

# Ventura County Area Agency on Aging Data Reporting Manual for Title III B, Title III C, and Title III D Programs

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This guide is a companion piece to the Contractors manual and to the contract between the VCAAA and our providers. It is also meant for VCAAA staff to convey to minimum set of data elements that must be collected from participants and reported to CDA. Please refer to your contract for the actual services contracted scope of service and service unit measurement and definition. Providers are only allowed to provide and report on services that they are contracted to provide.

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The Older Americans Act (OAA) and the Older Californians Act (OCA) require a report of statistical data reflecting the number of service units provided and the number of registered clients or the estimated clients/audience reached

The Ventura County Area Agency on Aging implements different provider reporting procedures, depending on the type of service being provided. Data that is required to be collected and reported is based on federal National Aging Program Information System requirements (NAPIS) and is not negotiable. Every attempt must be made to gather accurate data from program participants. Contact your grants manager if you have any questions about which category your program is reporting on. For VCAAA staff, consult with your supervisor if you have questions.

## Required Title III B, Title III C and Title III D Client Information

For these programs, all providers are required to have a completed intake form on file for each person served. Intake forms have been created for each program with the required fields on the form. Click on the service category to take you to the required form(s) that must be filled out for that program.

VCAAA reviews registered client level details for completeness. The client's information is self-reported and collected annually. If a client declines to provide information, document the action. Service cannot be denied to eligible clients declining to provide information. All of the listed data elements, with the exception of birth date, include a "Declined to State" option which is calculated separately from "missing" information. Missing information occurs when a client is not asked to identify the required demographic data element or information was not entered into the AAA database.

Every effort should be made to collect complete and accurate information. If data is missing (either on the paper form or entered into Q), your grants manager and the Office Systems Coordinator will contact you and require that the information be collected and entered.

Service Category (click on the word to see the definition)	Client Form to use	Service Units	ADL & IADL Required	Nutritional Risk Required	Funding Source
<a href="#">Personal Care</a>	<a href="#">EHP Referral Form</a>	Hour	X		III B
<a href="#">Homemaker</a>	<a href="#">EHP Referral Form</a>	Hour	X		III B
<a href="#">Chore</a>	<a href="#">EHP Referral Form</a>	Hour	X		III B
<a href="#">Home-Delivered Meals</a>	1. <a href="#">Intake (English)/ Intake (Spanish)</a> 2. <a href="#">Assessment Form</a>	Meal	X	X	III C
<a href="#">Case Management</a>	<a href="#">Intake form</a>	Hour	X	X	III B
<a href="#">Congregate Meals</a>	<a href="#">Intake (English)/ Intake (Spanish)</a>	Meal		X	III C
<a href="#">Nutritional Counseling</a>	<a href="#">Intake Form</a>	Session per Participant		X	III C
<a href="#">Peer Counseling</a>	<a href="#">Intake form</a>				III D
<a href="#">Cash/Material Aid</a>	<a href="#">EHP Referral Form</a>	Assistance	X	x <sup>1</sup>	III B
<a href="#">Transportation</a>	<a href="#">EHP Referral Form</a>	One way trip	X		III B
<a href="#">Personal/Home Security</a>	<a href="#">EHP Referral Form</a>	Product	X		III B
<a href="#">Residential Repairs/modifications</a>	<a href="#">EHP Referral Form</a>	Modification	X		III B

For clients receiving these services, the following information is required:

- ✓ [First Name](#)
- ✓ [Last Name](#)
- ✓ [Birthdate](#)
- ✓ [Gender](#)
- ✓ [City](#)
- ✓ [Zip Code](#)
- ✓ [Rural Designation](#)
- ✓ [Race](#)
- ✓ [Ethnicity](#)
- ✓ [Marital Status](#)
- ✓ [Poverty Status](#)
- ✓ [Living Arrangement](#)

A definition for these categories is as follows:

Category	Definition
First Name	Use the clients given name, not nickname
Last Name	Use the clients legal last name
Birthdate	Required field to verify eligible – actual date of birth
Gender	Options are male, female and other
City	City where the client lives
Zip Code	<a href="#">See the zip code chart</a>

<sup>1</sup> Any request relating to food and nutrition requires a nutritional risk assessment.

Rural Designation	<p>AoA defines “rural” as an area that is not defined as urban. Urban areas comprise (1) urbanized areas (as central place and lists adjacent densely settled territories with a combined minimum population of 50,000) and (2) an incorporated place or a census-designated place with 20,000 or more inhabitants.</p> <p>Often a client may not know how to declare their rural designation. You may apply a rural designation on behalf of the client. If applied, make sure those areas, such as zip codes, are documented in your procedures.</p> <p>In Ventura County clients that live in the following zip codes ONLY can be counted as rural:</p> <ul style="list-style-type: none"> <li>✓ 93040 – Piru</li> <li>✓ 93066 – Somis</li> <li>✓ 91307 – Bell Canyon (the portion that is in Ventura County)</li> </ul> <p>Everyone else is counted as “urban”.</p>
Gender	Options are male, female, declined to state or other.
Race	<p>The following reflects the Office of Management and Budget’s (OMB) reporting requirement for collecting race, and California’s Government Code Section 8310.5 reporting requirement for collecting different Asian and Native Hawaiian/Other Pacific Islander groups.</p> <p>The follow options are available to report:</p> <ul style="list-style-type: none"> <li>• White</li> <li>• American Indian or Alaska Native</li> <li>• Chinese</li> <li>• Japanese</li> <li>• Korean</li> <li>• Filipino</li> <li>• Vietnamese</li> <li>• Asian Indian</li> <li>• Black or African American</li> <li>• Guamanian</li> <li>• Hawaiian</li> <li>• Laotian</li> <li>• Other Asian</li> <li>• Cambodian</li> <li>• Samoan</li> <li>• Other Pacific Islander</li> <li>• Other Race</li> <li>• Multiple Race</li> <li>• Declined to State</li> </ul>
Ethnicity	<p>The following reflects the OMB’s ethnicity reporting requirement. Hispanic or Latino origin is a <u>separate question from the race category</u>.</p> <p>The following options are available to report ethnicity:</p> <ul style="list-style-type: none"> <li>• Not Hispanic/Latino</li> <li>• Hispanic/Latino</li> </ul> <p>Note – when the person identifies as white, the ethnicity is not Hispanic/Latino unless the person specifies that they are.</p>
Marital Status	<p>The following options are available:</p> <ul style="list-style-type: none"> <li>• Declined to state</li> <li>• Domestic partner</li> <li>• Divorced</li> <li>• Married</li> </ul>

	<ul style="list-style-type: none"> <li>• Separated</li> <li>• Single (never married)</li> <li>• Widow</li> </ul>
Poverty Status	Clients are marked as “At or Below 100% FPL”, “Above 100% FPL”, or “Decline to State” depending on their income as it relates to the Federal Poverty Level. The latest Federal Poverty Level information can be found at <a href="http://aspe.hhs.gov/poverty/index.shtml#latest">http://aspe.hhs.gov/poverty/index.shtml#latest</a> .
Living Arrangement	<p>AoA defines “living alone” as a one person household (using the Census definition of household) where the householder lives by his or herself in an owned or rented place of residence in a non-institutional setting.</p> <p>The following living arrangement options are available to report:</p> <ul style="list-style-type: none"> <li>• Alone</li> <li>• Not alone</li> </ul>

## ADL/IADL’s Explained

For clients receiving these services, the Older Americans Acts uses the Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) functional impairment scale to identify individuals with functional limitations. ADL’s and IADL’s are a measurement of the inability to perform one or more of the following six activities of daily living without personal assistance, or stand-by assistance, supervision, or cues: eating, dressing, bathing, toileting, transferring in and out of bed/chair, and walking; AND one or more of the following eight instrumental activities of daily living: preparing meals, shopping for personal items, medication management, managing money, using telephone, doing heavy housework, doing light housework, transportation ability.

### How to Determine the Score:

The ADL and IADL functional ability rating scale is applied to each question. The Q System counts the number ADLs and IADLs where verbal or human assistance is required. An applicant’s or client’s sum determines the overall level of functional impairment. Optional ADL and IADL activities are not included in the computation.

ADL/IADL - Required Functional Rating	Example
ADL: Eating	Reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth, chewing, swallowing food and liquids, manipulating food on plate. Cleaning face and hands as necessary following a meal.
ADL: Bathing	Bathing means cleaning the body using a tub, shower, or sponge bath including getting a basin of water, managing faucets, getting in and out of a tub, reaching head and body parts for soaping, rinsing, and drying.
ADL: Toileting	Able to move to and from, on and off toilet or commode, empty commode, manage clothing and wipe and clean body after toileting, use and empty bedpans, ostomy and/or catheter receptacles and urinals, apply diapers and disposable barrier pads. Menstrual care: able to apply

	external sanitary napkin and clean body.
ADL: Transferring in/out of bed/chair	Moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or repositioning to prevent skin breakdown.
ADL: Walking	Walking or moving inside, moving from one area of indoor space to another without necessity of handrails. Can respond adequately to the presence of obstacles that must be stepped around. Includes ability to go from inside to outside and back.
ADL: Dressing	Putting on and taking off, fastening and unfastening garments and undergarments, special devices such as back braces, corsets, elastic stockings/garments and artificial limbs or splints.
IADL: Meal Preparation	Planning menus. Washing, peeling, slicing vegetables, opening packages, cans, and bags, mixing ingredients, lifting pots and pans, reheating food, cooking, safely operating stove, setting the table, serving the meal, cutting food into bite-sized pieces. Washing, drying, and putting away the dishes.
IADL: Shopping	Compile list, bending, reaching, and lifting, managing cart, or basket, identifying items needed, transferring items to home, putting items away, ordering prescriptions over the phone and picking them up, and buying clothing.
IADL: Medication Management	Physically and mentally able to identify, organize, schedule, handle, and consume (inject, instill or insert) the correct amount of the prescribed medication at the specified time according to a doctor's prescription.
IADL: Money Management	Physically and mentally handles the receipt of monies, expenditures, and receipt and payment of bills in a timely and primarily correct manner.
IADL: Using Telephone	Obtains number, dials, handles receiver, can speak and hear response, and terminates call, may include use of instrument with loudspeaker or hearing devices. Able to use telephone during emergency situations to call 911 or other help.
IADL: Heavy Housework	Cleaning oven and stove, cleaning and defrosting refrigerator, moving light furniture to clean under and behind, vacuuming upholstery and under cushions, providing deep cleaning activities such as washing and cleaning baseboards, window tracks, cabinets, doors, drapes/blinds, etc.
IADL: Light Housework	Sweeping, vacuuming, mopping floors, washing kitchen counters and sinks, cleaning bathroom, taking out garbage, dusting and picking up.
IADL: Transportation	Using private or public vehicles, cars, buses, trains, or other forms of transportation to get to medical appointments, purchase food, shop, pay bills, or arrange for services, to socialize and participate in entertainment or religious activities. Can arrange for getting and using public transportation or get to, enter and operate a private vehicle.

Providers are to assess the person's ability based on the following scale:

#### ADL & IADL Functional Impairment Rating Scale

(1) Independent: Can perform a task without human assistance.
(2) Verbal Assistance: Requires verbal assistance such a reminding to complete a task
(3) Some Human Help: Requires some physical assistance to perform a task.
(4) Lots of Human Help: Requires substantial assistance to perform a task.
(5) Dependent: Totally dependent on another person to perform a task.

Please note that in the Q database (2) verbal assistance reads verbal cueing, (3) some human help reads standby and (4) lots of human help reads hands on. These will not be changed as the Multipurpose Senior Services Program (MSSP) is required to use these names for these functional impairments on all their paperwork.

#### Nutritional Risk

Older Americans Act programs use nutritional screening to identify individuals at nutritional risk or with malnutrition. VCAAA uses a standard tool across all programs as it corresponds with the categories used in our database system. Information is also used for targeting and reporting purposes. The California Department of Aging uses the nutritional risk data to determine if we are reaching individuals who are medium to high nutritional risk. CDA bases its target on nationwide analysis of high nutritional risk averages.

Program	Target Percentage of all reported participants
Congregate Meals (C-1)	21% or higher at nutritional risk
Home-Delivered Meals (C-2)	65% or higher at nutritional risk

Every attempt should be made to have clients accurately fill out this information. **An annual nutritional risk assessment is required and must be entered into the Q system.**

#### Reporting Services Where An Intake Form Is Not Required

Check your contract to see if you are to report service units in the following categories. If you are contracted to do so, an intake form for each client served/activity undertook may not be required. However, depending on the program there may be additional requirements. View the [additional requirements box](#) to see what the additional requirements are:

Service Category (click on the word to see the definition)	Additional Requirements	Service Unit Measurement	Aggregate number reported	Funding Source
<a href="#">Community Education</a>		Activity	X	III B
<a href="#">Comprehensive Assessment</a>		Hour	X	III B

<a href="#">Disaster Preparedness Materials</a> * see <a href="#">Disaster Registry</a>	<a href="#">Intake form</a>	Product	X	III B
<a href="#">Elder Abuse Prevention, Education and Training</a>		Session	Units should match <a href="#">CDA 1037</a>	VII B
<a href="#">Elder Abuse Prevention Educational Materials</a>		Product	Units should match <a href="#">CDA 1037</a> )	VII B
<a href="#">Health Promotion and Disease Prevention</a>		Contact	X	III D
<a href="#">Information and Assistance</a>	<a href="#">x</a>	contact	X	III B
<a href="#">Legal Services</a>	<a href="#">Intake form required</a>	Hour	Yes, and Units should be reported on and match <a href="#">CDA 1022</a>	III B/HICAP
<a href="#">Nutrition Education</a>		Session per Participant	X	III C
<a href="#">Outreach</a>		Contact	X	III B
<a href="#">Peer Counseling</a>		Hour	X	III B
<a href="#">Personal Affairs Assistance</a>		Contact	X	III B
<a href="#">Public Information</a>		Activity	X	III B
<a href="#">Telephone Reassurance</a>		Contact	X	III B
<a href="#">Visiting</a>		Hour	X	III B
<a href="#">Transportation – Senior Nutrition</a>	<a href="#">x</a>	One way trip	X	III B
<a href="#">Medication Management</a>		contact	x	III D

Transportation (senior nutrition) - a roster of people provided rides along with the number of rides is required. This list must be cross referenced with the number of meals that each rider has consumed. The intent of the program is to provide transportation to the meal site, not the senior center.

Information and Assistance – data entry of all client information is required into the ReferNet System.

**Note** – Actual numbers of unduplicated clients served must be reported on the appropriate form. Service providers are required to develop a mechanism to count and report unduplicated client numbers.



## Disaster Registry

The VCAAA along with the County of Ventura Human Services Agency has a disaster registry in which people aged 60 and over can voluntarily register. The registry interacts with Sheriff's Department Office of Emergency Services. Information such as name, address, phone number, emergency contact name and number is collected along with general medical condition, supply needs (oxygen, etc) and what kind of assistance seniors might need during an emergency will be indicated on a map of the area. During an actual emergency this information helps emergency response personnel to better allocate limited resources. The Office of Emergency Services will be able to ensure that emergency workers have general information about medical and supply needs. The disaster registry is voluntary and no response is guaranteed.

Initial automated calls are made by the County of Ventura's Reverse 911 system with follow-up calls made by trained, live social workers. Messages may include heat advisories, instructions on what to do or where to go to be out of danger. Through the enrollment in the database, the VCAAA cannot promise that seniors will get a telephone call or a visit to their home for every emergency. However, enrollment helps the VCAAA better work with emergency workers to ensure safety.

The option of enrolling in the registry is provided to seniors receiving disaster kits, however service providers may enroll other seniors in the registry by completing the [disaster registry form](#) and returning it to the VCAAA (attention: [Martin.Marquez@Ventura.Org](mailto:Martin.Marquez@Ventura.Org)).

Required elements include:

- a. Degree of contact necessary:
  1. Critical, the person must be moved with the assistance of an Ambulance or other emergency vehicle.
  2. Urgent, personal contact is required to assist this person.
  3. Moderate, a phone call is all that is required.
  4. Contact by Emergency Staff not needed. Person is not to be contacted.
- b. Impairment that the emergency staff should be aware of (pick only one):
  1. Deaf
  2. Blind
  3. Bed bound
  4. Wheelchair dependant
  5. Mental disability
  6. No impairments
- c. Special Needs/Equipment Required (pick only one):
  1. Respirator
  2. Oxygen
  3. Insulin
  4. Life Support Medications
  5. Dialysis
  6. Bowel or Bladder Issues
  7. Nasal/Gastro Tubes/Suctions
  8. No Special Needs



## Data Entry Into the Q System

For those grantees or VCAAA staff that enters Title III B, Title III C or Title III D data into the Q systems, the following guides are available:

Source of Funding	Service	Type of Guide
Title III B	Case Management	Q Guide for Mandatory Fields
Title III B	Information and Assistance	VCAAA Information and Assistance ReferNet Guide
Title III B	Personal Care	Q Guide for Mandatory Fields
Title III B	Homemaker	Q Guide for Mandatory Fields
Title III B	Chore	Q Guide for Mandatory Fields
Title III B	Transportation – Medi-ride	Q Guide for Mandatory Fields
Title III B	Cash/Material Aid	Q Guide for Mandatory Fields
Title III B	Transportation – senior nutrition	Q Guide for Mandatory Fields
Title III B	Personal/Home Security	Q Guide for Mandatory Fields
Title III B	Residential Repairs/modifications	Q Guide for Mandatory Fields
Title III C	Nutrition Counseling	Q Guide for Mandatory Fields
Title III C	Home Delivered Meals	Care Access for Senior Nutrition Guide
Title III C	Congregate Meals	Care Access for Senior Nutrition Guide
All	All services	Running Reports in Q Guide

The guides are available on the VCAAA website or by email from [Martin.Marquez@ventura.org](mailto:Martin.Marquez@ventura.org) or by contacting your grants manager.

## VCAA Service Area by Zip Code

**IN ZIP CODE  
ORDER →**

**ALL zip codes  
are entered in  
the “Q”  
database as  
URBAN  
except for the  
RURAL zip  
codes of:  
-93040-Piru  
-93066-Somis  
- 91307-Bell  
Canyon (the  
portion that  
is in Ventura  
County.**

ZIP CODE	CITY	COUNTY
91301	AGOURA HILLS	Los Angeles *
91307	BELL CANYON** (RURAL)	**
91319	NEWBURY PARK	Ventura
91320	NEWBURY PARK-THOUSAND OAKS	Ventura
91358	THOUSAND OAKS - Hampshire Rd.	Ventura
91359	THOUSAND OAKS-WESTLAKE VILLAGE	Ventura
91360	THOUSAND OAKS - Northwest	Ventura
91361	THOUSAND OAKS-WESTLAKE VILLAGE Lake Sherwood - Hidden Valley	Ventura
91362	THOUSAND OAKS - North Ranch/East	Ventura
91363	WESTLAKE VILLAGE - THOUSAND OAKS	Los Angeles *
91376	AGOURA HILLS	Los Angeles *
91377	AGOURA HILLS-OAK PARK	Ventura
93001	VENTURA - Includes Casitas Springs	Ventura
93002, 93003	VENTURA	Ventura
93004	VENTURA - Saticoy/East	Ventura
93005, 93005, 93006, 93007	VENTURA	Ventura
93009	VENTURA - Government Center	Ventura
93010	CAMARILLO - West	Ventura
93011	CAMARILLO - Central	Ventura
93012	CAMARILLO - East - Santa Rose Valley	Ventura
93013, 93014	CARPINTERIA	Santa Barbara *
93015, 93016	FILLMORE	Ventura
93020, 93021	MOORPARK	Ventura
93022	OAK VIEW	Ventura
93023	OJAI - Meiners Oaks	Ventura
93024	OJAI	Ventura
93030	OXNARD – East	Ventura
93031, 93032	OXNARD - Central	Ventura
93033	OXNARD - College Park	Ventura
93034	OXNARD – South	Ventura
93035	OXNARD - Channel Islands/South	Ventura
93036	OXNARD – North	Ventura
93040	PIRU (RURAL)	Ventura
93041, 93042	PORT HUENEME - Pt. Mugu NAWC	Ventura
93043	PORT HUENEME - CB Base	Ventura
93044	PORT HUENEME	Ventura
93060, 93061	SANTA PAULA	Ventura
93062	SIMI VALLEY - East	Ventura
93063	SIMI VALLEY - Northeast - Santa Susana	Ventura
93064	SIMI VALLEY - Southwest/Brandeis	Ventura
93065	SIMI VALLEY - Northwest	Ventura
93066	SOMIS (RURAL)	Ventura
93093	SIMI VALLEY - Central	Ventura
93094	SIMI VALLEY - Central	Ventura
93099	SIMI VALLEY - Central	Ventura

\* **Not** eligible to receive services unless client or care receiver reside in Ventura County.

\*\*91307 is on the LA-County border. To confirm eligibility, ask client to provide a copy of their Ventura County property tax bill (which shows client's address, parcel #, etc.).

To view zip code location go to: <http://www.zip-codes.com/search.asp>

## TITLE III B, TITLE III C AND TITLE III DEFINITIONS OF SERVICES

Service Category	Unit Measure	Definitions
<b>Personal Care</b>	1 Hour	Personal assistance, stand-by assistance, supervision or cues. (such as with eating, bathing, toileting, transferring in/out of bed/chair, walking, dressing, grooming).
<b>Homemaker</b>	1 Hour	Assistance such as preparing meals, shopping for personal and household items, managing money, using the telephone or doing light housework.
<b>Chore</b>	1 Hour	Assistance such as heavy housework, yard work or sidewalk and other home maintenance for a person.
<b>Home-Delivered Meals</b>	1 Meal	A meal provided to an eligible individual in his or her place of residence, that meets all of the requirements of the Older Americans Act and State/Local laws, assures a minimum one-third of the current Dietary Reference Intake, and shall comply with Dietary Guidelines for Americans.
<b>Case Management</b>	1 Hour	Assistance either in the form of access coordination in circumstances where the older person is experiencing diminished functioning capacities, personal conditions or other characteristics which require the provision of services by formal service providers or family caregivers. Activities of case management include such practices as assessing needs, developing care plans, authorizing and coordinating services among providers, and providing follow-up and reassessment, as required.
<b>Congregate Meals</b>	1 Meal	A meal provided to an eligible individual in a congregate group setting, that meets all of the requirements of the Older Americans Act and State/Local laws, and assures a minimum one-third of the Dietary Reference Intake, and shall comply with Dietary Guidelines for Americans.
<b>Nutrition Counseling</b>	1 Session Per Participant	Individualized guidance to individuals who are at nutritional risk because of their health or nutrition history, dietary intake, chronic illnesses, or medications use, or to caregivers. Counseling is provided one-on-one by a registered dietitian, and addresses the options and methods for improving nutrition status. Nutrition counseling may be made either in person or by any other means deemed appropriate (e.g., telephone, emails, etc.)
<b>Transportation</b>	1 One Way Trip	Transportation from one location to another. Does not include any other activity. May include travel vouchers and transit passes.
<b>Legal Assistance</b>	1 Hour	Legal advice, counseling and/or representation by an attorney or other person acting under the supervision of an attorney.

<b>Nutrition Education</b>	1 Session Per Participant	A program to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants, caregivers, or participants in a group or individual setting overseen by a dietitian or individual of comparable expertise. Methods of education may include demonstrations, audio-visual presentations, or small group discussions for congregate program participants. Handout materials may be used, but not limited to, as the sole education component for home-delivered meal program participants.
<b>Information and Assistance</b>	1 Contact	A service that: (A) provides individuals with information on services available within the communities; (B) links individuals to the services and opportunities that are available within the communities; (C) to the maximum extent practicable, establishes adequate follow-up procedures. Internet web site "hits" are to be counted only if information is requested and supplied and (C) is satisfied. Maximum extent practicable includes offering a follow-up call to all individuals who were linked to a service. Individuals can remain anonymous and refuse a follow-up call.
<b>Outreach</b>	1 Contact	Interventions (one-on-one contacts) with individuals initiated by an agency or provider for the purpose of identifying potential clients (or their age 60+ caregivers) and encouraging their use of existing services and benefits.
<b>Health Promotion</b>	1 Contact	Provide health risk assessments; routine health screening; nutrition counseling/education services; evidence-based health promotion; physical fitness, group exercise, music, art therapy, dance movement and programs for multigenerational participation; home injury control services; screening for the prevention of depression and coordination of other mental health services; gerontological and social service counseling; and education on preventative health services. Primary activities are normally on a one-to-one basis; if done as a group activity, each participant shall be counted as one contact unit.
<b>Cash / Material Aid</b>	1 Assistance	Arrange for and provide assistance to participants in the form of commodities, surplus food distribution, emergency cash assistance, and vouchers.
<b>Community Education</b>	1 Activity	Educating groups of older persons, their families, friends, and community organizations/facility staff on rights, benefits, entitlements, and health and wellness information for older persons either residing at home or in an institutional setting.
<b>Comprehensive Assessment</b>	1 Hour	Evaluating a person's physical, psychological, and social needs, financial resources, and the strengths and weaknesses of their informal support system and the immediate environment as a basis for determining current functional ability and potential improvement in order to develop the appropriate services needed to maximize functional independence.

<b>Health</b>	1 Hour	Activities such as health screening, physical fitness, therapy, and hospice to assist older individuals to improve or maintain physical health and secure necessary medical, preventive health, or health maintenance services. Health screening, therapy, and hospice must be provided by a licensed health professional or by a paraprofessional supervised by a licensed health professional. Does not include services covered by Medicare, Medi-Cal, or other health insurance.
<b>Medication Management</b>	1 Contact	Medication Management is a required service with a separate funding allocation to provide medication screening and education to an individual and/or the caregiver to prevent incorrect medication administration and adverse drug reactions. Primary activities are normally on a one-to-one basis; if done as a group activity, each participant shall be counted as one contact unit.
<b>Peer Counseling</b>	1 Hour	Use the skills and/or life experiences of trained volunteers, under qualified supervision, to provide advice, guidance, and support in a self-help approach in order to enhance well-being and enable clients to make informed choices.
<b>Personal Affairs Assistance</b>	1 Contact	Provide assistance in writing letters and with the completion of financial forms, including tax forms, and other written or electronic documents.
<b>Personal / Home Security</b>	1 Product	Services for the security and safety of their home environment, by providing safety features such as: medical alert, alarms, assistive devices (including provision of assistive technology services and assistive technology devices).
<b>Public Information</b>	1 Activity	Contact with multiple current or potential clients or caregivers through publications, publicity campaigns, and other mass media campaigns including Internet websites.
<b>Residential Repairs / Modifications</b>	1 Modification	Residential modifications of homes that are necessary to facilitate the ability of older individuals to remain at home and that are not available under other programs. Includes minor repairs/renovations in order to meet safety, health issues, and code standards.
<b>Telephone Reassurance</b>	1 Contact	Telephone a client to provide contact and safety checks to reassure and support older individuals.
<b>Visiting</b>	1 Hour	Visit a client to provide contact and safety checks to reassure and support older individuals.
<b>Disaster Preparedness Materials</b>	1 Product	Assemble and distribute disaster preparedness materials such as File of Life or preparedness kits that will assist seniors in the event of an emergency.
<b>Elder Abuse Prevention, Education and Training</b>	1 Session	Public education and training of professionals to develop, strengthen, and carry out programs for the prevention, detection, assessment, and treatment of, intervention in, investigation of, and response to elder abuse, neglect, and exploitation (including financial exploitation). This includes training for Title III E caregivers.
<b>Elder Abuse Prevention Educational Materials</b>	1 Product	Educational materials and guidance kits distributed for the prevention, detection, assessment, and treatment of, intervention in, investigation of, and response to elder abuse, neglect, and exploitation (including financial exploitation).

## VCAAA DISASTER KITS

### TO RECEIVE A KIT YOU MUST BE 60 YEARS OF AGE OR OLDER

There is no charge for services, however, donations are accepted. You will not be denied services if you choose not to donate. Please call (805) 477-7311 to donate.

Name : _____ Address: _____ City & Zip: _____	Phone: _____ Birth Date: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		
<b>Additional Information</b>			
<b>Marital Status:</b> <input type="checkbox"/> Declined to State <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Missing <input type="checkbox"/> Separated <input type="checkbox"/> Single (never married) <input type="checkbox"/> Widowed			
<b>Race - Please choose one</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> American Indian or Alaska Native  <input type="checkbox"/> Asian Indian  <input type="checkbox"/> Black or African American  <input type="checkbox"/> Cambodian  <input type="checkbox"/> Chinese  <input type="checkbox"/> Declined to State  <input type="checkbox"/> Filipino  <input type="checkbox"/> Guamanian  <input type="checkbox"/> Hawaiian  <input type="checkbox"/> Japanese         </div> <div style="width: 50%;"> <input type="checkbox"/> Korean  <input type="checkbox"/> Laotian  <input type="checkbox"/> Missing  <input type="checkbox"/> Multiple Race  <input type="checkbox"/> Other Asian  <input type="checkbox"/> Other Pacific Islander  <input type="checkbox"/> Other Race (includes Hispanic/Latino)  <input type="checkbox"/> Samoan  <input type="checkbox"/> Vietnamese  <input type="checkbox"/> White         </div> </div>	Ethnicity: <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <hr/> Number of people that live in your house? _____ <hr/> Are you a female head of house? <input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> Are you diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> Do you require a low-sodium meal? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Please indicate your annual income level:</b> <div style="display: flex;"> <div style="width: 50%;"> <u>Married</u>  <input type="checkbox"/> Below \$14,570 (at or below 100% FPL)  <input type="checkbox"/> \$14,571 or more  <input type="checkbox"/> Declined to state         </div> <div style="width: 50%;"> <u>Single</u>  <input type="checkbox"/> Below \$10,830 (at or below 100% FPL)  <input type="checkbox"/> \$10,831 or more  <input type="checkbox"/> Declined to state         </div> </div>	Emergency contact name and phone number: _____		
<b>Do you want to be included in the County's Voluntary Disaster Registry?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
Degree of Contact Necessary (check only one): <input type="checkbox"/> A - Critical, the person must be moved with the assistance of an Ambulance or other emergency vehicle. <input type="checkbox"/> B - Urgent, personal contact is required to assist this person. <input type="checkbox"/> C - Moderate, a phone call is all that is required. <input type="checkbox"/> Z - Contact by Emergency Staff not needed. Person is not to be contacted.			
<b>If yes, please complete the following to describe your situation:</b> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> A – Deaf  <input type="checkbox"/> B – Blind  <input type="checkbox"/> C – Bed Bound  <input type="checkbox"/> D – Wheelchair  <input type="checkbox"/> E – Mental Disability  <input type="checkbox"/> Z – No Impairment         </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> A - Respirator  <input type="checkbox"/> B - Oxygen  <input type="checkbox"/> C - Insulin  <input type="checkbox"/> D - Life Support Medications  <input type="checkbox"/> E - Dialysis  <input type="checkbox"/> F – Bowel or Bladder Issues  <input type="checkbox"/> G – Nasal/Gastro Tubes/Suctions  <input type="checkbox"/> Z – No Special Needs         </td> </tr> </table>		<input type="checkbox"/> A – Deaf <input type="checkbox"/> B – Blind <input type="checkbox"/> C – Bed Bound <input type="checkbox"/> D – Wheelchair <input type="checkbox"/> E – Mental Disability <input type="checkbox"/> Z – No Impairment	<input type="checkbox"/> A - Respirator <input type="checkbox"/> B - Oxygen <input type="checkbox"/> C - Insulin <input type="checkbox"/> D - Life Support Medications <input type="checkbox"/> E - Dialysis <input type="checkbox"/> F – Bowel or Bladder Issues <input type="checkbox"/> G – Nasal/Gastro Tubes/Suctions <input type="checkbox"/> Z – No Special Needs
<input type="checkbox"/> A – Deaf <input type="checkbox"/> B – Blind <input type="checkbox"/> C – Bed Bound <input type="checkbox"/> D – Wheelchair <input type="checkbox"/> E – Mental Disability <input type="checkbox"/> Z – No Impairment	<input type="checkbox"/> A - Respirator <input type="checkbox"/> B - Oxygen <input type="checkbox"/> C - Insulin <input type="checkbox"/> D - Life Support Medications <input type="checkbox"/> E - Dialysis <input type="checkbox"/> F – Bowel or Bladder Issues <input type="checkbox"/> G – Nasal/Gastro Tubes/Suctions <input type="checkbox"/> Z – No Special Needs		

\*\*\*Note – all information provided is confidential\*\*\*

# **Senior Nutrition Program Meal Registration**

## **TO RECEIVE MEALS YOU MUST BE 60 YEARS OF AGE OR OLDER**

There is no charge for services, however, donations are accepted. You will not be denied services if you choose not to donate. Note – all information provided is confidential.

Name : _____		Phone: _____	
Address: _____		Birth Date: _____	
City & Zip: _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
<b>Additional Information</b>			
<b>Marital Status:</b> <input type="checkbox"/> Declined to state <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Missing <input type="checkbox"/> Separated <input type="checkbox"/> Single (never married) <input type="checkbox"/> Widowed			
<b>Race - Please choose one</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> American Indian or Alaska Native  <input type="checkbox"/> Asian Indian  <input type="checkbox"/> Black or African American  <input type="checkbox"/> Cambodian  <input type="checkbox"/> Chinese  <input type="checkbox"/> Declined to State  <input type="checkbox"/> Filipino  <input type="checkbox"/> Guamanian  <input type="checkbox"/> Hawaiian  <input type="checkbox"/> Japanese         </div> <div style="width: 50%;"> <input type="checkbox"/> Korean  <input type="checkbox"/> Laotian  <input type="checkbox"/> Missing  <input type="checkbox"/> Multiple Race  <input type="checkbox"/> Other Asian  <input type="checkbox"/> Other Pacific Islander  <input type="checkbox"/> Other Race (includes Hispanic/Latino)  <input type="checkbox"/> Samoan  <input type="checkbox"/> Vietnamese  <input type="checkbox"/> White         </div> </div>		<b>Ethnicity:</b> <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <hr/> Number of people that live in your house? <hr/> Are you a female head of house? <input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> Are you diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> Do you require a low-sodium meal? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Please indicate your annual income level:</b> <div style="display: flex;"> <div style="width: 50%;"> <u>Married</u>  <input type="checkbox"/> Below \$14,570 (at or below 100% FPL)  <input type="checkbox"/> \$14,571 or more  <input type="checkbox"/> Declined to state         </div> <div style="width: 50%;"> <u>Single</u>  <input type="checkbox"/> Below \$10,830 (at or below 100% FPL)  <input type="checkbox"/> \$10,831 or more  <input type="checkbox"/> Declined to state         </div> </div>		Emergency contact name and phone number:  	
<b>Nutritional Risk</b>			



**Please check all that apply:**

- ☐ I have an illness or condition that made me change the kind/or amount of food I eat..
- ☐ I eat fewer than two (2) meals per day.
- ☐ I eat few fruit or vegetables or milk products.
- ☐ I have three (3) or more servings of beer, liquor, or wine every day.
- ☐ I have tooth or mouth problems dental or mouth problems that make it hard to eat.
- ☐ I don't always have enough money to buy the food I need.
- ☐ I eat alone most of the time.
- ☐ I take three (3) or more prescribed or over the counter drugs a day.
- ☐ Without wanting to, I have lost or gained ten (10) pounds in the last six (6) months.
- ☐ I am not always physically able to shop, cook, and/ or feed myself.

**Program Eligibility**

HDM:                      Congregate:                      PUMP                      Meal Site:

**HOME-DELIVERED MEALS APPLICANTS ONLY**

You must be 60 years of age or older, homebound due to illness or disability and unable to prepare your own meals.

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Are you homebound due to illness or disability?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you drive?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you able to prepare meals?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a microwave?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have freezer space for frozen meals?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you interested in weekend meals or other services?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| I am: disabled <input type="checkbox"/> deaf <input type="checkbox"/> blind <input type="checkbox"/>       |                              |                             |
| I use a: walker <input type="checkbox"/> cane <input type="checkbox"/> wheelchair <input type="checkbox"/> |                              |                             |

I certify under penalty of perjury that all statements on this form are true and correct.

Applicant Signature: \_\_\_\_\_

**Programa de Nutrición para la Tercera Edad**  
**Inscripción para el servicio de comidas**  
**PARA RECIBIR COMIDAS DEBE TENER 60 AÑOS DE EDAD O MAYOR**

No hay ningún cargo por servicios, sin embargo, se aceptan donaciones. No se le negarán los servicios en caso de que decida no dar un donativo. **Nota: toda la información proporcionada es Confidencial.**

Nombre: _____ Dirección: _____ Ciudad & Código Postal: _____	Teléfono: _____ Fecha de Nacimiento: _____ Género: <input type="checkbox"/> Hombre <input type="checkbox"/> Mujer <input type="checkbox"/> Otro
<b>Información adicional</b>	
<b>Estado civil:</b> <input type="checkbox"/> Se negó a declarar <input type="checkbox"/> Divorciado <input type="checkbox"/> Compañero de hogar <input type="checkbox"/> No está en la lista <input type="checkbox"/> Separado <input type="checkbox"/> Soltero (nunca casado) <input type="checkbox"/> Viudo	
<b>Raza - elija uno</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Indio Americano o Nativo de Alaska  <input type="checkbox"/> Indio Asiático  <input type="checkbox"/> Afroamericano  <input type="checkbox"/> Camboya  <input type="checkbox"/> Chino  <input type="checkbox"/> Se negó a declarar  <input type="checkbox"/> Filipino  <input type="checkbox"/> Guamés  <input type="checkbox"/> Hawaiano  <input type="checkbox"/> Japonés           </div> <div style="width: 45%;"> <input type="checkbox"/> Coreano  <input type="checkbox"/> Laos  <input type="checkbox"/> No está en la lista  <input type="checkbox"/> Múltiples razas  <input type="checkbox"/> Otros Asiáticos  <input type="checkbox"/> Otros isleños del Pacífico  <input type="checkbox"/> Otras razas (incluye Hispano/Latino)  <input type="checkbox"/> Samoa  <input type="checkbox"/> Vietnamita  <input type="checkbox"/> Blanco           </div> </div>	<b>Etnico:</b> <input type="checkbox"/> No Hispano/Latino <input type="checkbox"/> Hispano/Latino <hr/> ¿Número de personas que viven en tu casa? _____ <hr/> ¿Eres una mujer cabeza de casa? <input type="checkbox"/> Sí <input type="checkbox"/> No <hr/> ¿Eres diabético? <input type="checkbox"/> Sí <input type="checkbox"/> No <hr/> ¿Necesita una comida con poca sal? <input type="checkbox"/> Sí <input type="checkbox"/> No
<b>Indique su nivel de ingreso anual:</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>Casado</u>  <input type="checkbox"/> Por debajo de \$14.570 (por debajo del 100% FPL)  <input type="checkbox"/> \$14.571 o más  <input type="checkbox"/> Se negó a declarar           </div> <div style="width: 45%;"> <u>Soltero</u>  <input type="checkbox"/> Por debajo de \$10.830 (por debajo del 100% FPL)  <input type="checkbox"/> \$10.831 o más  <input type="checkbox"/> Se negó a declarar           </div> </div>	Contacto de Emergencia: nombre y número de teléfono.
<b>Riesgo Nutricional</b>	

**Marque todas las opciones que correspondan:**

- ☐ Tengo una enfermedad o afección que afecta el tipo o la cantidad de comida que ingiero.
- ☐ Como menos de dos (2) comidas diarias.
- ☐ Como pocas frutas o verduras o productos lácteos
- ☐ Tomo tres (3) o más vasos de vino, cerveza o licor cada día.
- ☐ Tengo problemas dental o de boca que hacen difícil comer.
- ☐ No siempre dispongo de dinero suficiente para comprar los alimentos que necesito.
- ☐ Como solo la mayor parte del tiempo.
- ☐ Tomo tres (3) o más medicamentos recetados por día.
- ☐ Bajé o aumenté diez (10) libras en los últimos seis (6) meses.
- ☐ Mi capacidad física no siempre me permite hacer compras o cocinar

**SÓLO PARA SOLICITANTES DE COMIDAS A DOMICILIO**

Debe tener 60 años de edad o mayor, imposibilitado debido a enfermedad o discapacidad, y no puede preparar sus propias comidas.

- |   |                                 |                                  |
|---|---------------------------------|----------------------------------|
| ¿Estás imposibilitado debido a una enfermedad o discapacidad?         | <input type="checkbox"/> Sí     | <input type="checkbox"/> No      |
| ¿Conduces?  | <input type="checkbox"/> Sí     | <input type="checkbox"/> No      |
| ¿Es capaz de preparar comidas?  | <input type="checkbox"/> Sí     | <input type="checkbox"/> No      |
| ¿Tienes un microondas?  | <input type="checkbox"/> Sí     | <input type="checkbox"/> No      |
| ¿Tienes espacio en tu congelador para guardar comidas congeladas?     | <input type="checkbox"/> Sí     | <input type="checkbox"/> No      |
| ¿Estás interesado en comidas para el fin de semana u otros servicios? | <input type="checkbox"/> Sí     | <input type="checkbox"/> No      |
| Soy: <input type="checkbox"/> Discapacitado                           | <input type="checkbox"/> Ciego  | <input type="checkbox"/> Sordo   |
| Uso: <input type="checkbox"/> Silla de ruedas                         | <input type="checkbox"/> Bastón | <input type="checkbox"/> Andador |

Certifico bajo pena de perjurio que todas las declaraciones en este formulario son verdaderos y correctos.

Firma del solicitante: \_\_\_\_\_ Fecha \_\_\_\_\_

# **Senior Nutrition Program** **Home Delivered Meals Assessment Worksheet**

Name _____	Birth Date _____
Address _____	Phone _____
City & Zip _____	Emergency Contact _____

## **Additional Information**

Is applicant homebound? _____	Does applicant have freezer space for 5 meals? _____
Is applicant disabled? _____	Does applicant have oven/microwave? _____
Does applicant drive? _____	Can applicant prepare meals? _____
Does applicant have help at home? _____	Can applicant attend a congregate meal site if transportation is provided? _____

## **Activities of Daily Living (ADL's) (please check 1 for each activity)**

	Independent – needs no help	Verbal Cueing Required	Standby Assistance Required	Hands on Assistance Required	Dependent on others for the task
Eating					
Dressing					
Transfers					
Bathing					
Toileting					
Grooming					
Walking					

## **Instrumental Activities of Daily Living (IADL'S) (please check 1 for each activity)**

	Independent – needs no help	Verbal Assistance Required	Some Human Help Required	Lots of Human Help Required	Dependent on others for the task
Doing Light Housework					
Laundry					
Shopping/errand					
Prepare Meals/cleanup					
Use available transportation					
Use the Telephone					
Manage Medication					
Manage Money					
Stair Climbing					
Mobility Indoors					
Doing Heavy Housework					

## **Program Eligibility**

HDM Eligible: <input type="checkbox"/> No <input type="checkbox"/> Yes	Referred to Congregate: _____	Start Date: _____	Reassessment Date: _____
Notes/Referrals for Other Services: _____			



## VENTURA COUNTY AREA AGENCY ON AGING ELDERHELP PROGRAM (EHP) REFERRAL FORM

Please e-mail this form to [Elder.Help@ventura.org](mailto:Elder.Help@ventura.org) or fax to 805-477-7312

(email is preferred)

REQUESTING AGENCY INFO	
Requesting Agency:	Today's Date:
Requestor:	Phone Number:
Email Address or Fax #: of Requestor:	

PLEASE SELECT EHP SERVICE		
<input type="checkbox"/> Personal Care	<input type="checkbox"/> Homemaker (Light Cleaning)	<input type="checkbox"/> Chore (Deep Cleaning)
<input type="checkbox"/> Home Modification and/or Assistive Devices	<input type="checkbox"/> Medi-Ride Transportation	<input type="checkbox"/> Dial-A-Ride Tickets

REQUIRED INFO ABOUT THE CLIENT	
Full Name of Client:	
Street Address where care or transportation is to be provided from:	
City:	Zip Code:
Date of Birth*: <i>*EHP is funded by the Federal Older American's Act which requires clients be age 60+. The only exception is for Medi-Ride transportation - additional grant funds were obtained by VCAAA to provide a limited number of rides to disabled adults under age 60.</i>	
Phone Number of Client:	Primary Language:
Gender : <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Marital Status:
<b>Race - Please choose one:</b>	<b>Ethnicity:</b>
<input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Chinese <input type="checkbox"/> Cambodian <input type="checkbox"/> Other Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Guamanian	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino
<b>Annual Income Level:</b>	

<input type="checkbox"/> Japanese <input type="checkbox"/> Filipino <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Laotian <input type="checkbox"/> Declined to State		<input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other Race (includes Hispanic/Latino) <input type="checkbox"/> Multiple Race		<b>Married</b> <input type="checkbox"/> Below \$14,570 (at or below 100% FPL) <input type="checkbox"/> \$14,571 or more <input type="checkbox"/> Declined to state	<b>Single</b> <input type="checkbox"/> Below \$10,830 (at or below 100% FPL) <input type="checkbox"/> \$10,831 or more <input type="checkbox"/> Declined to state
Does the client live alone? <input type="checkbox"/> No <input type="checkbox"/> Yes					
<b>Daily Activities - Help is Needed:</b>	Independent – needs no help	Verbal Assistance	Some Human Help Required	Lots of Human Help Required	Dependent on others for the task
Eating/Feeding Self	<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"/>
Transferring	<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"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Grooming</b>					
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing Meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing Medicines	<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"/>
Using the Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing Heavy Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing Light Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use Available Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CAREGIVER INFO (IF APPLICABLE)</b>					
Caregiver/Alternate Contact Name:					
Phone Number for Caregiver/Alternate Contact:					

<b>ADDITIONAL INFO FOR HOMEMAKER OR CHORE SERVICE ONLY</b>
Does the client have any hoarding issues? <input type="checkbox"/> No <input type="checkbox"/> Yes
Does the client have IHSS? <input type="checkbox"/> No <input type="checkbox"/> Yes Additional Comments:

<b>ADDITIONAL INFO FOR HOME MODIFICATION AND/OR ASSISTIVE DEVICES ONLY</b>
What needs to be done?
Does the client own their home? <input type="checkbox"/> No <input type="checkbox"/> Yes
If not, has landlord been contacted re: these needs? <input type="checkbox"/> No <input type="checkbox"/> Yes

ADDITIONAL INFO FOR MEDI-RIDE TRANSPORTATION ONLY	
Type of vehicle needed ( <b>check one</b> ): <input type="checkbox"/> gurney van <input type="checkbox"/> wheelchair van <input type="checkbox"/> town car	
Does the person use a wheelchair? <input type="checkbox"/> No <input type="checkbox"/> Yes – what kind?	
Are they aware that referral has been made? <input type="checkbox"/> No <input type="checkbox"/> Yes	
What is the time and date of the medical appointment? <b>A minimum of 5 business days notice is required to process transportation requests</b>	
Name of Doctor/Hospital: Address: City: Nearest Cross Streets:	
Roundtrip Appointment? <input type="checkbox"/> No <input type="checkbox"/> Yes	How long is the appointment?
Is escort riding with them? <input type="checkbox"/> No <input type="checkbox"/> Yes	Name and phone number of escort: _____
<b>REQUIRED</b> - Has the client been certified for ADA transportation? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Please scan or fax a copy of client's ADA transportation card or application.</b>	
Justification why this service is needed and the client cannot take SCAT access or a regular car to the medical appointment?	

FOR VCAAA USE ONLY	
Date EHP Referral Received:	Approved: <input type="checkbox"/> No <input type="checkbox"/> Yes
Comments:	
Date Requesting Agency Contacted:	
Approved Service:	<input type="checkbox"/> Personal Care <input type="checkbox"/> Homemaker <input type="checkbox"/> Chore <input type="checkbox"/> Dial-A-Ride Tickets <input type="checkbox"/> Medi-Ride Transport (ADA Cert on File: _____) <input type="checkbox"/> Home Mod/Assist Devices (Ownership: _____)
Units approved:	Service Date(s) Approved:
Price per Unit:	Vendor Selected:



## Sample Legal Services Intake Form

LEGAL SERVICE PROVIDER NAME:										
AREA AGENCY ON AGING		PSA NUMBER	COUNTY SERVED							
UNDUPLICATED CLIENT <input type="checkbox"/> Yes <input type="checkbox"/> No		CLIENT ID NUMBER:	OPEN DATE / /							
UNIT of SERVICE # of Units of Service (1 hour increments): _____ Hours		CLOSE DATE / /								
CLIENT NAME (FIRST, MI, LAST):			CLIENT TELEPHONE:							
CLIENT ADDRESS:										
CITY:		STATE	ZIP CODE							
CLIENT DATE of BIRTH (mo/day/year) / /		CLIENT DECLINED BIRTH DATE INFORMATION <input type="checkbox"/>								
ETHNICITY: HISPANIC/LATINO * <input type="checkbox"/>		GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other								
<table border="0"> <tr> <td rowspan="4"> <b>RACE * (CHECK ONLY ONE):</b>   <input type="checkbox"/> CAUCASIAN  <input type="checkbox"/> AFRICAN AMERICAN  <input type="checkbox"/> NATIVE AMERICAN/ NATIVE ALASKAN </td> <td> <b>ASIAN/PACIFIC ISLANDER:</b>  <input type="checkbox"/> Asian Indian  <input type="checkbox"/> Cambodian  <input type="checkbox"/> Filipino  <input type="checkbox"/> Japanese </td> <td> <input type="checkbox"/> Chinese  <input type="checkbox"/> Korean  <input type="checkbox"/> Laotian  <input type="checkbox"/> Vietnamese  <input type="checkbox"/> Other Asian </td> <td> <input type="checkbox"/> Guamanian  <input type="checkbox"/> Hawaiian  <input type="checkbox"/> Samoan  <input type="checkbox"/> Other Pacific Islander </td> </tr> <tr> <td colspan="3"> <input type="checkbox"/> TWO OR MORE RACES     <input type="checkbox"/> RACE UNKNOWN/ SOME OTHER RACE     <input type="checkbox"/> CLIENT DECLINED TO PROVIDE INFORMATION </td> </tr> </table>				<b>RACE * (CHECK ONLY ONE):</b>  <input type="checkbox"/> CAUCASIAN <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> NATIVE AMERICAN/ NATIVE ALASKAN	<b>ASIAN/PACIFIC ISLANDER:</b> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese	<input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	<input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> TWO OR MORE RACES <input type="checkbox"/> RACE UNKNOWN/ SOME OTHER RACE <input type="checkbox"/> CLIENT DECLINED TO PROVIDE INFORMATION		
<b>RACE * (CHECK ONLY ONE):</b>  <input type="checkbox"/> CAUCASIAN <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> NATIVE AMERICAN/ NATIVE ALASKAN	<b>ASIAN/PACIFIC ISLANDER:</b> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese	<input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	<input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander							
	<input type="checkbox"/> TWO OR MORE RACES <input type="checkbox"/> RACE UNKNOWN/ SOME OTHER RACE <input type="checkbox"/> CLIENT DECLINED TO PROVIDE INFORMATION									
	<b>CLIENT CHARACTERISTICS (Check All That Apply)</b>									
	Frail / Disabled *	<input type="checkbox"/>	Limited English Proficiency (LEP)	<input type="checkbox"/>						
Homebound	<input type="checkbox"/>	Rural	<input type="checkbox"/>							
Lives Alone	<input type="checkbox"/>	Greatest Economic Need * (Minority)	<input type="checkbox"/>							
Institutionalized *	<input type="checkbox"/>	Greatest Economic Need * (Non-Minority)	<input type="checkbox"/>							
Suspected Victim of Elder Abuse / Exploitation *	<input type="checkbox"/>	Greatest Economic Need * (Minority Status Unknown)	<input type="checkbox"/>							
<b>TYPE OF CASES BY LEGAL PROBLEM CODE</b>										
<b>A. Consumer / Finance</b>										
A1. <input type="checkbox"/> Bankruptcy/Debt Relief     A 2. <input type="checkbox"/> Contracts     A3. <input type="checkbox"/> Other Consumer / Finance										
<b>B. Employment</b>										
B1. <input type="checkbox"/> Discrimination     B2. <input type="checkbox"/> Other Employment										
<b>C. Family</b>										
C1. <input type="checkbox"/> Divorce/Custody/Visitation/Grandparents rights     C2. <input type="checkbox"/> Conservatorship     C3. <input type="checkbox"/> Other Family										
<b>D. Health / Community Based Care</b>										
D1. <input type="checkbox"/> Medi-Cal Issues     D2. <input type="checkbox"/> Medicare Issues     D3. <input type="checkbox"/> Other Health / Community Based Care										
<b>E. Housing</b>										
E1. <input type="checkbox"/> Landlord/Tenant     E2. <input type="checkbox"/> Real Property: Home Loans/Foreclosure/Reverse Mortgages E3. <input type="checkbox"/> Other Housing										
<b>F. Income Maintenance</b>										
F1. <input type="checkbox"/> Social Security     F2. <input type="checkbox"/> SSI     3. <input type="checkbox"/> Pension/Retiree Benefits     F4. <input type="checkbox"/> Other Income Maintenance										
<b>G. Individual Rights</b>										
G1. <input type="checkbox"/> Immigration/Naturalization     G2. <input type="checkbox"/> Elder Abuse/Neglect/Exploitation     G3. <input type="checkbox"/> Other Individual Rights										
<b>H. Miscellaneous / Other</b>										
H1. <input type="checkbox"/> Estate Planning/Wills/Trusts     H2. <input type="checkbox"/> Advance Health Care Directives     H3. <input type="checkbox"/> Power of Attorney     H4. <input type="checkbox"/> Other Miscellaneous										

## Senior Nutrition Counseling Client Form

Name : _____ Address: _____ City & Zip: _____	Phone: _____ Birth Date: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		
<b>Additional Information</b>			
<b>Marital Status:</b> <input type="checkbox"/> Declined to State <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single (never married) <input type="checkbox"/> Widowed			
<b>*Race: (Please Check ONE)</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race  Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian  Hawaiian/Other Pacific Islander: <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to State	Ethnicity: <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino  Number of people that live in your house? _____  Are you a female head of house? <input type="checkbox"/> Yes <input type="checkbox"/> No  Do you feel isolated? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Please indicate your annual income level:</b>  <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <u>Married</u>  <input type="checkbox"/> At or Below 100% FPL            (Below \$14,570 )  <input type="checkbox"/> \$14,571 or more.  <input type="checkbox"/> Declined to state         </td> <td style="width: 50%; vertical-align: top;"> <u>Single</u>  <input type="checkbox"/> At or Below 100% FPL            (Below \$10,830 )  <input type="checkbox"/> \$10,831 or more  <input type="checkbox"/> Declined to state         </td> </tr> </table>	<u>Married</u> <input type="checkbox"/> At or Below 100% FPL (Below \$14,570 ) <input type="checkbox"/> \$14,571 or more. <input type="checkbox"/> Declined to state	<u>Single</u> <input type="checkbox"/> At or Below 100% FPL (Below \$10,830 ) <input type="checkbox"/> \$10,831 or more <input type="checkbox"/> Declined to state	Are you able to prepare your own meals? <input type="checkbox"/> Yes <input type="checkbox"/> No  Are you diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No  Do you need Low Sodium meals? <input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Married</u> <input type="checkbox"/> At or Below 100% FPL (Below \$14,570 ) <input type="checkbox"/> \$14,571 or more. <input type="checkbox"/> Declined to state	<u>Single</u> <input type="checkbox"/> At or Below 100% FPL (Below \$10,830 ) <input type="checkbox"/> \$10,831 or more <input type="checkbox"/> Declined to state		
<b>Please check all that apply:</b> <input type="checkbox"/> I have an illness or condition that changes the kind and/or amount of food I eat. <input type="checkbox"/> I eat fewer than two (2) meals per day. <input type="checkbox"/> I eat few fruits or vegetables or milk products <input type="checkbox"/> I have three (3) or more servings of beer, liquor, or wine every day. <input type="checkbox"/> I have dental or mouth problems that make it hard to eat. <input type="checkbox"/> I don't always have enough money to buy the food I need. <input type="checkbox"/> I eat alone most of the time. <input type="checkbox"/> I take three (3) or more prescribed or over the counter drugs a day. <input type="checkbox"/> Without wanting to I have lost/gained ten (10) pounds in the last six (6) months. <input type="checkbox"/> I am not always physically able to shop, cook, and/ or feed myself.			
<b>What do you hope to get out of this nutritional counseling session?</b> <div style="height: 40px; border: 1px solid black; margin-top: 5px;"></div>			



Heavy Housework					
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Ventura County Area Agency on Aging  
**Title III B Registered Client Intake Form FY 2013-2014 – Page 2**

**NUTRITIONAL ASSESSMENT (ANNUAL)**  
**Required for IIIC,D Nutritional Counseling and IIIB Case Management**

<b>Nutritional Assessment:</b>	<b>No</b>	<b>Yes</b>
Has the client made any changes in lifelong eating habits because of health problems?	0	2
Does the client eat fewer than 2 meals per day?	0	3
Does the client eat few fruits or vegetables or milk products?	0	2
Does the client have 3 or more drinks of beer, liquor or wine almost every day?	0	2
Does the client have tooth or mouth problems that make it hard to eat?	0	2
Does the client sometimes <b>not</b> have enough money to buy food?	0	4
Does the client eat alone most of the time?	0	1
Does the client take 3 or more different prescribed or over-the-counter drugs per day (aspirin, herbs, laxatives, etc.)?	0	1
Without wanting to, has the client lost or gained 10 pounds in the past 6 months?	0	2
Is the client not always physically able to shop, cook and/or feed themselves (or to get someone to do it for them)?	0	2
<b>Total Score Today (if equal to or greater than 6, the client is at high nutritional risk):</b>		
<b>Declined to State:</b>		

**FOR PROVIDERS OF TITLE III B CASE MANAGEMENT ONLY:** You are required to offer to each older individual seeking Title III case management services a list of agencies that provide similar services within the jurisdiction of the AAA as specified in subsection (i), (ii), and (iii), of the USC 42 Section 3026 (a)(8)(C). **Date that list was provided to client:**\_\_\_\_\_