AAACAP Caregiver Intake FY25

For AAACAP office use only:
CG's SAMS ID No:
Recipient's SAMS ID:

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 – Caregiver's Information (The unpaid person who provides care to the recipient, such as family member, adult child, friend or other)

*Full Name (First and Last Name):		*Date of Birth:	*Relationship to Recipient:
*Gender: ☐ Female ☐ Male ☐ Other ☐ Unknown	*Area Code and Phone No: ☐ Cell	Email Address:	
*Street Address (City, ST, Zip Code & County): ☐ Resides with Recipient		Bldg# If any:	Language:
*Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Pacific Islander ☐ Non-Minority (White, Non-Hispanic) ☐ White Hispanic ☐ Other	*Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	*Marital Status: ☐ Married ☐ Separated ☐ Widow ☐ Never Married ☐ Divorced ☐ Not Reported	

Part II – Care Recipient's Information

*Full Name (First and Last Name):		*Date of Birth:	*Primary Language:
*Gender: ☐ Female ☐ Male ☐ Other ☐ Unknown	*Area Code and Phone No: ☐ Cell	Email Address:	
*Street Address (City, ST, Zip Code & County): ☐ Resides with Caregiver		Bldg # if any: ☐ Unknown	
*Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Pacific Islander ☐ Non-Minority (White, Non-Hispanic) ☐ White Hispanic ☐ Other	*Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	*Marital Status: ☐ Married ☐ Separated ☐ Widow ☐ Never Married ☐ Divorced ☐ Not Reported	
*Person Lives Alone: ☐ Yes ☐ No ☐ Don't Know			
Any pest infestations? ☐ Yes ☐ No Bedbugs reported in the home: ☐			

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:		**Care Recipient:**	**Spouse or Other Household Member**
☐ SSI, ☐ SSDI ☐ VA ☐ Job	# Of Household:		☐ Declined
☐ Other Benefits (e.g. SNAP)			
Monthly Income from:		**Caregiver:**	**Spouse or Other Household Member**
☐ SSI, ☐ SSDI ☐ VA ☐ Job	# Of Household:		☐ Declined

Part III – Care Recipient's Diagnosis/Medical Conditions

Enrolled in? ☐ Medicaid ☐ Medicare	**Receiving?** ☐ Home-Delivered meals	**Have served in the military?** ☐ Yes ☐ No
Support Devices: ☐ Wheelchair ☐ Walker ☐ Cane ☐ Rollator Walker ☐ Other ☐ None		

Part IV – Referral

Name of the Person making Referral: ☐ **Self-referred**	**Phone #:**	**Agency Name:**

Part V – Reason for Service Requested

Please specify the reason for requesting services:

Additional Note:

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

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

Referred to TX Health and Human Services (HHS)? ☐ Yes ☐ No	**Has In-Home Services (Attendant or Caregiver) in place?** ☐ HHS ☐ Veterans Aid and Attendance
On Hospice: ☐ Yes ☐ No Hospice provides a CNA or Relief support: ☐ Yes	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 services in place

Signature of Individual Completing Intake Form:	Date: