Agency Name: YWCA of San Gabriel Valley - FY 2019-2020 Client Name: \_Date: \_\_

UNIVERSAL INTAKE FORM									
Fun	Funding Identifier:								
Title	IIIB 🗆		Title IIIE	☐ Title IIIE(G		ages 🗆	]		
	1a	Applicant Last Name	Middle Initial GetCare ID #						
IDENTIFICATION	Date of	Birth (D.O.B.)		Age					
	Home A	Address (Number/Street)	City	(	State	Zip Code			
	Mailing Address (If different than home address)			City	5	State	Zip Code		
	Home Phone			Work Phone	(	Cell Phone			
	Email A	Email Address							
	1b Rural Designation			Unincorporated City					
	ID	☐ Rural ☐ Urban ☐ Decline	☐ Yes ☐ No ☐ Declined to State						
	Sex at b	pirth	Gender						
	☐ Male	e ☐ Female ☐ Declined to Sta	☐ Male ☐ Female ☐ Transgender Female to Male						
			☐ Transgender Male to Female ☐ Genderqueer/ Gender						
				☐ Non-binary	☐ Non-binary ☐ Not Listed ☐ Declined to State				
OGRAPHICS	Sexual Orientation  Straight/Heterosexual Bisexual Gay/Lesbian/Same Gender-Loving Questioning/Unsure  Not Listed Declined to State								
OGR	Veteran ☐ Yes ☐ No ☐ Declined to State			Spouse of Veteran ☐ Yes ☐ No ☐ Declined to State					
DEM(	Race								
	☐ White ☐ American Indian or Alaska Native ☐ Chinese ☐ Japanese ☐ Filipino ☐ Korean ☐ Vietnamese								
	☐ Asian Indian ☐ Laotian ☐ Cambodian ☐ Other Asian ☐ Black or African American ☐ Guamanian								
	☐ Haw	aiian □ Samoan □ Other Pad	cific Islander	☐ Other Race ☐	] Multiple Rac	e 🗆 De	clined to State		
	Ethnicity								
	□ Not Hispanic/Latino □ Hispanic/Latino □ Declined to State								

 $\square$  Single (Never Married)  $\square$  Married  $\square$  Domestic Partner  $\square$  Separated  $\square$  Divorced

 $\square$  Declined to State

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Relationship Status

☐ Widowed

Agency	Name:		Client Nam	e:		Date:				
	Type of Residence				Does the indi	vidual				
	☐ House ☐ Apartment ☐ Hotel ☐ Mobile Home				□ Rent □	☐ Rent ☐ Own ☐ Other				
	☐ Nursing Home ☐ Residential Care Home				☐ Declined t	☐ Declined to State				
	☐ Room and Boa	rd 🗆 H	omeless   Other   Decl	ined to State						
	Employment Status									
	☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Declined to State									
ont.	Living Arrangemer	nt			Federal Poverty Guideline (FPG)					
1b Cont.	☐ Lives alone without help ☐ Lives with others without he				Is your income	s your income □ At or below 100% FPG				
=	☐ Lives alone with help 4 hrs/day or less				☐ Above 100%	Above 100% FPG				
	☐ Lives with other	ers with help	☐ Declined to State		☐ Declined to	☐ Declined to State				
	Primary Language									
	☐ American Sign Language ☐ Arabic ☐ Armenian ☐ Cambodian ☐ Cantonese ☐ Chinese ☐ English									
	☐ Farsi ☐ French ☐ Korean ☐ Laotian ☐ Mandarin ☐ Japanese ☐ Russian ☐ Spanish ☐ Tagalog									
	☐ Thai ☐ Vietnamese ☐ Other ☐ Declined to State									
	Translation needed ☐ Yes ☐ No ☐ Declined to State									
	2 Contact Last Name			First Nam	ne	N ii				
STS	Address (Number/Street)			City	State		Zip Code			
NTACTS	Home Phone		Work Phone	Cell Phor	Cell Phone		Relationship			
00 /	Contact Name (Last, First, Middle Initial) – Optional									
ENC	Address (Number/Street)				State		Zip Code			
EMERGENCY CO	Home Phone		Work Phone	Cell Phor	ne	Relationship	)			
E	Primary Physician				Office Phone					
	Physician's Address			City		State Zip Code				

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Agenc	y Name:	: Client Name:		Date:						
	Are you currently receiving Social Securing Security Secu		rity	Do you currer (SSI) Benefits	you currently receive Supplemental Security Inco SI) Benefits?			ity Income		
	☐ Yes ☐ No ☐ Declined to State			☐ Yes ☐ No	☐ Declined to State					
	Do you	Do you participate in CalFresh (Food Stamps, SNAP, EBT)?								
	☐ Yes	☐ Yes ☐ No ☐ Declined to State								
BENEFITS	Do you	Do you have Health Insurance? ☐ Yes ☐No		Health Insurer's Name F		Policy Number: (Optional)				
N N	☐ De	clined to State								
BE	Do you	receive Medi-Cal?	Medi-Ca	al # (Optional)	D	Do you receive Medicare?				
	☐ Yes	Yes ☐ No ☐ Declined to State Issue date:			☐ Yes ☐ No ☐ Declined to State					
	Do you	Do you receive In-Home Supportive Services (IHSS)? ☐ Yes ☐ No ☐ Declined to State								
	Do you	receive any additional benefits? (i.e., Ve	terans Be	enefits, CAPI, et	tc.)					
	4	Referral Source								
	_	Last Name		lama.						
. 2	Last	vame	First Name			Phone				
RAL	Addre	ess		City			State Zip			
REFERRAL	Prese	Presenting Problems/Services Requested/Comments/Follow-up:								
≤	•									
	5 NUTRITIONAL RISK FACTORS (Add the numbers from each checked box to determine Nutrition Risk Score)									
l o	I have	e an illness or condition that made me cha								
OR		nt of food I eat.		2 □ Yes	□ No	□ Decline	ed to State			
L L	I eat f	ewer than 2 meals per day.	3 □ Yes	□ No	□ Decline	ed to State				
FA	I eat f	ew fruits or vegetables or milk products.	2 □ Yes	□ No	□ Decline	ed to State				
X	I have	ve 3 or more drinks of beer, liquor or wine almost every day.				□ No	□ Decline	ed to State		
쭚	I have	e tooth or mouth problems that make it ha	2 □ Yes	□ No	□ Decline	ed to State				
AL	I don'	t always have enough money to buy the f	4 □ Yes	□ No	□ Decline	ed to State				
NO N	I eat a	alone most of the time.	1 □ Yes	□ No	□ Decline	ed to State				
E	I take	3 or more different prescribed or over-the	1 □ Yes	□ No	□ Decline	ed to State				
NUTRITIONAL RISK FACTORS	Witho	out wanting to, I have lost or gained 10 pons.	unds in th	ne last 6	2 □ Yes	□ No	□ Decline	ed to State		
_		not always physically able to shop, cook a	nd/or fee	d myself.	2 □ Yes	□ No		ed to State		
		Total I	Nutrition	al Risk Score			s 6 or more, <sub>l</sub> <b>jh</b> Nutritional			

Activities of Dail		Verbal	Some Human	Lots of Human	T	Decline	
	Independent	Assistance	Help	Help	Dependent	State	
Eating							
Bathing							
Toileting							
Transferring							
Walking							
Dressing							
Instrumental Act	Independent	y Living (IADL)  Verbal  Assistance	Some Human Help	Lots of Human Help	Dependent	Decline State	
Meal Preparation							
Shopping							
Med. Mgmt.							
Money Mgmt.							
Using Phone							
Hvy. Housework							
Lt. Housework							
Transportation							
Disability Factors		Recent Hospita	al Discharge [	∃Yes □			
☐ Visually Impaire	d □ Hearing	peech Impaired	☐ Declined to	State			
☐ Physically Impa	aired □ Walkinç	Date of Discha	rge				
☐ Bedbound ☐	☐ Bedbound ☐ Memory Impaired ☐ Depression				Date To Stop Service		
☐ Cognitively Impa	aired $\square$ None	☐ Declined to S <sup>t</sup>	tate	Hospital			

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State

Agency Nam		Client Name:		Date:				
CERTIFICATION	7	CERTIFICATION  (To be completed by Interviewer and signed by Client)  I certify that the information on this form, provided to me by the client, is accurate and true to the best of my abilities. I also certify that I have informed the Client that this information may be shared with other providers for the purpose of providing services. Client signature establishes agreement to services.    Phone   Phone						
	Signatu			Date				
	Onem 1	and (Finty						
	Client S	Signature		Date				
DISENROLLMENT	8	REASON FOR DISENROLLMENT	Date	of disenrollment:				
OLLI	☐ Dec	eased $\square$ Moved Out of Service Area $\square$ No Longer Desires Services	s 🗆	No Longer SNF Certifiable				
:NR(	□ No L	No Longer Medi-Cal Eligible ☐ Institutionalization ☐ High Cost of Services ☐ Won't Follow Care Plan						
DISE	☐ On H	on Hold □ Service No Longer Needed □ Past Active □ On Waiting List □ Other Reason						
NOTE	ES:							
Thank you for completing the Universal Intake Form (UIF). As the aging population grows and funding remains limited, it is vital to capture this critical information to reinforce and substantiate the increased demand for older adult services. This information will assist the Los Angeles County Area Agency on Aging (AAA) in identifying unmet needs, effectively developing plans, and better coordinate services to								