Form 2276
October 2021-E

Intake

Area Agency on Aging of Golden Crescent

The information on this form is needed to provide services. All information is confidential and will be guarded against unofficial use and shared only to get services started or changed.

☐ ***Release of Information and Client Rights and Responsibilities* explained.**

Note: All items marked with an asterisk (*) are required.

Part I – Recipient Identification

*Date:	SPURS ID No.:		Primary Language:	
*Last Name:	*First Name:	*MI:	*Date of Birth:	*Gender:
*Street Address and Apt. No.:	*City:	*State:	*ZIP Code:	*County:
*Area Code and Phone No.: Home	Email Address:			

☐ Check if Mailing Address is different from Home Address and enter Mailing Address below:

*Street Address and Apt. No. or P.O. Box:	*City:	*State:	*ZIP Code:	*County:

***Ethnicity** *(Check One)*:	***Race** *(Check all that apply)*:	**Marital Status** *(Check One)*:
◯ Hispanic or Latino	☐ American Indian or Alaska Native	◯ Married
◯ Not Hispanic or Latino	☐ Asian	◯ Widowed
◯ Unknown	☐ Black or African American	◯ Divorced
	☐ Native Hawaiian or Pacific Islander	◯ Separated
	☐ Non-Minority (White, Non-Hispanic)	◯ Never Married
	☐ White – Hispanic	◯ Not Reported
*Person lives alone? ◯ Yes ◯ No ◯ Don't Know	Total No. of People in Household:	Monthly Household Income:
Use current Department of Health and Human Services Federal Poverty Guidelines for size of household to decide if person is at or below poverty.		*At or below poverty? ◯ Yes ◯ No ◯ Don't Know

Monthly Income from:	**Participant**	**Spouse**
Job		
Social Security		
Supplemental Security Income		
Veterans Affairs		
Other Sources		
Other Benefits [e.g., Supplemental Nutritional Assistance Program (SNAP)]		

Part II – Service(s) Requested *(Completed by AAA or provider staff)*

List of Requested Services:

Meals

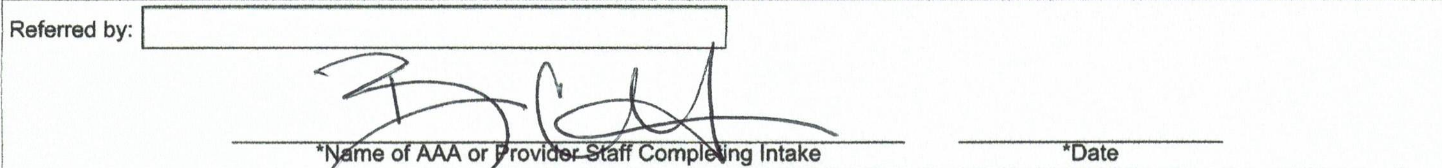
Are you enrolled in? ☐ Medicaid ☐ Medicare

Part III – Emergency Contact Information *(Completed by AAA or provider staff)*

Contact Name:	Relationship:	Area Code and Phone No.:
Primary Care Physician:		Area Code and Phone No.:

Part IV – Referral *(Completed by AAA or provider staff)*

Referred by:



*Name of AAA or Provider Staff Completing Intake — *Date

Part V – Nutrition Services *(Completed by AAA or provider staff)*

*Additional Eligibility Requirements if eligible person is under 60. Check which of the following applies:

☐ Eligible person is under 60 and the spouse of person 60 or older who takes part in the nutrition program.

☐ Eligible person is under 60, serves as volunteer at the nutrition site and the provider offers a meal according to AAA procedures.

☐ Eligible person is under 60, has a disability and lives in a housing facility occupied primarily by people 60 and over where congregate meals are served.

☐ Eligible person is under 60, has a disability, lives with a person eligible for a meal and the provider offers a meal according to AAA procedures.

Form 2277
March 2014-E

Client Information Release

Area Agency on Aging of Golden Crescent

Individual's Name	Individual's ID

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 and C are to be completed by the individual or personal representative.

I authorize the AAA 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.

Parts 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:

____

Parts B – Purpose of Release

☐ General: To assist in assessing, arranging and meeting individual service needs.

☐ Specific: ______________________

☐ Expiration:

This authorization expires at the point of reassessment, where applicable, or within three years of effective date. __________

Parts C – Signature

X

______________________ Signature – Individual or Personal Representative ______________________ Date

☐ Check if you are signing for the individual and describe your authority to act for the individual 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 individual's file.

______________________ Signature – Witness ______________________ Date

______________________ Signature – Witness ______________________ Date

Notice to Individual:

- 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.

Area Agency on Aging of Golden Crescent

Client Rights & Responsibilities and Release Information 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
Community Connections of Lavaca County/ Lavaca County Meals on Wheels Becky Janak, Program Manager P.O. Box 531 Hallettsville, TX 77964 361-798-2211 Lavacacountynutrition@gmail.com	Cheree Biggs, AAA Program Manager II Golden Crescent Area Agency on Aging 1908 N Laurent, Suite 600A, Victoria, TX 77901 (361) 578-1587 Ext, 215 | Chereeb@gcrpc.org Michael Ada, GCRPC Execute Director Golden Crescent Regional Planning Commission 1908 N Laurent, Suite 600A, Victoria, TX 77901 (361) 578-1587 | Michaela@gcrpc.org

Form#AIAAA_CR&R3.0
July 2, 2007

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

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.

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.

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

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.

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

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July 2, 2007

Funded by the Texas Department of Aging and Disability Services

Provider/Center: ______________________

Consumer Name: ______________________

Consumer ID: ______________________

Date: ______________________

DETERMINE YOUR NUTRITIONAL HEALTH

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
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