



# AGING & DISABILITY NETWORK CONSUMER INTAKE FORM

The service you are receiving is paid for in whole or in part by funds from the federal Older American's Act and the State of Iowa. Your responses on this form are confidential. The Department on Aging uses this important information to research the needs of older Iowans. Thank you for providing your information.

**Today's Date:**

**Last Name:**      **First:**      **MI:**  
**Date of Birth:**      /      /      or **Age:**  
**Address:**      **City:**      **State:**      **Zip:**  
**Home Phone:** (      )      **Cell Phone:** (      )      **Email:**

**Demographic Information**

**Do you live alone?**  Yes  No      **Number in Household:**

**Please Check Your Annual Total Household Income Range:**

<input type="checkbox"/> \$0 - \$11,880	<input type="checkbox"/> \$11,881 - \$16,020	<input type="checkbox"/> \$16,021 - \$20,160
<input type="checkbox"/> \$20,161 - \$24,300	<input type="checkbox"/> \$24,301 - \$28,440	<input type="checkbox"/> \$28,441 - \$32,580
<input type="checkbox"/> \$32,581 - \$36,730	<input type="checkbox"/> \$36,731 - \$40,890	<input type="checkbox"/> \$40,891 - or Above

**Veteran Status:**  Veteran  Veteran Dependent/Spouse

**Gender:**  Male  Female  Transgender

**Race:**  White  American Indian/Alaskan Native  Asian  African American/Black  
 Native Hawaiian/Other Pacific Islander

**Ethnicity:**  Hispanic or Latino  Not Hispanic or Latino

**Primary Language:**  English    Other:

**Does Medicaid pay for some of the services you receive in your home, such as homemaker, transportation, organizing your medications, bathing assistance, or meals?**

Yes  No  Don't Know

**In the past 30 days, how often were these statements true:**

**I have worried whether my food would run out before I got money to buy more.**

Often       Sometimes       Never

**The food that I bought just didn't last and I didn't have money to get more.**

Often       Sometimes       Never

During the past 7 days, how would you rate your ability to complete these routine activities?

	I didn't need help	I needed help sometimes	I always needed help	Activity did not occur
Shop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage your medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prepare meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use transportation ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>IADL – Data Entry:</i>	Independent	Sometimes dependent or limited assistance	Totally dependent	

How would you rate your ability to complete these activities?

	I don't need help	I need help sometimes	I always need help	Activity does not occur
Manage Money?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do heavy housework?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do light housework?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use the telephone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>IADL – Data Entry:</i>	Independent	Sometimes dependent or limited assistance	Totally dependent	

During the past 7 days, how would you rate your ability to complete these physical activities?

	I didn't need help	I needed help sometimes	I always needed help
Walk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathe?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dress?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get Out Of Bed Or Chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



# AGING & DISABILITY NETWORK CONSUMER INTAKE FORM

Consumer: \_\_\_\_\_

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***ADL – Data Entry:***

Independent

Sometimes dependent or limited assistance

Totally dependent

Consumer: \_\_\_\_\_

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*This section to be completed by provider.*

**Provider / Site:**New Intake Form: Updated Intake Form: **Check the box next to the service provided:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Adult Day Care /Day Health     | <input type="checkbox"/> Assisted Transportation               | <input type="checkbox"/> Chore               |
| <input type="checkbox"/> Evidence-Based Health Activity | <input type="checkbox"/> Health Promotion & Disease Prevention |  |
| <input type="checkbox"/> Homemaker                      | <input type="checkbox"/> Material Aid                          | <input type="checkbox"/> Nutrition Education |
| <input type="checkbox"/> Options Counseling             | <input type="checkbox"/> Personal Care                         | <input type="checkbox"/> Transportation      |
| <input type="checkbox"/> EAPA Consultation              | <input type="checkbox"/> EAPA Assessment & Intervention        |  |