

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
2026 Area Agency on Aging District 7, Inc. - Basic NAPIS Intake
USSA Senior Center Congregate Site

I. General Information	NAPIS Information:	
I.a. Assessment Information	Client in poverty?	Yes No
1. What is the date of the Assessment? _____ / _____ / 2026__	Client lives alone?	Yes No
	Client is Rural?	Yes No
2. Specify the type of assessment, or the reason for the assessment. <input type="checkbox"/> 1 - Initial Assessment <input type="checkbox"/> 2 - Reassessment	Ethnicity (check one)	
	African American	
	Non-minority (white)	
	Asian/Pacific Islander	
	Hispanic	
	American Indian/Alaskan	
3. What is the name of the person conducting this assessment?		
4. What is the name of the agency the assessor works for?	Characteristics (check all that apply)	
	<input type="checkbox"/> Abused/Neglected/Exploited	
	<input type="checkbox"/> Disabled	
	<input type="checkbox"/> Duplicated Mail	
	<input type="checkbox"/> Female Head of Household	
	<input type="checkbox"/> Frail	
	<input type="checkbox"/> Homebound	
	<input type="checkbox"/> Food Stamps	
	<input type="checkbox"/> State Resident	
	<input type="checkbox"/> Tribal	
	<input type="checkbox"/> Understands English	
	<input type="checkbox"/> US Citizen	
	<input type="checkbox"/> Veteran	
	<input type="checkbox"/> Veteran Dependent	
	<input type="checkbox"/> USDA Meals Eligible	
	Eligibility Reason	
	<input type="checkbox"/> Age	
	<input type="checkbox"/> Disabled in elderly housing	
	<input type="checkbox"/> Helper/spouse	
	<input type="checkbox"/> Other	
	<input type="checkbox"/> Tribal	
	<input type="checkbox"/> Volunteer	
5. Enter the client's mailing address or Post Office box.	<input type="checkbox"/> Health Insurance (Medicare, Medicaid, Private, Self-Ins., None)	
6. Enter the client's city.	<input type="checkbox"/> Highest Education Level in School	
7. Enter the client's state.	Directions to client's home.	
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?		

I.C. Contact Information	I.D. Client Demographics
1. What is the name of the client's primary care physician?	1. What is the client's date of birth? (Required) _____/_____/_____
2. What is the work phone number for the client's primary care physician?	2. What is the client's Social Security Number? (Last four digits are required for service) _____-_____-_____
3. What is the name of the emergency contact?	3. What is the client's gender? <input type="checkbox"/> 1- Female <input type="checkbox"/> 2 - Male <input type="checkbox"/> 3 - Transgendered
4. What is the relationship between the client and the person who is listed as the emergency contact?	4. What is the client's ethnicity? <input type="checkbox"/> 1-Non-minority (white, non-Hispanic) <input type="checkbox"/> 2-African American <input type="checkbox"/> 3-American Indian/Native Alaskan <input type="checkbox"/> 4-Asian/Pacific Islander <input type="checkbox"/> 5-Other
5. What is the home phone number of emergency contact?	5. What is the client's ethnicity? <input type="checkbox"/> 1-Not Hispanic or Latino <input type="checkbox"/> 2-Hispanic or Latino
6. What is the work number or cell number of the emergency contact?	6. Specify the client's current language. <input type="checkbox"/> 1-English <input type="checkbox"/> 2-American Sign Language <input type="checkbox"/> 3-Spanish <input type="checkbox"/> 4-Other
SERVICES TO BE PROVIDED	
Service: <input type="checkbox"/> Home Delivered Meals <input checked="" type="checkbox"/> Congregate Meals	7. Select the client's current marital status. <input type="checkbox"/> 1-Single <input type="checkbox"/> 2-Married <input type="checkbox"/> 3-Separated <input type="checkbox"/> 4-Widowed <input type="checkbox"/> 5-Divorced <input type="checkbox"/> 6-Life Partner
Funding Source: <input checked="" type="checkbox"/> Title III C-1 <input type="checkbox"/> Title III C-2 <input type="checkbox"/> Title XX <input type="checkbox"/> PASSPORT <input type="checkbox"/> CARE <input type="checkbox"/> Choices <input type="checkbox"/> Self-Pay	8. Indicate the type of residence that the client currently resides in. <input type="checkbox"/> 1-House/Mobile Home <input type="checkbox"/> 2-Private Apartment <input type="checkbox"/> 3-Private apartment in senior housing <input type="checkbox"/> 4-Residential care home <input type="checkbox"/> 5-Other
Start Date: Description of service: Congregate meals served Monday thru Friday at the USSA Senior Center Congregate Site.	9. How long has the client lived in her/his current residence? <input type="checkbox"/> 1-Less than 12 months <input type="checkbox"/> 2-One to three years <input type="checkbox"/> 3-Three years or more

<p>10. Select the client's current living arrangement.</p> <p><input type="checkbox"/> 1-Lives alone</p> <p><input type="checkbox"/> 2-Lives with spouse/partner only</p> <p><input type="checkbox"/> 3-Lives with spouse/partner & child</p> <p><input type="checkbox"/> 4-Lives with child(not spouse/partner)</p> <p><input type="checkbox"/> 5-Lives with others</p> <p><input type="checkbox"/> 6-Other</p>	<p>II. Nutrition Risk</p>												
<p>11. Is the client currently employed?</p> <p><input type="checkbox"/> 1-No</p> <p><input type="checkbox"/> 2-Yes - full/part time not specified</p>	<p>II.A. Nutrition</p>												
<p>12. How many people are there in the client's household?</p> <p><input type="checkbox"/> 1 - One person</p> <p><input type="checkbox"/> 2 - Two people</p> <p><input type="checkbox"/> 3 - Three people</p> <p><input type="checkbox"/> 4 - Four or more people</p>	<p>1. Has the client made any changes in lifelong eating habits because of health problems?</p> <p><input type="checkbox"/> 1 - No</p> <p><input type="checkbox"/> 2 - Yes</p>												
<p>13. Specify the client's monthly income and source.</p> <p style="text-align: center;">\$ <input style="width: 150px; height: 20px;" type="text"/></p>	<p>2. Does the client eat fewer than two meals per day?</p> <p><input type="checkbox"/> 1 - No</p> <p><input type="checkbox"/> 2 - Yes</p>												
<p>14. Is the client's income level below the national poverty level?</p> <p><input type="checkbox"/> 1-No</p> <p><input type="checkbox"/> 2-Yes</p>	<p>3. Does the client eat fewer than five servings of fruits or vegetables every day?</p> <p><input type="checkbox"/> 1 - No</p> <p><input type="checkbox"/> 2 - Yes</p>												
<p>15. How many prescription medications does the client take?</p> <p style="text-align: center;"><input style="width: 150px; height: 20px;" type="text"/></p>	<p>4. Does the client eat fewer than two servings of dairy products (milk, yogurt, or cheese) every day?</p> <p><input type="checkbox"/> 1 - No</p> <p><input type="checkbox"/> 2 - Yes</p>												
<p>16. Who else lives in the household and specify their monthly income.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Name</th> <th style="width: 30%;">Income amount/source</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> </tbody> </table>	Name	Income amount/source											<p>5. Does the client sometimes not have enough money to buy food?</p> <p><input type="checkbox"/> 1 - No</p> <p><input type="checkbox"/> 2 - Yes</p>
Name	Income amount/source												
	<p>6. Does the client have trouble eating well due to problems with chewing/swallowing?</p> <p><input type="checkbox"/> 1 - No</p> <p><input type="checkbox"/> 2 - Yes</p>												
	<p>7. Does the client eat alone most of the time?</p> <p><input type="checkbox"/> 1 - No</p> <p><input type="checkbox"/> 2 - Yes</p>												
	<p>8. Without wanting to, has the client lost or gained 10 pounds in the past six months?</p> <p><input type="checkbox"/> 1 - No</p> <p><input type="checkbox"/> 2 - Yes</p>												
	<p>9. Is the client not always physically able to shop, cook and/or feed themselves (or to get someone to do it for them)?</p> <p><input type="checkbox"/> 1 - No</p> <p><input type="checkbox"/> 2 - Yes</p>												
	<p>10. Does the client have 3 or more drinks of beer, liquor, or wine almost every day?</p> <p><input type="checkbox"/> 1 - No</p> <p><input type="checkbox"/> 2 - Yes</p>												

<p>11. Does the client take 3 or more different prescribed or over-the-counter drugs per day?</p> <p><input type="checkbox"/> 1 - No</p> <p><input type="checkbox"/> 2 - Yes</p>	<p>4. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TRANSFER?</p> <p><input type="checkbox"/> 0-Independent</p> <p><input type="checkbox"/> 1-Supervision</p> <p><input type="checkbox"/> 2-Minimal assistance required</p> <p><input type="checkbox"/> 3-Mostly dependent</p> <p><input type="checkbox"/> 4-Totally dependent</p> <p><input type="checkbox"/> 5-Activity does not occur</p>
III. ADL's/IADL's	
III.A. Activities of Daily Living (ADL)	
<p>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)?</p> <p><input type="checkbox"/> 0-Independent</p> <p><input type="checkbox"/> 1-Supervision</p> <p><input type="checkbox"/> 2-Requires assistance sometimes</p> <p><input type="checkbox"/> 3-Mostly dependent</p> <p><input type="checkbox"/> 4-Totally dependent</p> <p><input type="checkbox"/> 5-Activity does not occur</p>	<p>5. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform EATING?</p> <p><input type="checkbox"/> 0-Independent</p> <p><input type="checkbox"/> 1-Supervision</p> <p><input type="checkbox"/> 2-Sometimes dependent</p> <p><input type="checkbox"/> 3-Mostly dependent</p> <p><input type="checkbox"/> 4-Totally dependent</p> <p><input type="checkbox"/> 5-Unknown</p>
<p>2. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform DRESSING?</p> <p><input type="checkbox"/> 0-Independent</p> <p><input type="checkbox"/> 1-Supervision</p> <p><input type="checkbox"/> 2-Limited assistance</p> <p><input type="checkbox"/> 3-Extensive assistance</p> <p><input type="checkbox"/> 4-Total dependence</p> <p><input type="checkbox"/> 5-Activity did not occur</p>	<p>6. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform WALKING IN HOME?</p> <p><input type="checkbox"/> 0-Independent</p> <p><input type="checkbox"/> 1-Supervision</p> <p><input type="checkbox"/> 2-Limited assistance</p> <p><input type="checkbox"/> 3-Extensive assistance</p> <p><input type="checkbox"/> 4-Total dependence</p> <p><input type="checkbox"/> 5-Activity did not occur</p>
<p>3. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TOILET USE?</p> <p><input type="checkbox"/> 0-Independent</p> <p><input type="checkbox"/> 1-Supervision</p> <p><input type="checkbox"/> 2-Sometimes dependent</p> <p><input type="checkbox"/> 3-Mostly dependent</p> <p><input type="checkbox"/> 4-Totally dependent</p> <p><input type="checkbox"/> 5-Activity does not occur</p>	III.B. Instrumental Activities of Daily Living (IADL)
	<p>1. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MEAL PREPARATION?</p> <p><input type="checkbox"/> 0-Independent</p> <p><input type="checkbox"/> 1-Sometimes dependent</p> <p><input type="checkbox"/> 2-Mostly dependent</p> <p><input type="checkbox"/> 3-Totally Dependent</p> <p><input type="checkbox"/> 4-Activity does not occur</p>

<p>2. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MANAGING MEDICATIONS?</p> <p><input type="checkbox"/> 0-Independent <input type="checkbox"/> 1-Needs reminders <input type="checkbox"/> 2-Somewhat dependent <input type="checkbox"/> 3-Totally Dependent <input type="checkbox"/> 4-Activity does not occur</p>	<p>6. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform SHOPPING?</p> <p><input type="checkbox"/> 0-Independent <input type="checkbox"/> 1-Somewhat dependent <input type="checkbox"/> 2-Mostly dependent <input type="checkbox"/> 3-Totally Dependent <input type="checkbox"/> 4-Activity does not occur</p>
<p>3. Specify the client's ability to manage money.</p> <p><input type="checkbox"/> 0-Completely independent <input type="checkbox"/> 1-Needs assistance sometimes <input type="checkbox"/> 2-Needs assistance most of the time <input type="checkbox"/> 3-Completely Dependent <input type="checkbox"/> 4-Activity does not occur</p>	<p>7. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TRANSPORTATION?</p> <p><input type="checkbox"/> 0-Independent <input type="checkbox"/> 1-Somewhat dependent <input type="checkbox"/> 2-Mostly dependent <input type="checkbox"/> 3-Totally Dependent <input type="checkbox"/> 4-Unknown</p>
<p>4. Specify the client's ability to perform heavy housework.</p> <p><input type="checkbox"/> 0-Independent <input type="checkbox"/> 1-Needs assistance sometimes <input type="checkbox"/> 2-Needs assistance most of the time <input type="checkbox"/> 3-Unable to perform tasks <input type="checkbox"/> 4-Activity does not occur</p>	<p>8. Rank the client's ability to use the Telephone.</p> <p><input type="checkbox"/> 0-Independent <input type="checkbox"/> 1-Able to perform but needs verbal assistance <input type="checkbox"/> 2-Can perform with some human help <input type="checkbox"/> 3-Can perform with a lot of human help <input type="checkbox"/> 4-Cannot perform function at all without human help <input type="checkbox"/> 5-Paramedical services needed</p>
<p>5. Specify the client's ability to perform light housekeeping.</p> <p><input type="checkbox"/> 0-Independent <input type="checkbox"/> 1-Needs assistance sometimes <input type="checkbox"/> 2-Needs assistance most of the time <input type="checkbox"/> 3-Unable to perform tasks <input type="checkbox"/> 4-Activity does not occur</p>	
<p>Client Signature</p>	<p>Date</p>
<p>Signature of person Conducting Assessment</p>	<p>Date</p>

**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)

- | | |
|--|---|
| <input type="checkbox"/> Home Telephone
<input type="checkbox"/> Written Communication
<input type="checkbox"/> Mail message to home address
<input type="checkbox"/> Other | <input type="checkbox"/> Leave message with contact person
<input type="checkbox"/> Leave message with call back phone number only
<input type="checkbox"/> 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:

