TEXAS
Health and Human Services

Form 2276
October 2021-E

Intake

Area Agency on Aging of Brazos Valley Agency on Aging

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: N/A
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	N/A	
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:
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: N/A		Area Code and Phone No.: N/A

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.

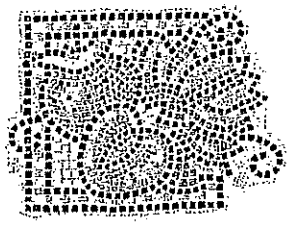
☐ Eligible person is under 60, has a disability, lives with a person eligible for a meal and the provider offers a meal according to AAA procedures.

Provider/Center: WCHLA

Consumer Name: _____

Consumer ID: _____

Date: _____



The Warning Signs of poor nutritional health are often overlooked. Use this checklist to find out if you are at nutritional risk.

DETERMINE YOUR NUTRITIONAL HEALTH

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
The Nutrition Screening Initiative is funded in part by a grant from Ross Products Division of Abbott Laboratories, Inc.

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Area Agency on Aging
OF THE BRAZOS VALLEY

Area Agency on Aging of the Brazos Valley
Client Rights & Responsibilities and Release of Information for Older Americans Act Programs

The Area Agency on Aging of the Brazos Valley welcomes you to our programs, made available to you through the Older Americans Act of 1965. These programs and a variety of services are administered by the Area Agency on Aging with funding provided through Texas Health and Human Services, client contributions and local funding.

Programs and services are designed for people who age 60 or older, their family members, and other caregivers. Our goal is to help older people lead independent, meaningful and dignified lives in their own homes and communities as long as possible. Our program supports that goal by providing limited support services and by assisting you in finding answers when you want help. Your 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.

Release of Information:
Information we gather through an intake or through an assessment may be shared to plan, arrange and deliver services to meet your individual client needs. The information collected is required by your local service provider, the Area Agency on Aging (AAA), and Texas Health and Human Services. All of your information will be kept confidential and guarded against unofficial use.

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:

Texas Health & Human Services	Brazos Valley Area Agency on Aging
P.O. Box 12786 | 701 W. 51st	P.O. Drawer 4128 | 3991 E. 29th St.
Austin, TX 78751	Bryan, TX 77805 | Bryan, TX 77802
Main: 512-424-6500	Main: 979-595-2806
Fax: 512-438-4374	Toll free: 800-994-4000
MC-W235	Fax: 979-595-2810
Gina Carter, Director, Office of Area Agencies on Aging	Stacey Urbanczyk, Program Manager

4. You have the right to participate in the development of a care plan to address unmet needs (If Applicable).
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 (If Applicable).
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 (If Applicable).
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 you are unable or choose not to make a contribution. All contributions are confidential and are used only to expand or enhance the service(s) for which a contribution was 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 you will not be using services.
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.

_____

Print Client Name

_____ _____

Client Signature Date