Agency Name: City of Culver City Client Name: _____ Date: FY 2019-2020

UNIVERSAL INTAKE FORM

Funding Identifier:

Title IIIB ☐ Title C1 ☐ Title C2 ☐ Title IIIE ☐ Title IIIE(G) ☐ Linkages ☐

IDENTIFICATION

1a	Applicant Last Name	First Name	Middle Initial	GetCare ID #

Date of Birth (D.O.B.)	Age	Social Security # (*Optional*)	
Home Address *(Number/Street)*	City	State	Zip Code
Mailing Address *(If different than home address)*	City	State	Zip Code
Home Phone	Work Phone	Cell Phone	
Email Address			

DEMOGRAPHICS

1b

Rural Designation
☐ Rural ☐ Urban ☐ Declined to State

Unincorporated City
☐ Yes ☐ No ☐ Declined to State

Sex at birth
☐ Male ☐ Female ☐ Declined to State

Gender
☐ Male ☐ Female ☐ Transgender Female to Male
☐ Transgender Male to Female ☐ Genderqueer/ Gender
☐ Non-binary ☐ Not Listed ☐ Declined to State

Sexual Orientation
☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same Gender-Loving ☐ Questioning/Unsure
☐ Not Listed ☐ Declined to State

Veteran ☐ Yes ☐ No ☐ Declined to State

Spouse of Veteran ☐ Yes ☐ No ☐ Declined to State

Race
☐ White ☐ American Indian or Alaska Native ☐ Hispanic/Latino ☐ Black or African American
☐ Chinese ☐ Japanese ☐ Filipino ☐ Korean ☐ Vietnamese ☐ Asian Indian ☐ Laotian ☐ Cambodian
☐ Other Asian ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race
☐ Multiple Race ☐ Declined to State

Relationship Status
☐ Single (Never Married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed
☐ Declined to State

Agency Name: City of Culver City Client Name: _____ Date: FY 2019-2020

1b Cont.

Type of Residence

☐ House ☐ Apartment ☐ Hotel ☐ Mobile Home

☐ Nursing Home ☐ Residential Care Home

☐ Room and Board ☐ Homeless ☐ Other ☐ Declined to State

Does the individual

☐ Rent ☐ Own ☐ Other

☐ Declined to State

Employment Status

☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Declined to State

Living Arrangement

☐ Lives alone without help ☐ Lives with others without help

☐ Lives alone with help 4 hrs/day or less

☐ Lives with others with help ☐ Declined to State

Federal Poverty Guideline (FPG)

Is your income ☐ At or below 100% FPG

☐ Above 100% FPG

☐ 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

EMERGENCY CONTACTS

2

Contact Last Name	First Name		Middle Initial
Address *(Number/Street)*	City	State	Zip Code
Home Phone / Work Phone	Cell Phone	Relationship	
Contact Name (*Last, First, Middle Initial*) – *Optional*			
Address *(Number/Street)*	City	State	Zip Code
Home Phone / Work Phone	Cell Phone	Relationship	
Primary Physician		Office Phone	
Physician's Address	City	State	Zip Code

Agency Name: City of Culver City Client Name: _____ Date: FY 2019-2020

BENEFITS

3	Are you currently receiving Social Security Benefits? ☐ Yes ☐ No ☐ Declined to State	Do you currently receive Supplemental Security Income (SSI) Benefits? ☐ Yes ☐ No ☐ Declined to State

Do you participate in CalFresh (Food Stamps, SNAP, EBT)? ☐ Yes ☐ No ☐ Declined to State

Do you have Health Insurance? ☐ Yes ☐No ☐ Declined to State	Health Insurer's Name	Policy Number: *(Optional)*
Do you receive Medi-Cal? ☐ Yes ☐ No ☐ Declined to State	Medi-Cal # *(Optional)* Issue date:	Do you receive Medicare? ☐ Yes ☐ No ☐ Declined to State

Do you receive In-Home Supportive Services *(IHSS)?* ☐ Yes ☐ No ☐ Declined to State

Do you receive any additional benefits? (i.e., Veterans Benefits, CAPI, etc.)

REFERRAL INFORMATION

4 Referral Source

Last Name	First Name	Phone	
Address	City	State	Zip Code

Presenting Problems/Services Requested/Comments/Follow-up:

NUTRITIONAL RISK FACTORS

5 **NUTRITIONAL RISK FACTORS**
(Add the numbers from each checked box to determine Nutrition Risk Score)

I have an illness or condition that made me change the kind and/or amount of food I eat.	2 □ Yes	□ No	□ Declined to State
I eat fewer than 2 meals per day.	3 □ Yes	□ No	□ Declined to State
I eat few fruits or vegetables or milk products.	2 □ Yes	□ No	□ Declined to State
I have 3 or more drinks of beer, liquor or wine almost every day.	2 □ Yes	□ No	□ Declined to State
I have tooth or mouth problems that make it hard for me to eat.	2 □ Yes	□ No	□ Declined to State
I don't always have enough money to buy the food I need.	4 □ Yes	□ No	□ Declined to State
I eat alone most of the time.	1 □ Yes	□ No	□ Declined to State
I take 3 or more different prescribed or over-the-counter drugs a day.	1 □ Yes	□ No	□ Declined to State
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2 □ Yes	□ No	□ Declined to State
I am not always physically able to shop, cook and/or feed myself.	2 □ Yes	□ No	□ Declined to State
Total Nutritional Risk Score		(If total is 6 or more, participant is at **High** Nutritional Risk)	

Agency Name: City of Culver City Client Name: _____ Date: FY 2019-2020

ADL/IADL RISK FACTORS & DISABILITY FACTORS

6 ACTIVITIES OF DAILY LIVING (ADL)/INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) RISK FACTORS & DISABILITY FACTORS *(Excluding Title IIIE Caregiver Program)*

Activities of Daily Living *(ADL)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Eating	☐	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐	☐
Transferring	☐	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐

Instrumental Activities of Daily Living *(IADL)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Meal Preparation	☐	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐	☐
Med. Mgmt.	☐	☐	☐	☐	☐	☐
Money Mgmt.	☐	☐	☐	☐	☐	☐
Using Phone	☐	☐	☐	☐	☐	☐
Hvy. Housework	☐	☐	☐	☐	☐	☐
Lt. Housework	☐	☐	☐	☐	☐	☐
Transportation	☐	☐	☐	☐	☐	☐

Disability Factors

☐ Visually Impaired ☐ Hearing Impaired ☐ Speech Impaired

☐ Physically Impaired ☐ Walking Aid ☐ Wheelchair

☐ Bedbound ☐ Memory Impaired ☐ Depression

☐ Cognitively Impaired ☐ None ☐ Declined to State

Recent Hospital Discharge ☐Yes ☐ No

☐ Declined to State

Date of Discharge

Date To Stop Service

Hospital

Diabetic

☐ Yes ☐ No

☐ Declined to State

Have you been diagnosed with Alzheimer's or a related neurological disorder?

☐ Yes ☐ No ☐ Declined to State

Agency Name: City of Culver City Client Name: _____ Date: FY 2019-2020

TITLE IIIE CARE RECEIVER DEMOGRAPHICS

7 TITLE IIIE CARE RECEIVER DEMOGRAPHICS

Please make additional copies of Section 7 & 8 if more than one Care Receiver

Caregiver Relationship: ☐ Spouse ☐ Domestic Partner ☐ Sibling ☐ Son/Son-in-Law ☐ Daughter/Daughter-in-Law ☐ Grandparent ☐Other Relative ☐ Non-Relative ☐Other ☐ Declined to State

Care Receiver Last Name	First Name	Middle Initial	Care Receiver GetCare ID #

Address (Number & Street)	City	State	Zip Code

Rural Designation	Unincorporated City
☐ Rural ☐ Urban ☐ Declined to State	☐ Yes ☐ No ☐ Declined to State

Home Phone	Work Phone	Cell Phone	Emergency Contact Phone

Date of Birth (D.O.B.)	Age	Gender ☐ Male ☐ Female ☐ Declined to State

Social Security # (Optional)	Email Address

Veteran	Spouse of Veteran
☐ Yes ☐ No ☐ Declined to State	☐ Yes ☐ No ☐ Declined to State

Race

☐ White ☐ American Indian or Alaska Native ☐ Hispanic/Latino ☐ Black or African American

☐ Chinese ☐ Japanese ☐ Filipino ☐ Korean ☐ Vietnamese ☐ Asian Indian ☐ Laotian ☐ Cambodian

☐ Other Asian ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race

☐ Multiple Race ☐ Declined to State

Relationship Status

☐ Single *(Never Married)* ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

☐ Declined to State

Type of Residence	Does the individual	Living Arrangement
☐ House ☐ Apartment ☐ Hotel ☐ Room and Board ☐ Nursing Home ☐ Residential Care Home ☐ Mobil Home ☐ Homeless ☐ Other ☐ Declined to State	☐ Rent ☐ Own ☐ Other ☐ Declined to State	☐ Alone ☐ Not Alone ☐ Declined to State

Receive In-Home Supportive Services *(IHSS)?*	Federal Poverty Guideline (FPG) Is your Care Receiver income
☐ Yes ☐ No ☐ Declined to State	☐ At or below 100% FPG ☐ Above 100% FPG ☐ Declined to State

Have Health Insurance?	Receive Medicare?	Receive Social Security?	Receive Medi-Cal?
☐ Yes ☐ No ☐ Declined to State	☐ Yes ☐ No ☐ Declined to State	☐ Yes ☐ No ☐ Declined to State	☐ Yes ☐ No ☐ Declined to State

Agency Name: City of Culver City Client Name: _____ Date: FY 2019-2020

TITLE IIIE CARE RECEIVER ADL/IADL RISK FACTORS & DISABILITY FACTORS

8 TITLE IIIE CARE RECEIVER ACTIVITIES OF DAILY LIVING (ADL)/ INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) RISK FACTORS & DISABILITY FACTORS

Activities of Daily Living *(ADL) (Grandchildren exempt)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Eating	□	□	□	□	□	□
Bathing	□	□	□	□	□	□
Toileting	□	□	□	□	□	□
Transferring	□	□	□	□	□	□
Walking	□	□	□	□	□	□
Dressing	□	□	□	□	□	□

Instrumental Activities of Daily Living *(IADL) (Grandchildren exempt)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Meal Preparation	□	□	□	□	□	□
Shopping	□	□	□	□	□	□
Med. Mgmt.	□	□	□	□	□	□
Money Mgmt.	□	□	□	□	□	□
Using Phone	□	□	□	□	□	□
Hvy. Housework	□	□	□	□	□	□
Lt. Housework	□	□	□	□	□	□
Transportation	□	□	□	□	□	□

Disability Factors

☐ Visually Impaired ☐ Hearing Impaired ☐ Speech Impaired ☐ Physically Impaired ☐ Walking Aid

☐ Wheelchair ☐ Bedbound ☐ Memory Impaired ☐ Depression ☐ Cognitively Impaired ☐ None

☐ Declined to State

Diabetic

☐Yes ☐ No

☐ Declined to State

Has Care Receiver been diagnosed with Alzheimer's or a related neurological disorder?

☐ Yes ☐ No ☐ Declined to State

Agency Name: City of Culver City Client Name: _____ Date: FY 2019-2020

CERTIFICATION

9

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.

Completed by (Print Name)	*Phone*
Signature	*Date*
Client Name (Print)	
Client Signature	*Date*

DISENROLLMENT

10 **REASON FOR DISENROLLMENT** *Date of disenrollment:*

☐ Deceased ☐ Moved Out of Service Area ☐ No Longer Desires Services ☐ No Longer SNF Certifiable

☐ No Longer Medi-Cal Eligible ☐ Institutionalization ☐ High Cost of Services ☐ Won't Follow Care Plan

☐ On Hold ☐ Service No Longer Needed ☐ Past Active ☐ On Waiting List ☐ Other Reason

NOTES:

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 meet your needs.

WORKFORCE DEVELOPMENT, AGING AND COMMUNITY SERVICES
AREA AGENCY ON AGING
ELDERLY NUTRITION PROGRAM
STANDARDS OF CONDUCT FORM

Welcome to the Los Angeles County Elderly Nutrition Program (ENP) Congregate Meal site. We hope that you enjoy your mealtime experience and socializing with your friends. To ensure a pleasant and safe environment, Workforce Development, Aging and Community Services (WDACS) Area Agency on Aging (AAA) created the following Standards of Conduct to ensure that everyone can enjoy a pleasant mealtime atmosphere:

1. Do not engage in any activity that is prohibited by law, including but not limited to:

   - Drug use or being under the influence of illegal drugs
   - Gambling
   - Sexual Misconduct
   - Smoking
   - Fighting
   - Verbal Threats
   - Harassment
   - Disturbing the peace
   - Carrying weapons
   - Public Drunkenness

2. No person may interfere with any public agency employee's or volunteer's performance of his or her duties by obstructing or intimidating him, her, or other participants from carrying on business, and must leave the ENP Congregate Meal site if requested to do so by the office manager, supervisor, or a peace officer acting at the request of the office manager or supervisor of the ENP Congregate Meal site/public agency. *(California Penal Code Section 602.1(b))*

3. Do not engage in any activity or behavior that may alter or damage property.

4. Eat or drink only in designated areas. No alcoholic beverages are permitted on premises.

5. Restrooms shall not be used for bathing, shaving, or washing clothing.

6. Only service animals, accompanied by their owners, are allowed at ENP Congregate Meal sites.

7. Bicycles and shopping carts are not permitted inside the ENP Congregate Meal sites. Skates, skateboards, and collapsible scooters must be carried while on the premises. Wheelchairs and strollers shall be permitted only for the transportation of a person.

8. Children must be supervised at all times.

9. Petitioning, soliciting, distributing flyers, selling merchandise, or fundraising without the written permission of AAA is prohibited.

10. Participants shall not make unnecessary noise which disturbs other meal participants or staff. This includes:

    - Excessively loud talking
    - Loud-voiced use of cell phones
    - Use of other noisy audio or electronic devices

11. Participants shall wear clothing that covers the upper and lower torso of their bodies. Shoes must be worn at all times.

These standards are not intended to be a complete list and do not supersede any written rules of behavior imposed by an individual city, Parks and Recreation Department, or ENP Congregate Meal site.

☐ I agree to abide by the Rules of Acceptable Behavior

_____ _____

Name Date

Participants who do not follow the Standards of Conduct may be asked to leave as further explained in the WDACS AAA policy.

PARKS, RECREATION AND COMMUNITY SERVICES DEPARTMENT

CITY OF CULVER CITY

WAIVER, RELEASE OF LIABILITY AND ASSUMPTION OF RISK

NAME OF PARTICIPANT:

_____

ACTIVITY: CULVER CITY ELDERLY NUTRITION PROGRAM

RELEASE

In consideration of my participation in the above-stated activity on FY 2019-2020 , which includes but is not limited to ELDERLY NUTRTION PROFRAM I hereby waive, release and discharge any and all claims or rights to claims for damages for death, personal injury or property damage which I may have or which may hereafter accrue to me, as a result of my participation in said activity. This Release is intended to discharge in advance the promoters, sponsors, the City of Culver City, the officials and any involved municipalities or other public entities (and their respective agents and employees) from and against any and all liability arising out of or connected in any way with my participation in said activity, even though that liability may arise out of negligence or carelessness on the part of the persons or entities mentioned above resulting in personal injury, accidents, or illness (including death) and property loss.

I understand that the ELDERLY NUTRITION PROGRAM, by its very nature, includes inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. Knowing the risks of said activity, nevertheless, I hereby agree to assume those risks and to release and hold harmless all of the persons or entities mentioned above who, through negligence or carelessness, might otherwise be liable to me, or my heirs or assigns for damages.

It is further understood and agreed that this waiver, release of liability and assumption of risk is to be binding on my heirs and assigns. I agree to accept and abide by the rules and regulations of the City of Culver City. I give my permission to the City of Culver City to photograph me participating in the activity for use in City of Culver City publicity and publications and I will not seek compensation for such use.

_____

SIGNATURE OF PARTICIPANT

_____

DATE

Updated 05/13/2019