AAACAP Intake **FY25**

For AAACAP office use only:
SAMS ID No:

The information on this form is needed to provide services. All information is confidential and will be guarded against unofficial use and shared only to get services started.

☐ * ***Release of Information and Client Rights and Responsibilities*** **explained.**

Note: All items marked with an asterisk (*) are required. Date:

Part I – Recipient's Information

***Full Name:**	***Last Name:**	
***Date of Birth:**	**Primary Language:**	*Gender: ☐ Female ☐ Male ☐ Other ☐ Unknown
***Street Address** (City, ST, Zip Code & County):		**Bldg #** if any: ☐ Unknown
***Area Code and Phone No.:** ☐ Cell ☐ Home	☐ Check if Mailing Address is different from Home Address and list below:	
Email Address:		

***Ethnicity:**	**Marital Status:**	***Race:**
☐ Hispanic or Latino	☐ Married	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ Widowed	☐ Asian
☐ Unknown	☐ Divorced	☐ Black or African American
	☐ Separated	☐ Native Hawaiian or Pacific Islander
	☐ Never Married	☐ Non-Minority (White, Non-Hispanic)
	☐ Not Reported	☐ White – Hispanic

***Person lives alone** ☐ Yes ☐ No ☐ Don't Know	**Total No. of People in Household**:	**Monthly Household Income:**
Use current Department of Health and Human Services Federal Poverty Guidelines for size of household to decide if person is at or below poverty. **2025 limits: $1,956 individual; $2,644 couple**		***At or below poverty:** ☐ Yes ☐ No ☐ Don't Know

Monthly Income from:	**Recipient**	**Spouse or other Household Member:**
☐ SSI, ☐ SSDI ☐ VA ☐ Job		☐ Declined
☐ Other Benefits [e.g. SNAP]		

Enrolled in? ☐ **Medicaid** ☐ **Medicare**	**Receiving?** ☐ Home-Delivered meals	**Has served in the military?** ☐ Yes ☐ No

Any pest infestations? ☐ **Yes** ☐ **No**

Bedbugs reported in the home: ☐

Part II – Diagnosis/Medical Conditions

Support Devices: ☐ Wheelchair ☐ Walker ☐ Cane ☐ Rollator Walker ☐ Other ☐ None

Part III – Reason for Service Requested

Please specify the reason for requesting services:

Part IV – Emergency Contact Information OR Point of Contact (POC)

Contact Name:	**Relationship:**	**Area code and Phone No:**
Primary Care Physician:		**Area code and Phone No:**

Part V – Referral Source

Name of the Person making Referral:	**Area Code and Phone No:**	**Agency Name:**

Additional Notes:

Referred to TX Health and Human Services (HHS)?

☐ Yes ☐ No

On Hospice:

☐ Yes ☐ No

Hospice provides a CNA or Relief Support: ☐ Yes

Has In-Home Services (Attendant or Caregiver) in place?

☐ HHS ☐ Veterans Aid and Attendance

Managed Care Organization (MCO): ☐ United HealthCare ☐ Superior HealthPlan

☐ Home Health Services (Nurse, CNA, PT/OT, Speech Therapy, Wound Care, etc)

☐ Services on a private pay-basis ☐ No in-home support service in place

Signature of Individual Completing Intake Form:	Date: