TITLE III INAKE

Provider Name:	**Unique Participate ID:**
Region/Site Name:	**Registration/Assessment Date:** **Termination Date:** ***Reason:**

Service Categories (Titles 111B, IIIC and IIID):

☐ ***Personal Care (111B)** (A, I) ☐ ***Homemaker (111B)** (A, I) ☐ ***Chore (111B)** (A, I)

☐ ***Home-Delivered Meals** (A, I, N) ☐ ***Adult Day Care/Health (111B)** (A, I) ☐ ***Case Management (1118)** (A, I)

☐ ***Assisted Transportation (111B)** ☐ ***Congregate Meals** (N) ☐ ***Nutrition Counseling** (N)

☐ Other: _____

Notes: *Reference the Data Dictionary for allowable "Other" service categories; Requires A-ADLs, 1-IADLs, N-Nutritional Assessments on Page 2*

SECTION 1 (Client)

*(*) **Required for All Registered Programs***

PERSONAL DATA (Please print):	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: ☐ Declined/not stated
***What was your sex at birth? (Check only one)**	☐ Male ☐ Female ☐ Declined/not stated
***How do you describe your sexual orientation or sexual identity? (Check only one)**	☐ Straight /Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: ☐ Declined/not stated
***Have you ever served in the United States military?**	☐ Yes ☐ No ☐ Declined/not stated
***Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?**	☐ Yes ☐ No ☐ Declined/not stated
***Lives Alone?**	☐ Yes ☐ No ☐ Declined/not stated
***Rural?**	☐ Yes ☐ No ☐ Declined/not stated

If you identify as being military-affiliated check below:
"I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for12 months."

☐ Yes ☐ No

Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.qov or 1-800-952-5626.

Residential Address:	
Street:	
City:	
***Zip Code:**	
Mailing Address: Same as Residential? ☐ Yes - Skip	
Street:	
City:	
***Zip Code:**	
***Ethnicity:**	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined/not stated
***Race: (Check all that apply)**	☐ White ☐ Black ☐ American Indian/Alaska Native Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Declined/not stated
Federal Poverty Level (FPL)	☐ YES(At or below ☐ NO(Above FPL) ☐ Decline/not stated

Date of Birth: _____ Home Phone: _____

Emergency Contact – Name: _____ Phone Number: _____

SECTION 2 - AOL and IADL (Activities of Daily Living and Instrumental Activities of Daily Living - Annual Assessment)

***Required for (III-C):** Home Delivered Meals; **(III-B):** Personal Care, Homemaker, Chore, Adult Day Care, Case Management*

ADLs:	1- Independent	2-Verbal Assistance	3-Some Human Help	4-Lots of Human Help	5– Dependent	Declined to State
*Eating						
*Bathing						
*Toileting						
*Transferring In/Out of Bed/Chair						
*Walking						
*Dressing						
Notes:						

IADLS:	1- Independent	2-Verbal Assistance	3-Some Human Help	4-Lots of Human Help	5– Dependent	Declined to State
*Meal Preparation						
*Shopping						
*Medication Management						
*Money Management						
*Using Telephone						
*Heavy Housework						
*Light Housework						
*Transportation						
Notes:						

SECTION 3 - Nutritional Risk Assessment (Annual)

* ***Required for (IIIC):** Home-Delivered Meals, Congregate Meals; Nutritional Counseling*

*Nutritional Risk Assessment:	Circle if 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 2 meals per day.	3
I eat few fruits or vegetables or milk products.	2
I have 3 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 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the past 6 months.	2
I am not always physically able to shop, cook, and/or feed myself.	2
Total Score:	
Is Nutrition Risk total score 0-5 or 6+?	**0-5** | **6+**
☐ **Declined to State**	