Washington County Healthy Living Association
Client Intake & Service Request Form

Date: _____

Last Name: _____ MI: _____ First Name: _____

Gender: Male [ ] Female [ ] Birth Date:_____ Primary Language: _____

Home Address: Street/Apt.#: _____

City:_____ State:____ Zip Code:_____ County:_____

Phone: _____ Home [ ] Cell [ ] Other [ ]

[ ] Check if mailing address is home address

Mailing address: Street/Apt.# P.O. Box: _____

City: _____ State: ___ Zip code: _____ County: _____

Ethnicity (Check one):		Race (check all that apply):		Marital status (check one):	
Hispanic or Latino	[ ]	White-Non Hispanic	[ ]	Married	[ ]
Not Hispanic or Latino	[ ]	White - Hispanic	[ ]	Widowed	[ ]
Ethnicity not reported	[ ]	American Indian/Alaska Native	[ ]	Divorced	[ ]
		Asian	[ ]	Separated	[ ]
		Black or African American	[ ]	Never Married	[ ]
		Native Hawaiian/Pacific Islander	[ ]	Not Reported	[ ]
		Other Race	[ ]		
		Not Reported	[ ]		

Does client live alone? Yes [ ] No [ ]

Total number of family members in household including client: _____

Client living in poverty/low income? Yes [ ] No [ ]

Emergency Contact Information:

Contact Name: _____ Phone: _____

Relationship: _____

Service(s) requested: _____

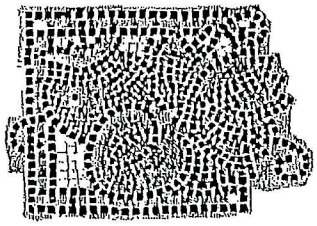
Print name of staff/provider/volunteer completing Intake: _____

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
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Area Agency on Aging

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

The Area Agency on Aging of 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 the Texas Department of Aging and Disability 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 the Texas Department of Aging and Disability 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:

Dept. of Aging & Disabilities Service	Brazos Valley Area Agency on Aging
P.O. Box 12786/ 701 W. 51st St.	P.O. Drawer 4128/3991 E. 29th St.
Austin, TX 78751	Bryan, TX 77805
512-438-3200 (telephone)	800-994-4000 (toll free)
512-438-4374 (fax number)	979-595-2806 (telephone)
MC-W235	979-595-2810 (fax)
Sue Fielder – Director	Ronnie Gipson, Program Manager

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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 Date

_____

Client Signature

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