COUNTY of VENTURA
Human Services Agency
Area Agency on Aging

Registered Client Intake Form
TITLE III E FAMILY CARE/CALZ RECEIVER-CAREGIVER – FY 2023-24
CONFIDENTIAL

CONTRACTOR:		DATE:	

CARE RECEIVER'S INFORMATION

Last Name:		First Name: *(No nicknames)*	
Phone:		Birth Date: *(Required)*	
Street Address:		City:	ZIP:
County:		Rural: (91307, 93066, 93040)	☐ Yes ☐ No ☐ Decline to State ☐ Missing

RACE – Please Choose (X) One:

☐ American Indian or Alaska Native	☐ Filipino	☐ Laotian	☐ Samoan
☐ Asian Indian	☐ Guamanian	☐ Multiple Race	☐ Vietnamese
☐ Black or African American	☐ Hawaiian	☐ Asian Indian	☐ White
☐ Cambodian	☐ Japanese	☐ Other Asian	☐ Decline to State
☐ Chinese	☐ Korean	☐ Other Pacific Islander	☐ Missing
		☐ Other Race	

Ethnicity:
☐ Not Hispanic/ Latino
☐ Hispanic/ Latino
☐ Decline to State
☐ Missing

MARITAL STATUS: ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single (Never Married) ☐ Widowed ☐ Decline to State ☐ Missing

VETERAN STATUS:

☐ **I consent to this agency and the California Department of Aging transmitting my name, email address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for 12 months.**

☐ Have you ever served in the United States military?
☐ Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?
☐ No
☐ Decline to State
☐ Missing

Preferred Language:

Client Lives:	☐ Alone ☐ Not Alone ☐ Decline to State ☐ Missing	Number of Persons Living in Household:	

INDICATE CARE RECEIVER'S INCOME LEVEL (approximate):

2-Person Household:	1-Person Household:
☐ At or below Federal Poverty Level *($19,720/year or less)*	☐ At or below Federal Poverty Level *($14,580/year or less)*
☐ Above Federal Poverty Level *($19,721/year or more)*	☐ Above Federal Poverty Level *($14,581/year or more)*
☐ Decline to State	☐ Decline to State

The Gay Bisexual and Transgender Disparities Reduction Act of 2016 (AB 959)

The State of CA requires that we ask you some demographic questions followed by three questions under the new CA State AB 959 Law, the Gay, Bisexual and Transgender Disparities Reduction Act of 2016. VCAAA values your privacy and you have the option to decline to state.

What was the Care Receiver's sex at birth?	☐ Female ☐ Male ☐ Decline to State ☐ Missing
What is the Care Receiver's Gender?	☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Decline to State ☐ Missing ☐ Not listed, please specify: _____
How do you describe Care Receiver's sexual orientation or sexual identity?	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Decline to State ☐ Missing ☐ Not listed, please specify: _____

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CALIFORNIA ACTIVITIES & INSTRUMENTAL ACTIVITIES (IADLS) OF DAILY LIVING (ADLS)
Please Check (✓) One of the Columns for Each Activity

	TYPE OF ASSISTANCE CARE RECEIVER NEEDS TO PERFORM TASK ➔	1 INDEPENDENT Needs No Help	2 VERBAL QUE Needs verbal reminders	3 STAND BY Needs some human help	4 HANDS ON Needs lots of human help	5 DEPENDENT Cannot perform task	Decline to State
ADLS	Eating	☐	☐	☐	☐	☐	☐
	Dressing	☐	☐	☐	☐	☐	☐
	Transferring	☐	☐	☐	☐	☐	☐
	Bathing	☐	☐	☐	☐	☐	☐
	Toileting	☐	☐	☐	☐	☐	☐
	Walking	☐	☐	☐	☐	☐	☐
IADLS	Light Housework	☐	☐	☐	☐	☐	☐
	Shopping/Errands	☐	☐	☐	☐	☐	☐
	Meal Prep/Cleanup	☐	☐	☐	☐	☐	☐
	Transportation	☐	☐	☐	☐	☐	☐
	Using Telephone	☐	☐	☐	☐	☐	☐
	Managing Medications	☐	☐	☐	☐	☐	☐
	Managing Money	☐	☐	☐	☐	☐	☐
	Heavy Housework	☐	☐	☐	☐	☐	☐
Care Receiver's Cognitive Impairment:		☐ None or Unknown	☐ Mild	☐ Moderate	☐ Severe		

CARE RECEIVER'S LIVING ARRANGEMENT: ☐ **With you** (caregiver) ☐ **Alone** in his/her home/apartment
☐ With spouse or partner ☐ In a board and care home, group home, assisted living facility or RCFE
☐ Nursing home ☐ Retirement community ☐ In home of other family member/friend ☐ Other ☐ Unknown

CAREGIVER'S INFORMATION

Last Name:		**First Name:** *(No nicknames)*			
Phone:		**Email:**		**Birth Date:** *(Required)*	
Street Address:		**City:**		**ZIP:**	
County:		**Rural:** (91307, 93066, 93040)	☐ Yes ☐ No ☐ Decline to State ☐ Missing		

RACE – Please Choose (X) One:

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☐ Asian Indian
☐ Black or African American
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Guamanian
☐ Hawaiian
☐ Japanese
☐ Korean
☐ Laotian
☐ Multiple Race
☐ Asian Indian
☐ Other Asian
☐ Other Pacific Islander
☐ Other Race
☐ Samoan
☐ Vietnamese
☐ White
☐ Missing
☐ Decline to State

Ethnicity:
☐ Not Hispanic/ Latino
☐ Hispanic/ Latino
☐ Decline to State
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MARITAL STATUS: ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single (Never Married) ☐ Widowed ☐ Decline to State ☐ Missing

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☐ Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?
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Client Lives:	☐ Alone ☐ Not Alone ☐ Decline to State ☐ Missing	**Number of Persons Living in Household:**	

Applicant's Income Level (approximate):

IF MARRIED: ☐ At or below Federal Poverty Level *($19,720/year or less)* ☐ Above Federal Poverty Level *($19,721/year or more)* ☐ Decline to State	**IF SINGLE:** ☐ At or below Federal Poverty Level *($14,580/year or less)* ☐ Above Federal Poverty Level *($14,581/year or more)* ☐ Decline to State

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What was your sex at birth?	☐ Female ☐ Male ☐ Decline to State ☐ Missing
What is your Gender?	☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Decline to State ☐ Missing ☐ Not listed, please specify:
How do you describe your sexual orientation or sexual identity?	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Decline to State ☐ Missing ☐ Not listed, please specify:

Relationship with Care Receiver:

☐ Daughter ☐ Son ☐ Spouse ☐ Domestic Partner ☐ Parent ☐ Grandparent
☐ Daughter-in-law ☐ Son-in- law ☐ Other Relative ☐ Non-Relative ☐ Decline to State ☐ Missing

Caregiver's Employment:	☐ FULL-TIME – 35+ hours per week ☐ PART-TIME – less than 35 hours per week ☐ On leave of absence ☐ Not employed (unemployed) ☐ Retired

Narrative/Case Notes *(Optional)*:

Reviewed By:		**Number of Hours:**	

Client Q Database/Unique Participant ID Number:

Calz Connect Eligibility

CAlz Connect is a new program being offered in Ventura County, designed to improve the quality of life for individuals living with dementia and decrease the burden that caregivers may face.

Care recipient has a diagnosis of Alzheimer's or related dementia?	☐ Yes ☐ No ☐ Decline to State

Care recipient 45+?	☐ Yes ☐ No	**Caregiver is 18+?**	☐ Yes ☐ No
Who is living in Ventura County? (at least 1 needs to live in County)	☐ Caregiver ☐ Care Recipient		

Preferred mailing address:	
Preferred email address:	
Involved in similar dementia program?	☐ Yes ☐ No If yes, please state:
Speaks English or Spanish: ☐ Yes ☐ No	Living at home: ☐ Yes ☐ No