TEXAS
Health and Human Services

Form 2276
October 2021-E

Intake

Area Agency on Aging of Nacogdoches County Aging Committee, Inc. NEW Congregate/Fitness

The information on this form is needed to provide services. All information is confidential and will be guarded against unofficial use and shared only to get services started or changed.

☑ ***Release of Information and Client Rights and Responsibilities* explained.**

Note: All items marked with an asterisk (*) are required.

Part I – Recipient Identification

*Date:	SPURS ID No.: N/A		Primary Language:	
*Last Name:	*First Name:	*MI:	*Date of Birth:	*Gender:
*Street Address and Apt. No.:	*City:	*State:	*ZIP Code:	*County:
*Area Code and Phone No.: Home	Email Address:			

☐ Check if Mailing Address is different from Home Address and enter Mailing Address below:

*Street Address and Apt. No. or P.O. Box:	*City:	*State:	*ZIP Code:	*County:

***Ethnicity** (Check One):*	***Race** (Check all that apply):*	***Marital Status** (Check One):*
○ Hispanic or Latino	☐ American Indian or Alaska Native	○ Married
○ Not Hispanic or Latino	☐ Asian	○ Widowed
○ Unknown	☐ Black or African American	○ Divorced
	☐ Native Hawaiian or Pacific Islander	○ Separated
	☐ Non-Minority (White, Non-Hispanic)	○ Never Married
	☐ White – Hispanic	○ Not Reported

*Person lives alone? ○ Yes ○ No ○ Don't Know	Total No. of People in Household:	Monthly Household Income: N/A
Use current Department of Health and Human Services Federal Poverty Guidelines for size of household to decide if person is at or below poverty.		*At or below poverty? ○ Yes ○ No ○ Don't Know

Monthly Income from:	**Participant**	**Spouse**
Job	N/A	N/A
Social Security	N/A	N/A
Supplemental Security Income	N/A	N/A
Veterans Affairs	N/A	N/A
Other Sources	N/A	N/A
Other Benefits [e.g., Supplemental Nutritional Assistance Program (SNAP)]	N/A	N/A

Part II – Service(s) Requested *(Completed by AAA or provider staff)*

List of Requested Services:
Circle all that you would like to participate in:

Congregate Lunch

Fitness

Are you enrolled in? ☐ Medicaid ☐ Medicare

Part III – Emergency Contact Information *(Completed by AAA or provider staff)*

Contact Name:	Relationship:	Area Code and Phone No.:
Primary Care Physician:		Area Code and Phone No.:

Part IV – Referral *(Completed by AAA or provider staff)*

Referred by: Community RX

Latasha Lathan

*Name of AAA or Provider Staff Completing Intake

*Date

Part V – Nutrition Services *(Completed by AAA or provider staff)*

*Additional Eligibility Requirements if eligible person is under 60. Check which of the following applies:

☐ Eligible person is under 60 and the spouse of person 60 or older who takes part in the nutrition program.

☐ Eligible person is under 60, serves as volunteer at the nutrition site and the provider offers a meal according to AAA procedures.

☐ Eligible person is under 60, has a disability and lives in a housing facility occupied primarily by people 60 and over where congregate meals are served.

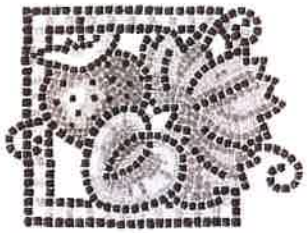
☐ Eligible person is under 60, has a disability, lives with a person eligible for a meal and the provider offers a meal according to AAA procedures.

Provider/Center: Nacogdoches County Aging Committee, Inc.

Consumer Name: _____

Consumer ID: _____

Date: _____



The Warning Signs of poor nutritional health are often overlooked. Use this checklist to find out if you are at nutritional risk.

DETERMINE YOUR NUTRITIONAL HEALTH

Read the statements below. Circle the number in the "Yes" column for those that apply to you. Add the circled numbers to get your total nutritional risk score.

	YES
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than two meals a day.	3
I eat few fruits or vegetables, or milk products.	2
I have three or more drinks of beer, liquor or wine almost every day.	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 three or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained ten pounds in the last six month.	2
I am not always physically able to shop, cook and/or feed myself.	2
TOTAL	

Nutritional Health Score

0 – 2	Good
3 – 5	Moderate Nutritional Risk
6 or More	High Nutritional Risk

Refer to the Determine Your Nutritional Health Handout to learn more about the warning signs of poor nutritional health.

The Nutrition Screening Initiative · 1010 Wisconsin Avenue, NW · Suite 800 · Washington, DC 2007
The Nutrition Screening Initiative is funded in part by a grant from Ross Products Division of Abbott Laboratories, Inc.

DETERMINE YOUR NUTRITIONAL HEALTH HANDOUT

Date: _____

Score: _____

If your Nutritional Health Score is:

0 – 2	**Good!** Recheck your Nutritional Health Score in six months.
3 – 5	**You are at moderate nutritional risk**. See what can be done to improve your eating habits and lifestyle. Your senior nutrition program, area agency on aging, senior citizens center, county extension agent or health department may be able to help. Recheck your Nutritional Health Score in three months.
6 or more	**You are at high nutritional risk**. The next time you see your doctor, dietitian or social service professional, talk with them about any problems you may have. Ask for help to improve your nutritional health.

The Determine Your Nutritional Health Checklist is based upon the warning signs described below. Use the first letters of the word **DETERMINE** to remind you of the warning signs.

Disease

Any disease, illness or chronic condition that causes you to change the way you eat, or makes it hard for you to eat, puts your nutritional health at risk.

Eating Poorly

Eating too little and eating too much both lead to poor health. Eating the same foods day after day or not eating fruit, vegetables, and milk products daily will also cause poor nutritional health.

Tooth Loss/Mouth Pain

A healthy mouth, teeth and gums are needed to eat. Missing, loose or rotten teeth or dentures that don't fit well, or cause mouth sores, make it hard to eat.

Economic Hardship

Having less, or choosing to spend less, than $25 - $30 per week for food makes it very hard to get the foods you need to stay healthy.

Reduced Social Contact

Being with people daily has a positive effect on morale, well-being and eating.

Multiple Medicines

The more medicines you take, the greater the chance for side effects such as increased or decreased appetite, change in taste, constipation, weakness, drowsiness, diarrhea, nausea, and other side effects. Vitamins or minerals when taken in large doses act like drugs and can cause harm. Alert your doctor to everything you take.

Involuntary Weight Loss/Gain

Losing or gaining a lot of weight when you are not trying to do so is an important warning sign that must not be ignored. Being overweight or underweight also increases your chance of poor health.

Needs Assistance in Self Care

Although most older adults are able to eat, one of every five has trouble walking, shopping, and buying and cooking food as they get older.

Elder Years Above Age 80

Most older adults lead full and productive lives. But as age increases, risk of frailty and health problems increase.

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Edition Date: 10/1/17

Area Agency on Aging

Area Agency on Aging of Deep East Texas
Client Rights & Responsibilities for Older Americans Act Programs

The Area Agency on Aging of Deep East Texas welcomes you as a participant in programs for older individuals and family caregivers in our region. This program is mandated by the Older Americans Act of 1965, as amended, and provides access and assistance and other supportive services. The programs and services are administered by the Area Agency on Aging with funding provided through the Texas Department of Aging and Disability Services, client contributions and local funding.

Programs and services are designed for individuals age 60 or older and/or their family members and other caregivers. Our goal is to assist older individuals in leading independent, meaningful and dignified lives in their own homes and communities as long as possible through the provision of limited support services. Information will not be released to anyone, or any agency without your informed consent, with the exception of records subpoenaed by a court of law.

Client rights and responsibilities:

1. You have the right to be treated with respect and consideration. You have the right to have your property treated with respect.
2. You may not be denied services on the basis of race, religion, color, national origin, sex, disability, marital status, or inability and /or unwillingness to contribute.
3. You have the right to make a complaint/grievance or recommend changes to policy or service, without restraint, interference, coercion, discrimination or reprisal. To make a complaint or grievance contact the Area Agency on Aging. Contact information is identified below:

Nacogdoches County Aging Committee, Inc.	Area Agency on Aging (AAA) Information
Nacogdoches Senior Center	Holly Anderson
1601 W. Austin Street	Director- AAA on Deep East Texas
Nacogdoches, Texas 75964	1405 Kurth Drive
Phone: 936-569-2072 Fax: 936-560-1797	Lufkin, Texas, 75904
Home Delivered Meals - Latasha Lathan	Phone: 409-381-5258
nacseniorcenter.com	handerson@detcog.org

4. You have the right to participate in the development of a care plan to address unmet needs. N/A
5. You have the right to be informed in writing of available services and the applicable charges if the services are not covered or are unavailable by Medicare, Medicaid, health insurance, or Older Americans Act funding.

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Area Agency on Aging

Area Agency on Aging of Deep East Texas

Client Rights & Responsibilities for Older Americans Act Programs

6. You have the right to make an independent choice of service providers from the list furnished by Area Agency on Aging where multiple service providers are available and change service providers when desired.
7. You have the right to be informed of any change in service(s).
8. You have the right to make a voluntary, confidential, contribution for services received through the Area Agency on Aging. Services will not be denied if an eligible participant is unable or chooses not to make a contribution. All contributions will be kept confidential and will be utilized to expand or enhance the service(s) for which they were provided.
9. You have the responsibility to inform the Area Agency on Aging or its service provider(s) of your intent to withdraw from the program or any known periods of absenteeism when services will not be utilized.
10. You have the responsibility to provide the Area Agency on Aging or its services provider(s) with complete and accurate information.

I hold this Area Agency on Aging program, its parent organization, funders, and the sponsoring state agencies harmless for any liability arising out of the services provided in accordance with program guidelines.

_____ _____

Client Signature Date

Were you ever a member of the United States Military (Circle one) Yes or No

If yes, which branch of the military were you in:_____

Your Official Title (Ranking):_____

Number of years of service:_____

What is your highest level of education completed?_____

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TEXAS
Health and Human Services

Form 2277
March 2014-E

Client Information Release

Area Agency on Aging of Nacogdoches County Aging Committee, Inc.

Individual's Name	Individual's ID

By signing this authorization, you are giving the Area Agency on Aging (AAA) permission to release all or part of your information provided, which includes health information. Failure to provide this authorization will result in limited service by the AAA. This release includes access to a continuum of service(s) available through the AAA or its providers.

Parts A, B and C are to be completed by the individual or personal representative.

I authorize the AAA to release my information to the following person or agency for the purpose(s) stated in Part A. My information will remain available to the person or agency indicated in accordance with the expiration event or date in Part B.

Parts A – Release of Information

I understand that my information may contain protected health information. Release my information to the following person or agency:

☑ Any person or agency necessary to meet my service needs.

☐ Only the persons or entities identified: _____

Check one of the following: ☐ Release all of my information. ☑ Release only the following information:

What is the condition of client? When will client be discharged, if available?

Parts B – Purpose of Release

☑ General: To assist in assessing, arranging and meeting individual service needs.

☐ Specific: _____

☐ Expiration:

This authorization expires at the point of reassessment, where applicable, or within three years of effective date. _____

Parts C – Signature

_____ Signature – Individual or Personal Representative

_____ Date

☐ Check if you are signing for the individual and describe your authority to act for the individual on the following line:

_____

Note: If the person requesting the release of information cannot sign his/her name, two witnesses to his/her mark (X) must sign below. Accept one witness signature in circumstances where it is not possible to obtain two witness signatures. Document the reason in the individual's file.

_____ Signature – Witness

_____ Date

_____ Signature – Witness

_____ Date

Notice to Individual:

- Once the authorization to release your information is granted, the AAA is not responsible for any redisclosure of the information by the recipient.
- You can withdraw permission you have given the AAA to use or disclose health information that identifies you, unless the AAA has already taken action based on your permission. You must withdraw your permission in writing.