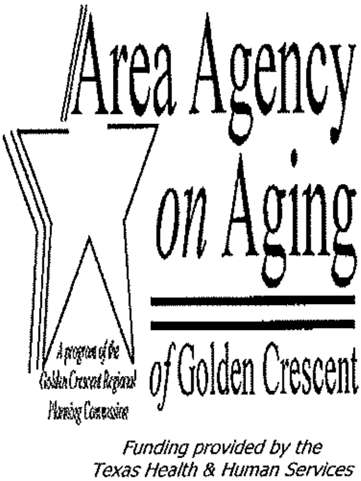

Funding provided by the Texas Health & Human Services

TEXAS Health and Human Services

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

CLIENT INTAKE AND SERVICE REQUEST FORM

FORMA DE ADMISIÓN Y SOLICITUD DE SERVICIOS PARA CLIENTES

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

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

CLIENT INTAKE AND SERVICE REQUEST FORM

(Items in **BOLD** must be completed)

Client Rights & Responsibilities and Release of Information have been clearly explained to the client. ☐

Date: ____________ Client ID Number (office use only)____________

Last Name: ____________ **MI:** ______ **First Name:** ____________

Gender: Male ☐ **Female** ☐ **Birth Date:** ____________ Primary Language: ____________

Home Address: Street/Apt. #: ____________

City: ____________ **State:** ______ **Zip Code:** ______ **County:** ______

☐ **Check if Mailing Address is Home Address**

Mailing Address: Street/Apt. #: ____________

City: ____________ State: ______ Zip Code: ______ County: ______

Phone: (______) ____________ Home ☐ Cell ☐ Other ☐ (Check One)

Ethnicity (Check One):

(1) Hispanic or Latino ☐

(2) Not Hispanic or Latino ☐

(3) Ethnicity Not Reported ☐

Race (Check all that apply):

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

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CLIENT INTAKE AND SERVICE REQUEST FORM, PAGE 2

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

Client living in poverty (Low Income)? **Yes** ☐ **No** ☐

Service(s) Requested: ____

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

☐ QMB & SLMB Would You Like More Information About these Programs?______________

To be completed by AAA/provider staff:

Print name of AAA/provider staff completing Intake: ______________________________

Nutrition Services*: If participant is "other Older Americans Act(OAA) or Nutrition Service Incentive Program (NSIP) eligible participant under 60 years of age", check which of the following applies:

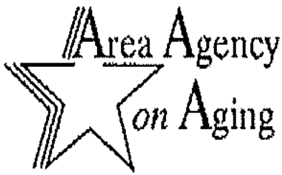
(1) Spouse is eligible and participates in congregate or home delivered meal program. ☐
(2) Serves as volunteer at the nutrition site in accordance with OAA standards. ☐
(3) Disabled/resides in the housing facility and wants to participate in the congregate meal program provided at the site. ☐
(4) Disabled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

Optional-Referred By____

Referral Contact Information: ____________________**Phone** ____________________**email**

Additional Notes Regarding Referral:

- ***Except for Nutrition and Caregiver Respite Services, Older Americans Act programs require that consumers be age 60 and over.***



Area Agency on Aging of Golden Crescent

Client Rights & Responsibilities for Older Americans Act Programs

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

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

Client rights and responsibilities:

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

Service Provider Information:	Area Agency on Aging Information
	Cindy Cornish, AAA Director Golden Crescent AAA 1908 N. Laurent, Suite 600 Victoria, TX 77901 361-578-1587, ex 223 1-800-252-9240 cindyco@gcrpc.org Michael Ada, GCRPC Executive Director Golden Crescent Regional Planning Commission 1908 N. Laurent, Suite 600 Victoria, TX 77901 361-578-1587, ex 204 michaela@gcrpc.org

Funded by the Texas Department of Aging and Disability Services

4. You have the right to participate in the development of a care plan to address unmet needs. ☐ N/A

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

6. You have the right to make an independent choice of service providers from the list furnished by the Area Agency on Aging where multiple service providers are available and change service providers when desired. ☐ N/A

7. You have the right to be informed of any change in service(s). ☐ N/A

8. You have the right to make a voluntary, confidential, contribution for services received through the Area Agency on Aging. Services will not be denied if an eligible participant is unable or chooses not to make a contribution. All contributions will be kept confidential and will be utilized to expand or enhance the service(s) for which they were provided.

9. You have the responsibility to inform the Area Agency on Aging or its service provider(s) of your intent to withdraw from the program or any known periods of absenteeism when services will not be utilized. ☐ N/A

10. You have the responsibility to provide the Area Agency on Aging or its services provider(s) with complete and accurate information.

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

____________________________________ ____________________

Client Signature Date

Funded by the Texas Department of Aging and Disability Services

Area Agency on Aging of Golden Crescent

1908 N. Laurent, Suite 600 Victoria, Texas 77901 361-578-1587, 1-361-578-8865 (fax) 1-800-252-9240, or dial 2-1-1

Client Information Release

Client Name:	**Client ID:** NA
By signing this authorization, you are giving the Area Agency on Aging (AAA) _____ permission to release all or part of your information provided, which includes health information. Failure to provide this authorization will result in limited service by the AAA. This release includes access to a continuum of service(s) available through the AAA or its providers.	

PARTS A, B & C TO BE COMPLETED BY CLIENT OR PERSONAL REPRESENTATIVE

I authorize the Area Agency on Aging to release my information to the following person or agency for the purpose(s) stated in Part A. My information will remain available to the person or agency indicated in accordance with the expiration event or date in Part B.

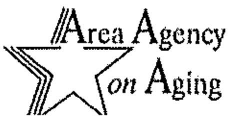
PART A – Release of Information
I understand that my information may contain protected health information. Release my information to the following person or agency: ☐ Any person or agency necessary to meet my service needs.
☐ Only the persons or entities identified:
Check one of the following: ☐ Release all of my information. ☐ Release only the following information:

PART B – Purpose of Release
☐ General: To assist in assessing, arranging, and meeting individual service needs.
☐ Specific:
☐ Expiration: This authorization expires at point of reassessment, where applicable, or within three years of effective date.

PART C – Signature	
(Client or Personal Representative)	(Date)
☐ Check if you are signing for the client and please describe your authority to act for the client on the following line:	
Note: If the person requesting the release of information cannot sign his/her name, two witnesses to his/her mark (X) must sign below. Accept one witness signature in circumstances where it is not possible to obtain two witness signatures. Document the reason in the client file.	
Witness:	Date:
Witness:	Date:

Notice to Client:

- ✓ Once the authorization to release your information is granted, the AAA is not responsible for any redisclosure of the information by the recipient.
- ✓ You can withdraw permission you have given the AAA to use or disclose health information that identifies you, unless the AAA has already taken action based on your permission. You must withdraw your permission in writing.



Agencia del Área para Adultos Mayores de Golden Crescent

1908 N. Laurent, Suite 600 Victoria, Texas 77901 361-578-1587, 1-361-578-8865 (fax), 1-800-252-9240, or dial 2-1-1

Divulgación de información del cliente

Nombre del cliente:	**Identificación del cliente:**
Al firmar esta autorización, usted da a la Agencia del Área para Adultos Mayores (AAA) _____ permiso para divulgar toda o parte de su información provista, que incluye información médica. Si no firma esta autorización, la AAA limitará los servicios que le ofrece. Esta autorización de divulgación da acceso a una gama de servicios disponibles por medio de la AAA o de sus proveedores.	

EL CLIENTE O SU REPRESENTANTE PERSONAL DEBE LLENAR LAS PARTES A, B Y C

Yo autorizo a la Agencia del Área para Adultos Mayores para que divulgue mi información a las siguientes personas o departamentos con el propósito indicado en la Parte A. La información estará disponible para la persona o el departamento indicado hasta el evento o la fecha de vencimiento anotada en la Parte B.

PARTE A. Divulgación de información
Entiendo que la información puede contener información médica protegida. Divulguen mi información a la siguiente persona o departamento: ☐Cualquier persona o departamento, si se tiene que hacer para satisfacer mis necesidades de servicios.
☐Sólo a las personas o entidades identificadas:
Marque una de las siguientes opciones: ☐ Divulguen toda mi información. ☐ Divulguen sólo la siguiente información:

PARTE B. Propósito de la divulgación
☐ General: asistir en evaluación, hacer arreglos, y a satisfacer las necesidades personales de servicios.
☐Específico:
Expiración: Esta autorización expira en el punto de la revaluación, donde esto se aplica, o tres años después de la fecha de vigencia.

PARTE C. Firmas	
(Cliente o Representante personal)	(Fecha)
☐ Marque este cuadro si firmó en nombre del cliente y describa en el siguiente renglón qué autoridad tiene para actuar por el cliente:	
Nota: si la persona que pide la divulgación de información no puede firmar su nombre, dos testigos de su marca (X) tienen que firmar a continuación. Acepte la firma de un solo testigo cuando no sea posible obtener la firma de dos testigos. Documente la razón en el archivo de cliente.	
Testigo:	Fecha:
Testigo:	Fecha:

Aviso al cliente:

- ✓ Una vez que se conceda la autorización para divulgar su información, la AAA no se hace responsable de ninguna divulgación de la información de parte del destinatario.
- ✓ Usted puede retirar el permiso que le haya dado a la AAA para usar o divulgar información de salud que lo identifique a usted, a menos que la AAA ya haya tomado alguna acción de acuerdo con su permiso. Si quiere retirar el permiso, tiene que hacerlo por escrito.