LIFE ElderCare

CLIENT INTAKE

Participant Name: (Last) (First) (MI)	**Unique Participant ID#**
	Termination Date:
	Reason:

(check) **Service Categories Requested or Interested in:**

		Notes:
☐ VIP Rides	☐ Friendly Visitor	
☐ Meals on Wheels	☐ Fall Prevention	

PERSONAL DATA (Please Print Clearly)	
Home Phone	
2nd Phone	
Email	
Street & Apt	
Cross Street	
City & Zip	
Gate Code	

Ethnicity	☐ Not Hispanic/Latino	☐ Hispanic/Latino	☐ Declined to State

Last 4 digits SS#					
Birthdate					Age:
MediCal?	☐ Yes	☐ No	☐ Declined to State		
Medicare?	☐ Yes	☐ No	☐ Declined to State		
SSI?	☐ Yes	☐ No	☐ Declined to State		
SSDI?	☐ Yes	☐ No	☐ Declined to State		

Relationship Status	☐ Single (never married)	☐ Married			
	☐ Divorced	☐ Separated	☐ Widowed		
	☐ Domestic Partner	☐ Declined to State			
Sexual Orientation	☐ Gay	☐ Lesbian	☐ Bisexual		
	☐ Heterosexual	☐ Other			
	☐ Declined to State				
Veteran	☐ Yes	☐ No	☐ Declined to State		
Gender	☐ Male	☐ Female	☐ Transgender		
	☐ Other	☐ Declined to State			

Emergency Contact Info	
Name	
Relationship	
Phone	
Email	

Language	Primary		Secondary	
Need Translation?	☐ Yes	☐ No		
Refer to CAPS program?	☐ Yes	☐ No		

Lives alone?	☐ Yes	☐ No	☐ Declined to State	
Female HoH?	☐ Yes	☐ No	☐ Declined to State	
Type of residence (gated, apt…)		**Pets** (type)		

Race				
☐ White	☐ Black	☐ Afghan	☐ Arabic	☐ Hindi
☐ Pakistani	☐ American Indian/Alaska Native			
☐ Other:	☐ Multiple Races			
Asian:				
☐ Asian Indian	☐ Cambodian	☐ Chinese		
☐ Filipino	☐ Japanese	☐ Korean		
☐ Laotian	☐ Vietnamese	☐ Other Asian		
Hawaiian/Other Pacific Islander:				
☐ Guamanian	☐ Hawaiian	☐ Samoan		
☐ Other Pacific Islander	☐ Declined to State			

Referred to LIFE by:

Lives with: (Note relationship i.e. son, spouse or partner, care provider, etc.) and usual times at client's home, i.e. weekdays, evenings, overnight.

NOTES:

Supports currently in place

Client is involved in these additional programs (check if yes):

In-Home Support Services IHSS	☐
In-Home Fall Prevention	☐
Out-of-Home Fall Prevention	☐
Exercise Program	☐
Cultural Groups (i.e. Lavender Seniors, Muslim Support Network, etc.)	☐
_____Other program	☐
_____Other program	☐

PACE ☐ Yes ☐ No Kaiser ☐ Yes ☐ No

What transportation? _____

Respite care for care provider? ☐ Yes ☐ No Cognitive (Alzheimer's) care? ☐ Yes ☐ No

Adult Day Care or Adult Day Health Care? ☐ Yes ☐ No Name _____ Days _____

Primary Care Physician / phone _____

Disaster Registry Form completed on _____/_____/_____ OR does not wish to complete

Below for internal purposes only

Referral to the City of Fremont **Date of Referral: _____** **COF – CM (initials):_____**

Your name_____ Your phone #_____

Reason for referral: _____

_____

_____

_____

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