ADRC Options Counseling Intake Form

Consumer Information

Date: ____/_____/________ Counselor: ____
Mo. Day Year

Method of contact: ☐ Phone ☐ E-mail ☐ In-person at your agency ☐ In-person at client's home
☐ In-person at another setting ☐ Other (specify) ___________________

Consumer Name (please print): ____

Birth date:_____/______/________ Age______ ☐ unknown
Mo. Day Year

E-mail address: ____

Address:____Apt. #:_________

City:____________________________________ Zip Code: ______________________

County_________________________Township:_____________________________

SSN (optional): ________-_______-_________

Phone1:___________________________ Phone :___________________________

TTY: ___________________________

Best time/number to reach consumer:____

Race/Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ American Indian ☐ Asian ☐ Unknown
☐ Other Specify_____________

Gender: ☐ Male ☐ Female ☐ Other

Limited English Speaking: ☐ Yes ☐ No Language ______________________________

If Caller is not the Consumer, please include Caller's information below

Caller's Information

Caller's Name (please print):____

Caller's relationship with consumer: ☐ Self ☐ Spouse ☐ Child ☐ Family other _____________
☐ Friend ☐ Professional ☐ Other_______________________________

Is caller a caregiver for the consumer (paid or unpaid) ☐yes ☐ no

Caller's age______

Address____Apt. #_________

City____________________________________ Zip Code ______________________

County_________________________Township______________________________

Phone1___________________________ Phone ___________________________

Best time/number to reach caller____

Version 11-15

If the caller is not the consumer, please be sure the answers to these questions refer to the consumer

Living and Caregiving Information

Living Arrangement: ☐ Alone ☐ Spouse ☐ Children ☐ Relatives ☐ Non-relatives

# of people in household __________ # of individuals dependent on consumer _______

Type of housing: ☐Living in own home ☐Living in someone else's home

☐Living in apartment ☐Other______________________

Does consumer provide more than 50% of support (care/financial) for a dependent? ☐Yes ☐No

Does anyone with whom the consumer lives with provide unpaid care for the consumer? ☐Yes ☐No

Does anyone who does not live with the consumer provide unpaid care for consumer? ☐Yes ☐No

Does the consumer have a paid caregiver? ☐Yes ☐No

Does this caregiver live with consumer? ☐Yes ☐No

Is the consumer thinking of moving to a nursing home within the next six months? ☐Yes ☐No

Disability and Health Information

Disability Type (check all that apply): ☐ Physical ☐ Mental illness ☐ Sensory

☐ Traumatic brain injury ☐ Developmental disabilities, intellectual disabilities

☐ Dementia ☐ Other Specify____

☐ No Disability ☐ Unknown (consumers/callers with no information about consumer's disability)

Current Health Condition(s) ____

____

Current Health Coverage ____

How did you learn about this agency and/or Options Counseling? ___________________________

____

Reason you called ____

____

Options Counseling Accepted: ☐Yes ☐No If No, Reason declined: ________________________

____

Financial Information

Monthly income and amount(s):

Social Security $_________________

Pension $________________

Other $______________

Total Income $________________

Estimated assets (savings, checking, CDs, IRA, stocks, bonds, mutual funds, etc.):

$ _________________

$ _________________

$ _________________

$ _________________

$ _________________

Do you have enough money to pay your bills each month? ☐ Yes ☐ No

Do you need help with budgeting/finances? ☐ Yes ☐ No

Who is currently helping consumer with budgeting? ____________________________________

Benefits

Check off all the benefits consumer is currently enrolled in:

☐ Low-Income Subsidy ☐ Medicaid ☐ SNAP ☐ Medicare Savings Programs ☐ CCP
☐ LIHEAP ☐ Other (specify) ____

Referrals

Consumer assisted with or given an application for:

☐ Medicaid ☐ Older Americans Act programs ☐ Medicare ☐SNAP ☐TANF ☐Social Security
☐ LIHEAP ☐ Other federal, state or county funded programs (please list) _____________________
____

☐ Consumer was referred to some other type of service (non-public services, resources or programs)
(Specify)____
☐ Consumer was not referred to any type of service
☐ Unknown

Issues to Address

Review each area to determine the consumer's needs

Category	Concerns/Current Situation
Medical	
Medication Management	
Mental Health	
Substance Abuse	
Financial	
Legal	
Transportation	
Housing	
Food	
Social Functioning	
Support Network	
In-home help	
Environmental	
Employment	
Mobility	
Spirituality/ Religion	
Other	

The following services were not appropriate for the client: ______________________________

____

Date: __________

Possible Options / Additional Notes:

Estimate time spent with consumer during session:_________________

Follow-up date:________________________