AGESMART COMMUNITY RESOURCES

Intake Form

Last Name_____ **First Name**_____ **Middle Initial**_____

Address_____ **Zip**_____ **City**_____

County_____ **State**_____

Email:_____

Phone_____-_____-_____ **DOB**____/____/____ Age_____

Gender: [ ] Male [ ] Female [ ]Other

Gender Identity: [ ]Male [ ]Female [ ]Transgender [ ]Declined to answer [ ]Not listed_____

Sexual Orientation: [ ]Straight/Hetero [ ]Bisexual [ ]Lesbian [ ]Gay [ ]Decline to answer
[ ] Not listed:_____

Race [ ] African American [ ] Native Amer./Alas. [ ] Asian/Pacific Islander [ ] White/Caucasian

Ethnicity [ ]Hispanic [ ]Non-Hispanic

Low Income [ ] Yes [ ] No **Limited Eng. Speaking** [ ] Yes [ ] No **Rural** [ ] Yes [ ] No

Marital Status [ ] M [ ] D [ ] S [ ] W [ ]Partner [ ] UNK [ ]Other:_____

Veteran Status: [ ] Yes [ ] No **Spouse of Veteran:** [ ] Yes [ ] No

Served During Wartime: [ ] Yes [ ] No **Branch of Service:**_____

Perceived Health Status: [ ]Excellent [ ]Very Good [ ]Good [ ]Fair [ ]Poor

Disabled: [ ] Yes [ ] No

Medicare Claim Number:_____ Part A:_____ PartB:_____

Social Security Number _____ **Medicaid RIN:**_____

Income:_____ **Monthly [ ]Yearly [ ] Sources:**_____

Assets Amount(savings, CDs, IRAs, investments, etc):_____

Survey

How often do you feel you lack companionship?_____Hardly Ever _____Some of the time ___Often

How often do you feel left out?_____Hardly Ever _____Some of the time _____Often

How often do you feel isolated from others?_____Hardly Ever _____Some of the time ___Often

Do you live alone? Yes [ ] No [ ] How many people are in your household?_____

Are you interested in Options Counseling, to determine appropriate long-term support choices based on person's needs, preferences, values and individual circumstances? [ ]Yes [ ]No

Entered into : Aging IS_____ STARS_____

Release of Information

Consumers Name: _____

Address: _____

Phone Number: _____ Date of Birth: _____

I _____, give permission to Collinsville Faith in Action to share information with other service agencies/providers for the purpose of providing assistance to me. This may include sharing Information about a disability or medical condition. Agencies may include, and are not limited to: DORS, DHS, CMS, SSA, VAMC, Mental Health, Hospitals, Rehab Facilities, Insurance Companies.

I Understand that my consent is valid until I revoke my consent. I also understand that I may revoke my consent at any time in writing.

I confirm that _____ from _____ has explained the purpose of this form to me and I understand its content. My signature below indicates my Consent.

Name (Please Print) _____ Consent Given Verbally: _____

Signature: _____ Date: _____

Signature of Collinsville Faith in Action Staff: _____ Date: _____

FIA COLLINSVILLE FAITH IN ACTION

Collinsville Faith in Action
233 North Seminary Street
Collinsville, IL 62234

By signing below I revoke my consent for Collinsville Faith in Action to share my information from this date forward.

Signature: _____ Date: _____