SENIOR CITIZENS AGING SERVICES FY-2007
INTAKE, PROFILE AND REFERRAL (IPR) FORM

INSTRUCTIONS

Title III reporting requirements provide statistical data for management and advocacy initiatives serving as indicators for new and continued funding of programs for seniors. The data collected is used for budget justifications, congressional inquiries, program development and mandated reports for federal, state and local agencies. Information must be accurate for it to be useful in supporting program services.

- FORM: This form is an Intake Profile and Referral (IPR) Form, and not an Assessment Form. Profile characteristics are used in developing new programs to meet the needs of the elderly. Each Service Provider may have their own Assessment Form for their specific programs.

- DATA RETENTION: Client data is retained in the main registry until a client remains on Inactive Status for over four (4) years or when a client is deceased.

- SSN: If a client does not yet have a Social Security Number (SSN), use 000 as the first three digits for their assigned number. The next two digits should be the month and the last four digits shall be the day and year the client was born. If a client was born on March 21, 1911, the SSN would be 000-03-2111. If born on November 9, 1933, the SSN would be 000-11-0933.

- INCOME LEVEL: The Income Level is based on the U.S. Department of Health and Human Services Poverty Guidelines and shall be completed before the Intake, Profile and Referral Form can be processed.

- REFUSAL TO ANSWER: Should a client refuse to answer a certain question, leave it blank. In the comments section, list the reason for not answering the question. This does not apply to Income Level.

- SIGNATURE: The signature of the client or responsible party is required before services can be provided.

- SPECIAL ACCOMMODATIONS: Clients requiring special accommodations shall inform the program in advance of their requirements.

- SECTION B:

  - Case Management Services. Case Management Services Program, at a minimum, conducts an assessment to individuals requesting Adult Day Care Services, In-Home Services and Home-Delivered Meals. Entry into these programs shall not be permitted before an assessment is made and eligibility established by Case Management Services.

  - Transportation Services. In order to meet demands, clients requesting transportation shall make reservations with the Transportation Services Program at least five (5) working days in advance for service. If the date requested cannot be accommodated, the Transportation Services Program shall recommend an alternate date. Requests for persons using wheelchairs or having a Personal Assistant/Personal Care Attendant shall be made in the same manner, whether for Center participation or to and from medical appointments, etc.

  - Elderly Nutrition Program. To the extent practicable, meals are adjusted to meet special dietary needs of eligible participants, and shall be supported by a statement from the client's doctor or religious leader stating the necessity for special meals, including nutrition supplements. Mechancial (chopped) or pureed (blendered) meals are not classified as special meals and shall be provided to the client at their request.

FOR ADULT PROTECTIVE SERVICES (APS)
REFERRALS PLEASE CONTACT 735-7382/84 OR
EMERGENCY RECEIVING HOME
AT 653-8855 TWENTY-FOUR HOURS A DAY
SEVEN DAYS A WEEK.

PRINT Download Clear Form

SENIOR CITIZENS AGING SERVICES FY-2007
INTAKE, PROFILE AND REFERRAL (IPR) FORM
PLEASE PRINT CLEARLY USING BLUE OR BLACK INK.

A. CLIENT INFORMATION	
Last Name	
First Name	
Middle Name	
Date of Birth	
Place of Birth	
SSN	
Gender	☐ Male ☐ Female
Village	
Home Address	
Mailing Address	
Ethnicity	
Citizenship	
Day Phone No.	
Night Phone No.	

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Living Arrangement
- ☐ Lives alone
- ☐ Lives with spouse
- ☐ Lives with family
- ☐ Lives with others
- ☐ Lives in Group Home

  Specify: _____
- ☐ Lives in Institution

  Specify:_____

Special Needs
- ☐ Language Interpreter

  Specify:_____
- ☐ Assistive Device(s)

  Specify:_____
- ☐ None identified at this time.

Mobility Status *(check all that apply)*
- ☐ Drives
- ☐ Walks slowly
- ☐ Walks with assistance
- ☐ Climbs steps with assistance
- ☐ Uses cane/crutches/walker
- ☐ Uses a wheelchair
- ☐ Bedridden
- ☐ Other:_____

Health Status
- ☐ Excellent
- ☐ Good
- ☐ Poor

Allergies	Specify:_____ _____ _____ _____ ☐ None known at this time.

Undergoing Treatment
- ☐ Hemodialysis
- ☐ Cancer
- ☐ Physical Therapy
- ☐ Other _____
- ☐ None at this time

Heath Insurance	
Policy No.	
Clinic	
Phone No.	
Primary Doctor	
Phone No.	

CLIENT'S NAME: _____SSN:_____CMS:_____SCO:_____

Income Level *Family Unit Size (FUS)*

Is your income less than

Unit Size	Per Month	Per Year	Yes	No
One (1)	$1,064.16	$12,770.00	☐	☐

Is your combined income less than

Unit Size	Per Month	Per Year	Yes	No
Two (2)	$1,426.66	$17,120.00	☐	☐

Is your combined income less than

Unit Size	Per Month	Per Year	Yes	No
Three (3)	$1,789.16	$21,470.00	☐	☐

☐ Four (4) or more in FUS, add $362.50 per month or $4,350.00 per year for each additional member.
$_____

B. SERVICES REQUESTED

- ☐ Case Management Services
- ☐ Adult Day Care Services
- ☐ In-Home Services
- ☐ Legal Assistance Services
- ☐ National Family Caregiver Support Program
- ☐ Senior Center Operations:_____
- ☐ Transportation Services:
  - ☐ Non-Assisted
  - ☐ Assisted
- ☐ Elderly Nutrition Program:
  - ☐ Congregate Meals
  - ☐ Home-Delivered Meals

  Specify Type of Meal
  - ☐ Regular
  - ☐ Mechanical/Chopped
  - ☐ Pureed/Blenderized
  - ☐ Special (*Provide document from client's religious leader or doctor to certify Special Meal request.*)
- ☐ Ombudsman Program
- ☐ Guam Medicare Assistance Program
- ☐ Senior Medicare Patrol Program

COMMENTS:_____
_____
_____

C. CAREGIVER INFORMATION

☐ Not Applicable	☐ Caregiver ☐ Paid ☐ Not Paid Paid by: _____
Last Name	
First Name	
Middle Name	
Date of Birth	
Day Phone No.	
Night Phone No.	
Relationship to Client	

D. GUARDIAN/AUTHORIZED REPRESENTATIVE INFORMATION

☐ Guardian
☐ Authorized Representative
☐ Not Applicable

Note:
Attach copy of Guardianship or Power of Attorney, as applicable.

Last Name	
First Name	
Middle Name	
Day Phone No.	
Night Phone No.	
Relationship to Client	

E. EMERGENCY CONTACT NUMBER

Last Name	
First Name	
Middle Name	
Day Phone No.	
Night Phone No.	
Relationship to Client	

CLIENT'S NAME: _____SSN:_____CMS:_____SCO:_____

F. HIGH RISK CLIENTS UNDER EMERGENCY DECLARATION

A client is considered High Risk under Emergency Declaration if any of the following exists. This information shall be provided to the client's village mayor in preparation for emergencies.

(*check all that apply)*

- ☐ Bedridden
- ☐ Requires transportation and/or escort assistance for evacuation to shelter, e.g., those living alone.
- ☐ Requires refrigeration of medication and/or is insulin dependent.
- ☐ Requires oxygen.
- ☐ Lives in substandard housing.
- ☐ Not Applicable

G. ELIGIBILITY AND CONSENT OF CLIENT

Individuals age sixty (60) years and older are eligible for Title III programs under the Older Americans Act. This Act also prioritizes services for:

- ♦ Persons who are frail, homebound by reason of illness or incapacitating disability, or otherwise isolated; and
- ♦ Persons with greatest economic need with particular attention to low-income individuals; persons with greatest social need with particular attention to low-income minority individuals, and those who reside in rural areas.

Voluntary contributions to Title III programs are encouraged and used to expand services. Services may not be denied because the client will not or cannot contribute to the cost of the program.

I CERTIFY THE INFORMATION GIVEN BY ME IS TRUE TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND IT WILL BE KEPT CONFIDENTIAL AND USED ONLY TO HELP ME RECEIVE THE BENEFITS/SERVICES WHICH I MAY BE ENTITLED.

I HEREBY AUTHORIZE THE DISCLOSURE AND RELEASE OF THIS INFORMATION ONLY FOR THE PURPOSES FOR WHICH IT IS INTENDED. THIS AUTHORIZATION MAY BE REVOKED BY THE UNDERSIGNED AT ANY TIME BY GIVING WRITTEN NOTICE TO THE PARTIES AUTHORIZED HEREIN.

Signature of Client or Authorized Representative (AR)	
Date	
Relationship to Client, if AR	

H. INTAKE INFORMATION

Intake Worker	
Signature of Intake Worker	
Date of Intake	
Time of Intake	
Organization	
Contact No.	

IPR Forwarded To

- ☐ Adult Protective Services
- ☐ Case Management Services
- ☐ Elderly Nutrition Program (Congregate Meals)
- ☐ Guam Medicare Assistance Program
- ☐ Legal Assistance Services
- ☐ National Family Caregiver Support Program
- ☐ Ombudsman Services
- ☐ Senior Center Operations
- ☐ Senior Medicare Patrol
- ☐ Transportation Services

Forwarded By	
Date Forwarded	
Time Forwarded	

I. RECEIVING ORGANIZATION INFORMATION

IPR Received By	
Date	
Time	

CLIENT'S NAME: _____ SSN: _____ CMS: _____ SCO: _____

IPR Referred To

- ☐ Adult Day Care Services
- ☐ Case Management Services
- ☐ Elderly Nutrition Program – Congregate Meals
- ☐ Elderly Nutrition Program – Home Delivered Meals
- ☐ Guam Medicare Assistance Program (MAP)
- ☐ In-Home Services
- ☐ Legal Assistance Services
- ☐ National Family Caregiver Support Program
- ☐ Senior Citizens Center Operations
- ☐ Senior Medicare Patrol Program
- ☐ Transportation Services
- ☐ Other:_____

Date of Initial Contact with Client	
Time of Initial Contact with Client	

Comments:_____

_____

J. CLIENT'S HOME

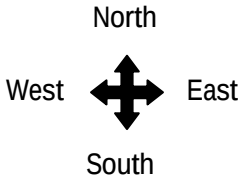
IF MAP IS SENT SEPARATELY, INCLUDE THE CLIENT'S NAME AND SSN AT TOP OF MAP

Does the home have an accessible driveway?	☐ Yes	☐ No
If you use a wheelchair, is there an accessible ramp?	☐ Yes	☐ No

All pets at your home shall be controlled by leash, case, etc. in accordance with P.L. 15-96 and 22-13.

DRAW A MAP TO THE CLIENT'S HOME

(Indicate primary and secondary access roads, type and color of the house, if fenced, landmarks such as adjacent to or across from the village community center, store, bus stop, etc.)



CLIENT'S NAME: _____SSN:_____CMS:_____SCO:_____