Please complete as much information on this intake as possible.

WHY?

Data collected from this intake is used to determine areas of need and funding for senior citizens.

If you fail to complete any portion of this intake, it will be determined that you do not need assistance in your Activities of Daily Living.

CAO of Scioto County, Inc. - Senior Nutrition Program
2023 Area Agency on Aging District 7, Inc. - Basic Napis Intake
USSA Senior Center Congregate Site

I. General Information

I.a. Assessment Information

1. What is the date of the Assessment?
_____/_____/_2023___

2. Specify the type of assessment, or the reason for the assessment.
- ☐ 1 - Initial Assessment
- ☐ 2 - Reassessment

3. What is the name of the person conducting this assessment?

4. What is the name of the agency the assessor works for?

I.B. Client Personal Information

1. What is the client's first name?

2. What is the client's middle initial?

3. What is the client's last name?

4. Enter the client's telephone number.

5. Enter the client's mailing address or Post Office box.

6. Enter the client's city.

7. Enter the client's state.

8. Enter the client's zip code.

9. Enter the client's residential address (only if different from mailing address)

10. Enter the client's residential city.

11. What township does the client live in?

NAPIS Information:

Client in poverty?	Yes	No
Client lives alone?	Yes	No
Client is Rural?	Yes	No

Ethnicity (check one)

- _____ African American
- _____ Non-minority (white)
- _____ Asian/Pacific Islander
- _____ Hispanic
- _____ American Indian/Alaskan

Characteristics (check all that apply)

- _____ Abused/Neglected/Exploited
- _____ Disabled
- _____ Duplicated Mail
- _____ Female Head of Household
- _____ Frail
- _____ Homebound
- _____ Food Stamps
- _____ State Resident
- _____ Tribal
- _____ Understands English
- _____ US Citizen
- _____ Veteran
- _____ Veteran Dependent
- _____ USDA Meals Eligible

Eligibility Reason

- _____ Age
- _____ Disabled in elderly housing
- _____ Helper/spouse
- _____ Other
- _____ Tribal
- _____ Volunteer

- _____ Health Insurance (Medicare,
- _____ Medicaid, Private, Self-Ins., None)

Highest Education Level in School

Directions to client's home.

I.C. Contact Information

1. What is the name of the client's primary care physician?

2. What is the work phone number for the client's primary care physician?

3. What is the name of the emergency contact?

4. What is the relationship between the client and the person who is listed as the emergency contact?

5. What is the home phone number of emergency contact?

6. What is the work number or cell number of the emergency contact?

SERVICES TO BE PROVIDED

Service:

- ☐ Home Delivered Meals
- ☒ Congregate Meals

Funding Source:

- ☒ Title III C-1
- ☐ Title III C-2
- ☐ Title XX
- ☐ PASSPORT
- ☐ CARE
- ☐ Choices
- ☐ Self-Pay

Start Date:

Description of service:

Congregate meals served Monday thru Friday at the USSA Senior Center Congregate Site.

I.D. Client Demographics

1. What is the client's date of birth? **(Required)**
_____/_____/_____

2. What is the client's Social Security Number?
(Last four digits are required for service)
___ ___ ___ - ___ ___ - ___ ___ ___ ___

3. What is the client's gender?
- ☐ 1- Female
- ☐ 2 - Male
- ☐ 3 - Transgendered

4. What is the client's ethnicity?
- ☐ 1-Non-minority (white, non-Hispanic)
- ☐ 2-African American
- ☐ 3-American Indian/Native Alaskan
- ☐ 4-Asian/Pacific Islander
- ☐ 5-Other

5. What is the client's ethnicity?
- ☐ 1-Not Hispanic or Latino
- ☐ 2-Hispanic or Latino

6. Specify the client's current language.
- ☐ 1-English
- ☐ 2-American Sign Language
- ☐ 3-Spanish
- ☐ 4-Other

7. Select the client's current marital status.
- ☐ 1-Single
- ☐ 2-Married
- ☐ 3-Separated
- ☐ 4-Widowed
- ☐ 5-Divorced
- ☐ 6-Life Partner

8. Indicate the type of residence that the client currently resides in.
- ☐ 1-House/Mobile Home
- ☐ 2-Private Apartment
- ☐ 3-Private apartment in senior housing
- ☐ 4-Residential care home
- ☐ 5-Other

9. How long has the client lived in her/his current residence?
- ☐ 1-Less than 12 months
- ☐ 2-One to three years
- ☐ 3-Three years or more

10. Select the client's current living arrangement.

- ☐ 1-Lives alone
- ☐ 2-Lives with spouse/partner only
- ☐ 3-Lives with spouse/partner & child
- ☐ 4-Lives with child(not spouse/partner)
- ☐ 5-Lives with others
- ☐ 6-Other

11. Is the client currently employed?

- ☐ 1-No
- ☐ 2-Yes - full/part time not specified

12. How many people are there in the client's household?

- ☐ 1 - One person
- ☐ 2 - Two people
- ☐ 3 - Three people
- ☐ 4 - Four or more people

13. Specify the client's monthly income and source.

$

14. Is the client's income level below the national poverty level?

- ☐ 1-No
- ☐ 2-Yes

15. How many prescription medications does the client take?

16. Who else lives in the household and specify their monthly income.

Name	Income amount/source

II. Nutrition Risk

II.A. Nutrition

1. Has the client made any changes in lifelong eating habits because of health problems?
   - ☐ 1 - No
   - ☐ 2 - Yes
2. Does the client eat fewer than two meals per day?
   - ☐ 1 - No
   - ☐ 2 - Yes
3. Does the client eat fewer than five servings of fruits or vegetables every day?
   - ☐ 1 - No
   - ☐ 2 - Yes
4. Does the client eat fewer than two servings of dairy products (milk, yogurt, or cheese) every day?
   - ☐ 1 - No
   - ☐ 2 - Yes
5. Does the client sometimes not have enough money to buy food?
   - ☐ 1 - No
   - ☐ 2 - Yes
6. Does the client have trouble eating well due to problems with chewing/swallowing?
   - ☐ 1 - No
   - ☐ 2 - Yes
7. Does the client eat alone most of the time?
   - ☐ 1 - No
   - ☐ 2 - Yes
8. Without wanting to, has the client lost or gained 10 pounds in the past six months?
   - ☐ 1 - No
   - ☐ 2 - Yes
9. Is the client not always physically able to shop, cook and/or feed themselves (or to get someone to do it for them)?
   - ☐ 1 - No
   - ☐ 2 - Yes
10. Does the client have 3 or more drinks of beer, liquor, or wine almost every day?
    - ☐ 1 - No
    - ☐ 2 - Yes

11. Does the client take 3 or more different prescribed or over-the-counter drugs per day?

- ☐ 1 - No
- ☐ 2 - Yes

III. ADL's/IADL's

III.A. Activities of Daily Living (ADL)

1. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform BATHING (including shower, full tub or sponge bath, exclude washing back or hair)?

- ☐ 0-Independent
- ☐ 1-Supervision
- ☐ 2-Requires assistance sometimes
- ☐ 3-Mostly dependent
- ☐ 4-Totally dependent
- ☐ 5-Activity does not occur

2. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform DRESSING?

- ☐ 0-Independent
- ☐ 1-Supervision
- ☐ 2-Limited assistance
- ☐ 3-Extensive assistance
- ☐ 4-Total dependence
- ☐ 5-Activity did not occur

3. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TOILET USE?

- ☐ 0-Independent
- ☐ 1-Supervision
- ☐ 2-Sometimes dependent
- ☐ 3-Mostly dependent
- ☐ 4-Totally dependent
- ☐ 5-Activity does not occur

4. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TRANSFER?

- ☐ 0-Independent
- ☐ 1-Supervision
- ☐ 2-Minimal assistance required
- ☐ 3-Mostly dependent
- ☐ 4-Totally dependent
- ☐ 5-Activity does not occur

5. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform EATING?

- ☐ 0-Independent
- ☐ 1-Supervision
- ☐ 2-Sometimes dependent
- ☐ 3-Mostly dependent
- ☐ 4-Totally dependent
- ☐ 5-Unknown

6. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform WALKING IN HOME?

- ☐ 0-Independent
- ☐ 1-Supervision
- ☐ 2-Limited assistance
- ☐ 3-Extensive assistance
- ☐ 4-Total dependence
- ☐ 5-Activity did not occur

III.B. Instrumental Activities of Daily Living (IADL)

1. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MEAL PREPARATION?

- ☐ 0-Independent
- ☐ 1-Sometimes dependent
- ☐ 2-Mostly dependent
- ☐ 3-Totally Dependent
- ☐ 4-Activity does not occur

2. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MANAGING MEDICATIONS?

- ☐ 0-Independent
- ☐ 1-Needs reminders
- ☐ 2-Somewhat dependent
- ☐ 3-Totally Dependent
- ☐ 4-Activity does not occur

3. Specify the client's ability to manage money.

- ☐ 0-Completely independent
- ☐ 1-Needs assistance sometimes
- ☐ 2-Needs assistance most of the time
- ☐ 3-Completely Dependent
- ☐ 4-Activity does not occur

4. Specify the client's ability to perform heavy housework.

- ☐ 0-Independent
- ☐ 1-Needs assistance sometimes
- ☐ 2-Needs assistance most of the time
- ☐ 3-Unable to perform tasks
- ☐ 4-Activity does not occur

5. Specify the client's ability to perform light housekeeping.

- ☐ 0-Independent
- ☐ 1-Needs assistance sometimes
- ☐ 2-Needs assistance most of the time
- ☐ 3-Unable to perform tasks
- ☐ 4-Activity does not occur

6. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform SHOPPING?

- ☐ 0-Independent
- ☐ 1-Somewhat dependent
- ☐ 2-Mostly dependent
- ☐ 3-Totally Dependent
- ☐ 4-Activity does not occur

7. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TRANSPORTATION?

- ☐ 0-Independent
- ☐ 1-Somewhat dependent
- ☐ 2-Mostly dependent
- ☐ 3-Totally Dependent
- ☐ 4-Unknown

8. Rank the client's ability to use the Telephone.

- ☐ 0-Independent
- ☐ 1-Able to perform but needs verbal assistance
- ☐ 2-Can perform with some human help
- ☐ 3-Can perform with a lot of human help
- ☐ 4-Cannot perform function at all without human help
- ☐ 5-Paramedical services needed

Client Signature Date

Signature of person Conducting Assessment Date

CAO of Scioto Co., Inc.
Social Service Department

Client Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their private health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means

I may be contacted in all the following means listed below except
(check all that apply)

- ☐ Home Telephone
- ☐ Written Communication
- ☐ Mail message to home address
- ☐ Other
- ☐ Leave message with contact person
- ☐ Leave message with call back phone number only
- ☐ Leave message with detailed information

Client Signature: _____ Date: _____

Printed Name: _____

The privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, is an adequate record.

Note: Uses & disclosures for PHI may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	Description of Disclosure/ Purpose of Disclosure

CAO of Scioto Co., Inc.
Social Service Department

Consent to Release Protected Health Information for Treatment, Payment, or Health Care Operations

I understand that CAO Social Service Department creates and uses a record of my health history, service history, and related financial information that may be used for:

* continuing care and service
* a way of communicating with other health care professionals who are involved in my care
* to provide information used in billing for my care
* review in quality assessment projects designed to help the CAO Social Service Department to improve it's ability to provide good service

My signature below authorizes the above uses of my records and also signifies that I was given a "NOTICE OF PRIVACY PRACTICES" and that the notice provides a more complete description of the ways my records might be used or disclosed when I become a client of the CAO Social Service Department. I understand that the Social Service Department's policies about using information might change from time to time and that I can obtain another copy of the notice from the CAO Social Service Department Privacy Officer at any time I would like.

I know that I can request restrictions in the way my records are used, but I also understand the CAO Social Service Department is not required to abide by my restrictions. I also understand that I can revoke this consent at anytime but this revocation will not apply to uses of my records between the date of this consent and the date of revocation.

Please restrict the use of my records as follows: _____

_____

_____

_____

Client Signature: _____ Date: _____

OFFICE USE ONLY
I attempted to obtain the client's signature in acknowledgement on this Notice of Privacy Practices but was unable to do so as documented below: Reason:
Date: Name:

CAO of Scioto Co., Inc. - CSBG Intake Form Program Year: 2023

SS#: _____ Last Name: _____ First Name: _____

DOB: _____ Address: _____

City: _____ Zip: _____ County: _____

Phone #: _____ Message Phone: _____ Cell Phone: _____

Gender:
☐ Female
☐ Male

Disabled:
☐ Yes
☐ No

Ethnicity:
☐ Black/African American ☐ Asian ☐ Hispanic or Latin
☐ Native American/Alaskan ☐ Native Hawaiian/Pacific Islander
☐ White/Caucasian ☐ Other ☐ Multi-Race (any 2 or more above)

Education:
☐ A. 0-8
☐ B. 9-12 (non-Grad)
☐ C. HS Grad/GED
☐ D. 12+
☐ E. 2-4 yr. Grad. College

Food Stamps:
☐ Yes
☐ No

Health Insurance:
☐ A. Medicaid ☐ C. Private ☐ E. None
☐ B. Medicare ☐ D. Self-Ins. ☐ F. Unknown

Housing ☐ Own ☐ Rent ☐ Homeless ☐ Other

Income Eligibility Period:
☐ D. Annually
☐ E. 13 weeks
☐ F. 3 months
☐ G. 6 months

Veteran:
☐ Yes
☐ No

 # In HH

Family Type
☐ Single Par/Female ☐ Single
☐ Single Par/Male ☐ Couple
☐ Two Parent ☐ Other

☐ A. Weekly
☐ B. Bi-weekly
☐ C. Monthly

Source of Income:
☐ A. Employment ☐ C. Social Security ☐ E. GA ☐ G. Pension ☐ I. Other
☐ B. Unemployment ☐ D. TANF/OWF ☐ F. SSI/SSD ☐ H. No Income ☐ J.Zero Income

Income Amt.

Other Household Members - Use codes from above ONLY for Information listed below

SS#						
Last Name						
First Name						
Date of Birth						
Male/Female						
Disabled (Y/N)						
Ethnicity						
Education						
Veteran (Y/N)						
Health Insur.						
Income Period						
Source						
Income Amt.						

I certify that this statement is true and correct to the best of my knowledge, and
I authorize the release of any or all information necessary for verification purposes.

Applicant signature: _____ Date: _____

Comments: _____

OCEAN Client ID# _____ Agency Site: Senior Nutrition Program