AGING & DISABILITY NETWORK CONSUMER INTAKE FORM FY19/20

The service you are receiving is paid for in whole or in part by funds from the federal Older American's Act and the State of Iowa. Your responses on this form are confidential. The Department on Aging uses this important information to research the needs of older Iowans. Thank you for providing your information.

Today's Date: _____

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

Date of Birth: _____ /_____ /_____ or **Age:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home Phone: (_____) _____ **Cell Phone:** (_____)_____

Email: _____

Demographic Information

Do you live alone? ☐ Yes ☐ No **Number in Household Including Yourself:** _____

Please Check Your Annual Total Household Income Range:

☐ $0 - $12,490 ☐ $12,491 - $16,910 ☐ $16,911 - $21,330
☐ $21,331 - $25,750 ☐ $25,751 - $30,170 ☐ $30,171 - $34,590
☐ $34,591 - $39,010 ☐ $39,011 - $43,430 ☐ $43,431 - or Above

Veteran Status: ☐ Not a Veteran ☐ Veteran ☐ Veteran Spouse/Dependent

Gender: ☐ Female ☐ Male ☐ Other

Race: ☐ White ☐ American Indian/Alaskan Native ☐ Asian
☐ African American/Black ☐ Native Hawaiian/Other Pacific Islander ☐ Other

Are You Hispanic or Latino: ☐ Yes ☐ No

Primary Language: ☐ English Other: _____

Does Medicaid pay for some of the services you receive in your home, such as homemaker, meals, transportation, organizing your medications, or bathing assistance?

☐ Yes ☐ No ☐ Don't Know

In the <u>past 30 days</u>, how often were these statements true:

I have worried whether my food would run out before I got money to buy more.

☐ Often ☐ Sometimes ☐ Never

The food that I bought just didn't last and I didn't have money to get more.

☐ Often ☐ Sometimes ☐ Never

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Consumer: _____

During the <u>past 7 days</u>, how would you rate your ability to complete these routine activities?

	I didn't need help	I needed help sometimes	I always needed help	Activity did not occur
Shop?	☐	☐	☐	☐
Manage your medications?	☐	☐	☐	☐
Prepare meals?	☐	☐	☐	☐
Use transportation?	☐	☐	☐	☐
IADL - Data Entry	0	1	2	3

How would you rate your ability to complete these activities?

	I don't need help	I need help sometimes	I always need help	Activity does not occur
Manage money?	☐	☐	☐	☐
Do heavy housework?	☐	☐	☐	☐
Do light housework?	☐	☐	☐	☐
Use the telephone?	☐	☐	☐	☐
IADL - Data Entry	0	1	2	3

During the <u>past 7 days</u>, how would you rate your ability to complete these physical activities?

	I didn't need help	I needed help sometimes	I always needed help
Walk?	☐	☐	☐
Bathe?	☐	☐	☐
Dress?	☐	☐	☐
Get out of bed or chair?	☐	☐	☐
Use the toilet?	☐	☐	☐
Eat?	☐	☐	☐
IADL - Data Entry	0	1	2

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Consumer: _____

Nutrition Risk Screening

☐ Yes	☐ No	**I have an illness or condition that made me change the kind and/or amount of food I eat.**
☐ Yes	☐ No	**I eat fewer than two meals per day.**
☐ Yes	☐ No	**I eat few fruits. (Less than 1 ½ cups daily)**
☐ Yes	☐ No	**I eat few vegetables. (Less than 2 cups daily)**
☐ Yes	☐ No	**I eat and/or drink few milk products. (Less than 3 cups daily)**
☐ Yes	☐ No	**I have three or more drinks of beer, liquor or wine almost every day.**
☐ Yes	☐ No	**I have tooth or mouth problems that make it hard for me to eat.**
☐ Yes	☐ No	**I don't always have enough money to buy the food I need.**
☐ Yes	☐ No	**I eat alone most of the time.**
☐ Yes	☐ No	**I take 3 or more different prescribed or over-the-counter drugs a day.**
☐ Yes	☐ No	**I have *gained* OR *lost* 10 pounds in the last 6 months without wanting to.**
☐ Yes	☐ No	**I am not always physically able to do one or more of: shopping, cooking, or feeding myself.**

The section below to be completed by provider ONLY.

Provider / Site: _____

NEW Intake Form: ☐ **UPDATED Intake Form:** ☐

Check the box next to the service provided:

☐ Case Management ☐ Congregate Meals ☐ Home Delivered Meals

☐ Nutrition Counseling ☐ Nutrition Education ☐ Options Counseling

☐ EAPA Assessment and Intervention