INSERT LOGO HERE

Older Relative Caregiver Services Intake Form

Tell us about yourself.

Today's Date: / /	**Preferred Phone: (** **)**
First Name:	**Last Name:** **MI:**
Date of Birth: / /	**Email:**
Address:	**City:** **State:** **Zip:**

The following data is asked by our funders and will not be disclosed by name.

Gender: ☐ Female ☐ Male ☐ Other | **Primary Language:** ☐ English ☐ Other:

Check the racial categories that apply to you: ☐ White ☐ Asian ☐ African American/Black ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐ Other:

Are you Hispanic or Latino? ☐ Yes ☐ No | **Are you a veteran?** ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

If Yes, is your annual household income more than $13,590? ☐ Yes ☐ No

If No, is your annual household income more than:

If 2 people, is your annual household income more than $18,310? ☐ Yes ☐ No

If 3 people, is your annual household income more than $23,030? ☐ Yes ☐ No

If 4 people, is your annual household income more than $27,750? ☐ Yes ☐ No

If 5 people, is your annual household income more than $32,470? ☐ Yes ☐ No

If 6 or more people, is your annual household income more than $37,190? ☐ Yes ☐ No

My relationship to the person to whom I provide informal care is:

Caring for Children

☐ Grandparent Age 55+ ☐ Other Relative Age 55+ ☐ Other Non-Relative Age 55+

Total Number of children age 18 and younger that I care for: ____________

OR

Caring for an Adult with a Disability

☐ Parent Age 55+ ☐ Grandparent Age 55+ ☐ Other Relative Age 55+ ☐ Other Non-Relative Age 55+

Total Number of persons who are disabled *and* between 19-59 years old that I care for: ______________

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Information about the person being cared for:		
First Name:	**Last Name:**	**MI**
Address:	**City:** **State:**	**Zip:**

Date of Birth: / /

Gender: ☐ Female ☐ Male ☐ Other

Are you interested in learning about any other services?

☐ Meals ☐ Transportation ☐ Nutrition Counseling ☐ Legal Assistance ☐ Caregiver Support

☐ Options to stay at home ☐ Options to return home ☐ Health and Wellness Classes

This section to be completed by the provider.

Consumer:

Provider:

☐ New Intake Form ☐ Updated Intake Form

Check the box next to the service provided:

- ☐ ORC Information & Assistance
- ☐ ORC Case Management
- ☐ ORC Counseling
- ☐ ORC Congregate Nutrition
- ☐ ORC Emergency Response System
- ☐ ORC Home Delivered Nutrition
- ☐ ORC Options Counseling

- ☐ ORC Respite *(indicate type below):*
  - ☐ In-home
  - ☐ Out-of-home (day)
  - ☐ Out-of-home (night)
  - ☐ Other
- ☐ ORC Support Groups

- ☐ ORC *Supplemental Services:*
  - ☐ Assistive Technology
  - ☐ Consumable Supplies
  - ☐ Home Modification/ Repair
  - ☐ Other