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Iowa Department on AGING

AGING & DISABILITY NETWORK Fiscal Year 2021
CONSUMER INTAKE FORM *No Nutrition Screening*

This section to be completed by provider.

Today's Date: _____ **New Intake Form:** ☒

Staff Initials _____ **Updated Intake Form:** ☐

Provider / Site: Benton County Volunteer Program

Check the box next to the service provided:

☐ Adult Day Care ☒ Assisted Transportation ☐ Chore ☐ Transportation

The service you are receiving is paid for entirely or partially by funds from the federal Older American's Act and the State of Iowa. Your responses on this form are confidential. The Department on Aging uses this information to comply with reporting requirements and research the needs of older Iowans. Thank you.

First Name: _____ **Address:** _____

MI: _____ **City:** _____

Last Name: _____ **State:** ____ **Zip:** _____

Date of Birth: ____/____/____ or **Age:** _____ **Home Phone:** (_____) _____

Cell Phone: (_____) _____

Email: _____

Demographic Information

Do you live alone? ☐ Yes ☐ No Number in Household (including yourself)

Please Check Your Annual Total Household Income Range:

☐ $0 - $12,760	☐ $12,761 - $17,240	☐ $17,241 - $21,720
☐ $21,721 - 26,200	☐ $26,201 - $30,680	☐ $30,681 - $35,160
☐ $35,161 - $39,640	☐ $39,641 - $44,120	☐ $44,121 - or Above

Veteran Status: ☐ Not A Veteran ☐ Veteran ☐ Veteran Spouse/Dependent

Gender: ☐ Female ☐ Male ☐ Transgender

Race: ☐ White ☐ American Indian/Alaskan Native ☐ Asian
☐ African American/Black ☐ Native Hawaiian/Other Pacific Islander
☐ Other: _____

Ethnicity: Are You Hispanic or Latino? Yes ☐ No ☐

Primary Language ☐ English ☐ Other:_____

AGING & DISABILITY NETWORK CONSUMER INTAKE FORM

Consumer: _____

Does Medicaid pay for some of the services you receive in your home, such as homemaker, transportation, organizing your medications, bathing assistance, or meals?

☐ Yes ☐ No ☐ Don't Know

In the past 30 days, how often were these statements true:

	Often	Sometimes	Never
I have worried whether my food would run out before I got money to buy more.	☐	☐	☐
The food that I bought just didn't last and I didn't have money to get more.	☐	☐	☐

Disability (applies only when consumer is 18-59)

Disabled? ☐ Yes ☐ No

Consumer ADL's/IADL's

During the past 7 days, how would you rate your ability to complete these routine activities?

	I didn't need help	I needed help sometimes	I always needed help	Activity did not occur
1. Shop?	☐	☐	☐	☐
2. Manage your medications?	☐	☐	☐	☐
3. Prepare meals?	☐	☐	☐	☐
4. Use transportation?	☐	☐	☐	☐
IADL – Data Entry:	Independent	Sometimes dependent or limited assistance	Totally dependent	

How would you rate your ability to complete these activities?

	I don't need help	I need help sometimes	I always need help	Activity does not occur
5. Manage Money?	☐	☐	☐	☐
6. Do heavy housework?	☐	☐	☐	☐
7. Do light housework?	☐	☐	☐	☐
8. Use the telephone?	☐	☐	☐	☐
IADL – Data Entry:	Independent	Sometimes dependent or limited assistance	Totally dependent	

During the past 7 days, how would you rate your ability to complete these physical activities?

	I didn't need help	I needed help sometimes	I always needed help	Activity did not occur
1. Walk?	☐	☐	☐	☐
2. Bathe?	☐	☐	☐	☐
3. Dress?	☐	☐	☐	☐
4. Get Out Of Bed Or Chair?	☐	☐	☐	☐
5. Use the toilet?	☐	☐	☐	☐
6. Eat?	☐	☐	☐	☐
ADL – Data Entry:	Independent	Sometimes dependent or limited assistance	Totally dependent	

BENTON COUNTY VOLUNTEER PROGRAM
MEDICAL TRANSPORTATION

LETTER OF AGREEMENT & EMERGENCY CONTACT SHEET

BCVP has been asked to place a volunteer for medical transportation for:

CLIENT CONTACT INFORMATION:

NAME			
ADDRESS			
CITY	**STATE**	**ZIP**	
HOME PHONE	**CELLULAR PHONE**		
DATE OF BIRTH	**EMAIL ADDRESS**		
Once BCVP has arranged my trip, I prefer to receive a confirmation from BCVP via: (Check Option Below) ☐ **Phone Call** on HOME or CELLULAR phone ☐ **Text Message** to Cellular Phone or ☐ **Email**			

EMERGENCY CONTACT INFORMATION:

NAME			
HOME PHONE	**CELLULAR PHONE**		
RELATIONSHIP TO CLIENT			

Upon signing, the client or authorized person making transportation requests, has read, understands and agrees to the following:

- ☐ I understand that the volunteers and the Benton County Volunteer Program (BCVP) are covered by auto liability insurance; however, if an incident occurs, the client and/or person making the transportation request will not hold the volunteer or the BCVP liable beyond the limits of said insurance.
- ☐ I understand that I can potentially be exposed to virus and other air-borne pathogens that can cause me to become ill and will not hold BCVP, staff or volunteers accountable to this risk.
- ☐ I agree to follow BCVP's **Health and Safety Guidelines** as stated on the back of this agreement.
- ☐ I attest that I am in stable mental and physical condition for transport.
- ☐ I affirm that the information I have provided is accurate.

SIGNED: _____ _____
(Client or Legal Guardian) (Date)

SIGNED: _____ _____
(BCVP Staff Receiving Information) (Date)

UPDATED: July 2020