Institute on Aging

INTAKE FORM

Intake Staff Name ____________________ Date __________

Referral ☐ MSSP ☐ Linkages ☐ Friendship Line ☐ Lifeways ☐ MOP ☐ Swindells
☐ SSE ☐ ADP ☐ Psychology ☐ Assessment ☐ OACM ☐ HDM

Last Name ____________________ First Name ____________________ ☐ M ☐ F

Address ____________________ City __________ State ____ Zip ______

Phone # ____________ Birth Date ____________ SSN # ____________

REFERRAL SOURCE

Last Name ____________________ First Name ____________________

Address ____________________ City __________ State ____ Zip ______

Phone ____________ Cell Phone ____________ Fax ____________

Email ____________________ Relationship to client ____________________

Agency ____

How did you hear about the IOA? ☐ Advertising ☐ E-News ☐ Internet
☐ Mailing ☐ Referral ☐ Events

Would you like to receive our newsletters? ☐ Yes ☐ No ☐ Already receive

Reason for Referral/Presenting Problems (230 character limit):

Was referral discussed with client? ☐ Yes ☐ No Level of Interest: ☐ High ☐ Low ☐ Unsure

Medi-Cal ☐ Yes ☐ No # ____________ Date Issued ____________

Medicare ☐ Yes ☐ A ☐ B ☐ D ☐ No # ____________ Date Issued ____________

Does client have ☐ LTC Insurance ☐ VA services ☐ Health Insurance ____________

Monthly Income $ ________ ☐ SSI ☐ VA ☐ GA ☐ Pension ☐ Other ____________

CLIENT INFORMATION

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partnered

Race/Ethnicity ☐ African-American ☐ Asian ☐ Caucasian ☐ Latin ☐ Pacific Islands
☐ Other Religious Affiliation

Primary Language Speaks English? ☐ Yes ☐ No

Sexual Orientation ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Transgender ☐ Heterosexual

Living Situation ☐ Alone ☐ Spouse/Partner ☐ Family ☐ Friend ☐ Other

☐ Own ☐ Rent ☐ House ☐ Apt ☐ Hotel ☐ Lic. Facility ☐ Sr. Hsg ☐ Other

IHSS? ☐ Yes ☐ No # of hrs ______ SW Name ____________ Phone ____________

Activated DPOA? ☐ No ☐ Yes, Name ____________ Relationship to client ____________

Is client conserved? ☐ No ☐ Yes, Name Phone

Safety Concerns ☐ None ☐ Yes, specify

Family/Social Support? ☐ No ☐ Yes, describe:

Does client have social worker/case manager? ☐ Yes ☐ No Private Caregiver? ☐ Yes ☐ No

Has there been APS involvement? ☐ Current ☐ Past ☐ Not applicable ☐ Unknown

Emergency Contact Phone Cell

Address

Does emergency contact speak English? ☐ Yes ☐ No Relationship to client

Primary Physician Phone Fax

Address

Services client is currently receiving?

Has Paratransit? ☐ Yes ☐ No ID#

ADLs and IADLs – Please check any of the following activities that the client requires assistance with and indicate who provides this assistance.

Activity	√	Who Provides Assistance?	Activity	√	Who Provides Assistance?
Eating	☐		Preparing meals	☐	
Transfers	☐		Taking medication	☐	
Ambulation	☐		Using telephone	☐	
Toileting	☐		Housework	☐	
Bathing	☐		Laundry	☐	
Washing/grooming	☐		Shopping	☐	
Dressing/undressing	☐		Money mgmt/Banking	☐	

Are there any impairments related to: (Check all that apply)

☐ Hearing ☐ Vision ☐ Speech ☐ Mobility ☐ Assistive Devices?

Medical History/Medications:

Any known medical allergies? ☐ No ☐ Yes, specify

Hospitalizations/ER visits (within last 6 months)? ☐ Yes ☐ No

Mental Health History/Cognitive Problems:

Current psychiatrist or MH professional Name Phone

Additional Information:

Additional Intake Information for MSSP/Linkages Program

Areas of Need or Concern

Medical Equipment   Transportation

IHSS ______ Socialization ______

Meals ______ Caregiver Burnout ______

Housing/Home safety/Repair ______ Mental Health Services ______

Would client be appropriate for case management? ☐ Yes ☐ No

Was the MSSP/Linkages Program explained to client/family? ☐ Yes ☐ No

Any concerns? ☐ No ☐ Yes, specify ______

Letter mailed to client? ☐ Yes ☐ No, specify ______

Ongoing case management needs:

Additional Intake Information for Assessment

What type of information would you like to gain from this assessment?

Name of contact to schedule assessment. Best time and place to see clients:

If consent is given, who should get a copy of the report? Please provide names & contact information.

Additional Intake Information for Psychology

Is home visit required? ☐ Yes ☐ No ***or*** Can client come to IOA for sessions? ☐ Yes ☐ No

Is client able to pay privately for sessions? ☐ Yes ☐ No

Where would client fit within sliding scale fee of $50 to $130 per session?

Contact to initiate services/schedule first visit? Name Phone

Indicate client's level of "open-ness" to receiving services

What is the client's level of insight around having a problem or needing assistance?

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Does the client have suicidal ideation? ☐ Yes ☐ No

If yes, suicidal ideation description:

Supplemental Information:

Click below to email this form.