



**Registered Client Intake Form
TITLE III B CASE MANAGEMENT – FY 2020-21**

CONFIDENTIAL

Referral Name:					DATE:		
Reason for Referral:							
CARE RECEIVER'S INFORMATION							
Last Name:			First Name: <i>(No nicknames)</i>				
Phone:			Birth Date: <i>(Required)</i>				
Street Address:			City:		ZIP:		
County:			Rural: (91307, 93066, 93040)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State		
RACE – Please Choose (X) One:					Ethnicity:		
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian <input type="checkbox"/> Samoan <input type="checkbox"/> Asian Indian <input type="checkbox"/> Guamanian <input type="checkbox"/> Multiple Race <input type="checkbox"/> Vietnamese <input type="checkbox"/> Black or African American <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other Asian <input type="checkbox"/> White <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Decline to State <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other Race					<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Decline to State		
Marital Status:			<input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Decline to State				
Veteran Status:			Preferred Language:				
Client Lives:			Number of Persons Living in Household:				
INDICATE CARE RECEIVER'S INCOME LEVEL (approximate):							
2-Person Household: <input type="checkbox"/> At or below Federal Poverty Level (\$16,910/year or less) <input type="checkbox"/> Above Federal Poverty Level (\$16,911/year or more) <input type="checkbox"/> Decline to State			1-Person Household: <input type="checkbox"/> At or below Federal Poverty Level (\$12,490/year or less) <input type="checkbox"/> Above Federal Poverty Level (\$12,491/year or more) <input type="checkbox"/> Decline to State				
The Gay Bisexual and Transgender Disparities Reduction Act of 2016 (AB 959)							
The State of CA requires that we ask you some demographic questions followed by three questions under the new CA State AB 959 Law, the Gay, Bisexual and Transgender Disparities Reduction Act of 2016. VCAA values your privacy and you have the option to decline to state.							
What was the Care Receiver's sex at birth?			<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Decline to State				
What is the Care Receiver's Gender?			<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Decline to State <input type="checkbox"/> Not listed, please specify: _____				
How do you describe Care Receiver's sexual orientation or sexual identity?			<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Decline to State <input type="checkbox"/> Not listed, please specify: _____				
CALIFORNIA ACTIVITIES & INSTRUMENTAL ACTIVITIES (IADLS) OF DAILY LIVING (ADLS)							
Please Check One of the Columns for Each Activity							
TYPE OF ASSISTANCE CARE RECEIVER NEEDS TO PERFORM TASK →		1 INDEPENDENT Needs No Help	2 VERBAL QUE Needs verbal reminders	3 STAND BY Needs some human help	4 HANDS ON Needs lots of human help	5 DEPENDENT Cannot perform task	Decline to State
A D L S	Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I A D L S	Light Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Shopping/Errands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Meal Prep/Cleanup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Using Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Managing Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Managing Money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Heavy Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care Receiver's Cognitive Impairment:			<input type="checkbox"/> None or Unknown <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe				
Client Q Database/Unique Participant ID Number:							