

TITLE III INTAKE AND CLIENT REGISTRATION FORM

Date Registered:				Date Updated:			
Name:		Last		First		MI	
Address:				Bldg #:		Apt/Lot #:	
City:				State:			
County:				Zip:			
Township:				Rural		YES NO	
Phone:				Gender: (Circle One)		Male Female	
Date of Birth:				US Citizen? (Circle One)		YES NO	
Number of Persons in Household:				Low Income? (Circle One)		YES NO	
Medicaid Eligibility? (Circle One)		REFUSED		YES NO		REJECTED	
Ethnicity: (Circle One)		N- Not Hispanic or Latino		H- Hispanic or Latino			
Primary Race: (Circle One)		B- Black/African American		N- Native Hawaiian or Pacific Islander			
		I- American Indian or Alaskan Native		A- Asian			
		W- White(Hispanic or Non Hispanic)					
Other Races: (Circle One)		B- Black/African American		N- Native Hawaiian or Pacific Islander			
		I- American Indian or Alaskan Native		A- Asian			
		W- White(Hispanic or Non Hispanic)					
Eligibility Criteria: (Circle One)		A- Age		S- Spouse of Eligible		D- Disabled (18-59)	
		H- Disabled lives in Senior Housing		V- Volunteer			
		E- Employee/Staff		O- Guest/Other		G- Caregiver	
Status: (Circle One)		Active		Deceased		Inactive Moved	
<input type="checkbox"/> Limited English proficiency				<input type="checkbox"/> At Risk of institutional placement			

_____ I give permission for _____ to share this information with
 Signature Community agencies.

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Emergency Contact and Caregiver Information

Doctor's Name:							
Phone:			Date of Last Visit:				
Emergency Contact:					Phone:		
Address:							
City:		State:		Zip:			
Relationship: (Circle One)	Husband	Wife	Son/Son in Law	Daughter/Daughter In Law		Other	Non- Relative
Emergency Contact:					Phone:		
Address:							
City:		State:		Zip:			
Relationship: (Circle One)	Husband	Wife	Son/Son in Law	Daughter/Daughter In Law		Other	Non- Relative
<p>If client is a Caregiver, you must complete the section below.</p> <p>FAMILY CAREGIVER INFORMATION</p>							
FCG Eligibility: (Circle all that apply)		FCG Over 60	FCG Under 60	Grand Parent Over 55	Enter # of Grand Children In next box		Enter total # of disabled persons 19-59 Receiving care
<p>ENTER INFORMATION BELOW FOR EACH OF THE 60+ PERSON(S) FOR WHOM THIS CLIENT PROVIDES CARE(i.e., the recipient(s) of the Caregiver's Assistance) (Use additional page if needed)</p>							
Relationship of Caregiver to recipient (Circle One)		Husband	Wife	Son/Son In Law	Daughter/ Daughter in Law		Other Non- Relative
Last				First			
Recipient Name:					Date Of Birth:		
Address:				City:			
State:			Zip:		Phone:		

Note: Entering Recipient names in NapisPak allows for cross referencing Caregiver Clients and Recipients who are also in the system as clients.

***Grey Shaded Boxes must be completed to satisfy Napis Requirements- Page 2**