MARC CLIENT INTAKE FORM - GRANDPARENT AS PARENTS

Client Information

Last Name:______________________________ First Name:______________________________ MI:_______

Gender: M F DOB:_____/_____/_____ SSN:______________________ DCN:______________________

Address:______________________________ City:______________________ Zip:______________

Phone Number:______________________________ Living Alone: ___Y ___ N

County: ___Cass ___Clay ___Jackson ___ Platte ___Ray ___Other:

Marital Status: ___Single ___Married ___Divorced ___ Partnered ___Separated ___Widowed (date of spouse's death):

Primary Language: ____ English ___ Spanish ___ Other:

Legal Status: ___ Responsible for Self ___Power of Attorney ___ Guardian

Name:______________________________ Phone Number:______________________

Eligibility: ___ Age Number of Children under the age of 18:________

Veteran: ___Yes ___ No Branch: Discharge Date:

Spouse/Widow of Veteran? ___Yes ___No

Ethinicity: ___Hispanic/Latino ___Not Hispanic/Latino

Race (mark more than one if necessary): ___African-American ___American Indian/Native Alaskan ___Asian ___Native Hawaiian/Pacific Islander ___White ___Other:

Citizenship Status

___ US Citizen
___ Permanent Res.

Income: ___Subsidized/Low-Income Housing ___ Medicaid ___SSI ___ Food Stamps ___Low Income ___Other:

Primary Emergency Contact:

Name:______________________________ Aware they are emergency contact? Y N

Home Number:______________ Work Phone:______________________ Relationship:______________________

Cell Number:______________________ Email:______________________________

Address:______________________________ City:______________________ Zip:______________

Second Emergency Contact:

Name:______________________________ Aware they are emergency contact? Y N

Home Number:______________ Work Phone:______________________ Relationship:______________________

Cell Number:______________________ Email:______________________________

Address:______________________________ City:______________________ Zip:______________

Service Information

MARC Service Area:__________ Service(s):____

Service Provider:____

Referral Information

____ Abuse/Neglect ____ Adult Day Care ____ Advocacy ____ Animal Services ____ Case Mgmt

____ Caregiver Services ____ Property Tax Credit ____ Disabilities ____ Funeral ____ Health Centers

____ Hearing ____ Home Health ____ Homemaker ____ Home Repairs ____ Home Del. Meals

____ Housing Options ____ Legal Services ____ Mental Hlth Srvs. ____ Ombudsman ____ Personal Care

____ Senior Center ____ Transportation ____ Veterans ____ Vision

____ Other:

Nutritional Status

	Yes	Comment
I have an illness or condition that made me change the kind/amount of food I eat.	2	
I eat fewer than 2 meals per day.	3	
I eat few fruits, vegetables, or milk products.	2	
I have 3 or more drinks of beer, liquor, or wine almost everyday.	2	
I have tooth or mouth problems that make it hard for me to eat.	2	
I don't always have enough money to buy the food I need.	4	
I eat alone most of the time.	1	
I take 3 or more different prescribed or over-the-counter drugs a day.	1	
Without wanting to, I have gained or lost 10 pounds in the past 6 months	2	Change:
I am not always physically able to shop, cook or feed myself.	2	Which:
Total score for each Yes response (0-2: low risk; 3-5 moderate risk: 6 or more high risk)		Risk level:

Client Signature Date

Intake Worker Signature Date

Referral Source: Telephone Number:

Notes:

Grandparent Name:____

GRANDPARENT AS PARENT - Grandchildren at residence		
Grandchild's Name	Grandchild's Date of Birth	Relationship

GRANDPARENT AS PARENT - Individuals 18-59 at residence, with a disability		
Individual's Name	Individual's Date of Birth	Relationship

Notes: