COUNTY OF LOS ANGELES
COMMUNITY AND SENIOR SERVICES

PROGRAM MEMO

Number: AAA 16-05	Date: June 30, 2016

SUBJECT: REVISED UNIVERSAL INTAKE FORM AND AREA AGENCY ON AGING MANAGEMENT INFORMATION SYSTEM REQUIREMENTS

PURPOSE

The purpose of this program memo is to release the revised hardcopy of the Universal Intake Form (UIF) and implement new assessment requirements within the Area Agency on Aging (AAA) Management Information System (MIS).

BACKGROUND

AAA reports client data based on information collected from the UIF and entered into the AAA MIS. All AAA Service Providers are required to complete a UIF for each AAA client who receives certain services. The revised UIF, Attachment I, supersedes the UIF released in Program Memo (PM) AAA 14-05: Revised Universal Intake Form dated August 14, 2014.

Depending on the particular service, the California Department of Aging requires different sets of client-level data. For example, certain information may be required for Supportive Services Program clients, but not required for Congregate Meal clients. Therefore, four (4) different assessment types have been created in the AAA MIS. These assessment types are grouped by services requiring the same set of client-level data. Separate assessment types in the AAA MIS will also alleviate the high percentages of missing client data continuously encountered.

POLICY/PROCEDURE

UNIVERSAL INTAKE FORM

To ensure the consistency and validity of data reporting requirements, Service Providers are prohibited from making any changes to the UIF. Service Providers may continue to make copies and complete only those sections of the UIF applicable to the program(s) or service(s) the client will be receiving. Service Providers must use the UIF to capture information for clients who receive the following services:

- Elderly Nutrition Program – Congregate Meals
- Elderly Nutrition Program – Home Delivered Meals
- Family Caregiver Support Program – Respite Services
- Family Caregiver Support Program – Supplemental Services
- Family Caregiver Support Program – Support Services
- Linkages Program
- Nutrition Counseling
- Supportive Services Program – Alzheimer's Day Care
- Supportive Services Program – Case Management

- Supportive Services Program – Homemaker
- Supportive Services Program – Personal Care

Effective July 5, 2016, Service Providers must use the revised UIF. The UIF is comprised of the following sections:

Funding Identifier
Section 1a - Identification
Section 1b - Demographics
Section 2 - Emergency Contacts
Section 3 - Benefits
Section 4 - Referral Information
Section 5 - Nutritional Risk
Section 6 - Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL) Risk Factors & Disability Factors
Section 7 - Title IIIE Care Receiver Demographics
Section 8 - Title IIIE Care Receiver ADL/IADL Risk Factors & Disability Factors
Section 9 - Certification
Section 10 - Disenrollment

Service Providers shall complete the UIF for all clients who receive at least one of the services listed above. Below is a brief overview of the sections that must be completed.

- Funding Identifier – Service Providers must select the appropriate Funding Identifier(s) for each AAA client. Only one UIF is required for each client per agency.
- Sections One (1a) through Four (4) must be completed for all clients who receive at least one of the services listed above.
- Section Five (5) must be completed for clients who are enrolled in Home Delivered Meals, Congregate Meals, Nutrition Counseling, Linkages, and/or the Supportive Services Program.
- Section Six (6) must be completed for clients who are enrolled in Home Delivered Meals, Linkages, and/or the Supportive Services Program.
- Section Seven (7) is only required for the Family Caregiver Support Program. This section captures demographic information of the Care Receiver.
- Section Eight (8) is also applicable only to the Family Caregiver Support Program. This section captures ADL, IADL, and Disability Factors of the Care Receiver. Please note, ADL/IADL information is not required for Grandchildren. However, Disability Factors are still required.
- Section Nine (9) is required for all clients who receive at least one of the services listed above. The client or client representative (responsible other) must sign the UIF to certify that the information provided is accurate. The interviewer must also sign the UIF to certify information accuracy and verify that the client agrees to accept service(s). If the UIF is completed via a telephone interview, Service Providers must note this is the Client Signature field by writing "Telephone Interview."
- Section Ten (10) is required for all clients who have terminated any of the services listed above or for all clients who have not received services for one year. Service Providers must indicate the appropriate reason and complete the date in which the client has terminated service(s).

Service Providers must continue to provide the necessary guidance to clients when completing the UIF. Clients may opt to "decline to state," but must be given an opportunity to provide a response to each question. Accurate data and the information created from data elements contribute to valuable knowledge about service use and client demographics.

MANAGEMENT INFORMATION SYSTEM ASSESSMENT TYPES AND FREQUENCY

The assessment types within the AAA MIS are applicable for clients enrolled in the Elderly Nutrition Program – Congregate Meals (CM) or Home Delivered Meals (HDM), Nutrition Counseling, Family Caregiver Support Program (FCSP), FCSP Grandparents (FCSP (G)), Linkages Program, and/or Supportive Services Program (SSP).

Effective July 5, 2016, Service Providers must input data in the AAA MIS by selecting and completing the respective assessment type(s) for which the client shall be receiving service(s). There are four (4) assessment types in the AAA MIS:

- Congregate Meal/Nutrition Counseling Assessment
- FCSP Caregiver/Care Receiver Assessment
- FCSP(G) Caregiver/Care Receiver Assessment
- SSP/HDM/Linkages Assessment

When an assessment type is selected, Service Providers must also select the frequency in which an assessment is required for each client. The frequency of an assessment is not dependent on the assessment type selected, but is based on the particular program or service. The drop down options for this field are:

- Three (3) months
- Six (6) months
- Annual

A date will automatically be calculated in the "Next Due" date field, depending on the frequency selected. The chart below depicts the frequency that must **always** be selected for each program or service.

Program/Service	Frequency
Congregate Meal	Annual
Nutrition Counseling	Six (6) Months
Family Caregiver Support Program	Annual
Family Caregiver Support Program (Grandparents)	Annual
Supportive Services Program	Six (6) Months
Linkages Program	Annual
Home Delivered Meals	Three (3) Months

The "Next Due" date field will be generated based on the date in which the physical UIF was completed. For example, a client who will be enrolled in the Supportive Service Program must first be assessed using the UIF. Once the physical UIF is completed, Service Providers must input an SSP/HDM/Linkages Assessment Type in the AAA MIS within 14 days of UIF completion. Service Providers must input the date in which the UIF was completed and select six (6) months as the frequency. The "Next Due" date field will be generated based on the UIF completion date Service Providers input in the AAA MIS.

MANAGEMENT INFORMATION SYSTEM ASSESSMENT SCORES

Assessment scores have been incorporated in the assessment types. The SSP/HDM/Linkages Assessment Type has a total Assessment Score that is currently pertinent only to the Home Delivered Meals waitlist. A Program Memo regarding the total Assessment Score is forthcoming. Those who receive a score of six (6) or more on the Nutrition Risk Factors must continue to be referred for Nutrition Counseling.

ADDITIONAL REQUIREMENTS

Effective September 30, 2016, Service Providers must also complete all data fields in the AAA MIS to complete and lock each assessment type. These data fields include the client's name, date of birth, address, and all fields in which declined to state is an option. In a case where a client refuses to provide a specific address, the client should at least provide a city and zip code. Service Providers may type "Declined to State" in the "Address" open text field. If the client is homeless, Service Providers may type in "Homeless" in the "Address" open text field, but must ensure homeless is selected under the "Type of Residence" field. Service Providers may input the agency's city and zip code for homeless clients.

Per PM AAA 16-02: Reassessment Requirements for Older Americans Act (OAA) Title III AAA Programs dated March 18, 2016, Service Providers must enter a reassessment for all continuing clients during the first quarter of the Fiscal Year in which they will be receiving services. Continuing clients are clients who will continue to receive services from one fiscal year to the next fiscal year. Performance with regards to PM AAA 16-02 will be tracked on a monthly basis. For example, if an agency has 150 current clients who will continue receiving services in Fiscal Year 2016-2017, 30% or 45 clients must have a reassessment entered into the AAA MIS by the end of July 2016. Seventy percent or 105 clients must have a reassessment entered by the end of August 2016. By the end of September 2016, all clients from Fiscal Year 2015-2016 should have a reassessment entered into the AAA MIS if they will be receiving services in Fiscal Year 2016-2017.

Service Providers will be unable to "copy to new" when entering a specific assessment type for the first time. However, once a particular assessment type has been completed for a client, Service Providers may "copy to new" that particular assessment type and make updates during each reassessment as needed.

Effective September 30, 2016, Service Providers must input an assessment or reassessment for each client *prior* to recording service delivery for the client. The AAA MIS will prevent Service Providers from recording service units for a client if the client does not have the respective assessment type completed and locked in the AAA MIS.

TECHNICAL ASSISTANCE

For technical assistance regarding how to navigate the AAA MIS or input data, please contact the AAA Information Technology Help Desk at (213) 739-7381 or css_aaa_techsupport@css.lacounty.gov.

Questions regarding this Program Memo may be directed to the appropriate AAA staff listed on the next page.

Program/Service	AAA Staff	Telephone	Email
Congregate Meals	Denise Ward	(213) 639-6353	dward@css.lacounty.gov
Family Caregiver Support Program	Cynthia Ear	(213) 738-4031	cear@css.lacounty.gov
Home Delivered Meals	Sheri Stanton	(213) 351-5069	sstanton@css.lacounty.gov
Linkages	Cynthia Ear	(213) 738-4031	cear@css.lacounty.gov
Nutrition Counseling	Denise Ward	(213) 639-6353	dward@css.lacounty.gov
Supportive Services Program	Agueda Covarrubias	(213) 738-2682	acovarrubias@css.lacounty.gov

Anna Avdalyan (ak)
Anna Avdalyan, Program Manager
Area Agency on Aging Division

AA:CK:ce

Attachment

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Los Angeles County Area Agency on Aging

Agency Name: _____ Date: _____

UNIVERSAL INTAKE FORM

Funding Identifier:

Title IIIB ☐ Title C1 ☐ Title C2 ☐ Title IIIE ☐ Title IIIE(G) ☐ Linkages ☐

IDENTIFICATION

1a	Applicant Last Name	First Name	Middle Initial	GetCare ID #

Date of Birth (D.O.B.)	Age	Social Security # (*Optional*)	
Home Address *(Number/Street)*	City	State	Zip Code
Mailing Address *(If different than home address)*	City	State	Zip Code
Home Phone	Work Phone	Cell Phone	
Email Address			

DEMOGRAPHICS

1b

Rural Designation ☐ Rural ☐ Urban ☐ Declined to State

Unincorporated City ☐ Yes ☐ No ☐ Declined to State

Gender ☐ Male ☐ Female ☐ Declined to State

Do you Identify as LGBT? ☐ Yes ☐ No ☐ Declined to State

Veteran ☐ Yes ☐ No ☐ Declined to State

Spouse of Veteran ☐ Yes ☐ No ☐ Declined to State

Race

☐ White ☐ American Indian or Alaska Native ☐ Chinese ☐ Japanese ☐ Filipino ☐ Korean ☐ Vietnamese

☐ Asian Indian ☐ Laotian ☐ Cambodian ☐ Other Asian ☐ Black or African American ☐ Guamanian

☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race ☐ Multiple Race ☐ Declined to State

Ethnicity ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State

Relationship Status ☐ Single (Never Married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined to State

Type of Residence

☐ House ☐ Apartment ☐ Hotel ☐ Mobile Home

☐ Nursing Home ☐ Residential Care Home

☐ Room and Board ☐ Homeless ☐ Other

☐ Declined to State

Does the individual

☐ Rent ☐ Own ☐ Other

☐ Declined to State

Employment Status

☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Declined to State

Living Arrangement

☐ Lives alone without help ☐ Lives with others without help

☐ Lives alone with help 4 hrs/day or less

☐ Lives with others with help ☐ Declined to State

Federal Poverty Guideline (FPG)

Is your income ☐ At or below 100% FPG

☐ Above 100% FPG ☐ Declined to State

Agency Name: _____ Client Name: _____ Date: _____

1b Cont.

Primary Language

☐ American Sign Language ☐ Arabic ☐ Armenian ☐ Cambodian ☐ Cantonese ☐ Chinese ☐ English ☐ Farsi ☐ French ☐ Korean ☐ Laotian ☐ Mandarin ☐ Japanese ☐ Russian ☐ Spanish ☐ Tagalog ☐ Thai ☐ Vietnamese ☐ Other ☐ Declined to State

Translation needed ☐ Yes ☐ No ☐ Declined to State

EMERGENCY CONTACTS

2

Contact Last Name	First Name	Middle Initial
Address *(Number/Street)*	City	State / Zip Code
Home Phone / Work Phone	Cell Phone	Relationship
Contact Name (*Last, First, Middle Initial*) – *Optional*		
Address *(Number/Street)*	City	State / Zip Code
Home Phone / Work Phone	Cell Phone	Relationship
Primary Physician		Office Phone
Physician's Address	City	State / Zip Code

BENEFITS

3

Are you currently receiving Social Security Benefits? ☐ Yes ☐ No ☐ Declined to State

Do you currently receive Supplemental Security Income (SSI) Benefits? ☐ Yes ☐ No ☐ Declined to State

Do you participate in CalFresh (Food Stamps, SNAP, EBT)? ☐ Yes ☐ No ☐ Declined to State

Do you have Health Insurance? ☐ Yes ☐No ☐ Declined to State	Health Insurer's Name	Policy Number: *(Optional)*
Do you receive Medi-Cal? ☐ Yes ☐ No ☐ Declined to State	Medi-Cal # *(Optional)* Issue date:	Do you receive Medicare? ☐ Yes ☐ No ☐ Declined to State

Do you receive In-Home Supportive Services *(IHSS)?* ☐ Yes ☐ No ☐ Declined to State

Do you receive any additional benefits? (i.e. Veterans Benefits, CAPI, etc.)

REFERRAL INFORMATION

4

Referral Source

Last Name	First Name	Phone
Address	City	State / Zip Code

Presenting Problems/Services Requested/Comments/Follow-up:

Agency Name: _____ Client Name: _____ Date: _____

NUTRITIONAL RISK FACTORS

5 NUTRITIONAL RISK

(Add the numbers from each checked box to determine Nutrition Risk Score)

I have an illness or condition that made me change the kind and/or amount of food I eat.	2 ☐ Yes	☐ No	☐ Declined to State
I eat fewer than 2 meals per day.	3 ☐ Yes	☐ No	☐ Declined to State
I eat few fruits or vegetables or milk products.	2 ☐ Yes	☐ No	☐ Declined to State
I have 3 or more drinks of beer, liquor or wine almost every day.	2 ☐ Yes	☐ No	☐ Declined to State
I have tooth or mouth problems that make it hard for me to eat.	2 ☐ Yes	☐ No	☐ Declined to State
I don't always have enough money to buy the food I need.	4 ☐ Yes	☐ No	☐ Declined to State
I eat alone most of the time.	1 ☐ Yes	☐ No	☐ Declined to State
I take 3 or more different prescribed or over-the-counter drugs a day.	1 ☐ Yes	☐ No	☐ Declined to State
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2 ☐ Yes	☐ No	☐ Declined to State
I am not always physically able to shop, cook and/or feed myself.	2 ☐ Yes	☐ No	☐ Declined to State
Total Nutritional Risk Score		(If total is 6 or more, participant is at **High** Nutritional Risk)	

ADL/IADL RISK FACTORS & DISABILITY FACTORS

6 ACTIVITIES OF DAILY LIVING (ADL)/INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) RISK FACTORS & DISABILITY FACTORS *(Excluding Title IIIE Caregiver Program)*

Activities of Daily Living *(ADL)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Eating	☐	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐	☐
Transferring	☐	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐

Instrumental Activities of Daily Living *(IADL)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Meal Preparation	☐	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐	☐
Med. Mgmt.	☐	☐	☐	☐	☐	☐
Money Mgmt.	☐	☐	☐	☐	☐	☐
Using Phone	☐	☐	☐	☐	☐	☐
Hvy. Housework	☐	☐	☐	☐	☐	☐
Lt. Housework	☐	☐	☐	☐	☐	☐
Transportation	☐	☐	☐	☐	☐	☐

Disability Factors

☐ Visually Impaired ☐ Hearing Impaired ☐ Speech Impaired

☐ Physically Impaired ☐ Walking Aid ☐ Wheelchair

☐ Bedbound ☐ Memory Impaired ☐ Depression

☐ Cognitively Impaired ☐ None ☐ Declined to State

Recent Hospital Discharge ☐ Yes ☐ No

☐ Declined to State

Date of Discharge

Date To Stop Service

Hospital

Diabetic

☐ Yes ☐ No

☐ Declined to State

Have you been diagnosed with Alzheimer's or a related neurological disorder?

☐ Yes ☐ No ☐ Declined to State

Agency Name: _____ Client Name: _____ Date: _____

TITLE IIIE CARE RECEIVER DEMOGRAPHICS

7 TITLE IIIE CARE RECEIVER DEMOGRAPHICS

Please make additional copies of Section 7 & 8 if more than one Care Receiver

Caregiver Relationship: ☐ Spouse ☐ Domestic Partner ☐ Sibling ☐ Son/Son-in-Law ☐ Daughter/Daughter-in-Law ☐ Grandparent ☐ Other Relative ☐ Non-Relative ☐ Other ☐ Declined to State

Care Receiver Last Name	First Name	Middle Initial	Care Receiver GetCare ID #

Address (Number & Street)	City	State	Zip Code

Rural Designation	Unincorporated City
☐ Rural ☐ Urban ☐ Declined to State	☐ Yes ☐ No ☐ Declined to State

Home Phone	Work Phone	Cell Phone	Emergency Contact Phone

Date of Birth (D.O.B.)	Age	Gender ☐ Male ☐ Female ☐ Declined to State

Social Security # (Optional)	Email Address

Veteran	Spouse of Veteran
☐ Yes ☐ No ☐ Declined to State	☐ Yes ☐ No ☐ Declined to State

Race

☐ White ☐ American Indian or Alaska Native ☐ Chinese ☐ Japanese ☐ Filipino ☐ Korean ☐ Vietnamese ☐ Asian Indian ☐ Laotian ☐ Cambodian ☐ Other Asian ☐ Black or African American ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race ☐ Multiple Race ☐ Declined to State

Ethnicity

☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State

Relationship Status

☐ Single *(Never Married)* ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined to State

Type of Residence	Does the individual	Living Arrangement
☐ House ☐ Apartment ☐ Hotel ☐ Mobile Home ☐ Nursing Home ☐ Residential Care Home ☐ Room and Board ☐ Homeless ☐ Other ☐ Declined to State	☐ Rent ☐ Own ☐ Other ☐ Declined to State	☐ Alone ☐ Not Alone ☐ Declined to State

Receive In-Home Supportive Services *(IHSS)?*	Federal Poverty Guideline (FPG) Is your Care Receiver income
☐ Yes ☐ No ☐ Declined to State	☐ At or below 100% FPG ☐ Above 100% FPG ☐ Declined to State

Have Health Insurance?	Receive Medicare?	Receive Social Security?	Receive Medi-Cal?
☐ Yes ☐ No ☐ Declined to State	☐ Yes ☐ No ☐ Declined to State	☐ Yes ☐ No ☐ Declined to State	☐ Yes ☐ No ☐ Declined to State

Agency Name: _____ Client Name: _____ Date: _____

TITLE IIIE CARE RECEIVER ADL/IADL RISK FACTORS & DISABILITY FACTORS

8 TITLE IIIE CARE RECEIVER ACTIVITIES OF DAILY LIVING (ADL)/ INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) RISK FACTORS & DISABILITY FACTORS

Activities of Daily Living *(ADL) (Grandchildren exempt)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Eating	☐	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐	☐
Transferring	☐	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐

Instrumental Activities of Daily Living *(IADL) (Grandchildren exempt)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Meal Preparation	☐	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐	☐
Med. Mgmt.	☐	☐	☐	☐	☐	☐
Money Mgmt.	☐	☐	☐	☐	☐	☐
Using Phone	☐	☐	☐	☐	☐	☐
Hvy. Housework	☐	☐	☐	☐	☐	☐
Lt. Housework	☐	☐	☐	☐	☐	☐
Transportation	☐	☐	☐	☐	☐	☐

Disability Factors

☐ Visually Impaired ☐ Hearing Impaired ☐ Speech Impaired ☐ Physically Impaired ☐ Walking Aid

☐ Wheelchair ☐ Bedbound ☐ Memory Impaired ☐ Depression ☐ Cognitively Impaired ☐ None

☐ Declined to State

Diabetic

☐Yes ☐ No

☐ Declined to State

Has Care Receiver been diagnosed with Alzheimer's or a related neurological disorder?

☐ Yes ☐ No ☐ Declined to State

Agency Name: _____ Client Name: _____ Date: _____

CERTIFICATION

9	***CERTIFICATION*** *(To be completed by Interviewer and signed by Client)* *I certify that the information on this form, provided to me by the client, is accurate and true to the best of my abilities. I also certify that I have informed the Client that this information may be shared with other providers for the purpose of providing services. Client signature establishes agreement to services.*

Completed by (Print Name)	*Phone*
Signature	*Date*
Client Name (Print)	
Client Signature	*Date*

DISENROLLMENT

10	**REASON FOR DISENROLLMENT**	*Date of disenrollment:*

☐ Deceased ☐ Moved Out of Service Area ☐ No Longer Desires Services ☐ No Longer SNF Certifiable

☐ No Longer Medi-Cal Eligible ☐ Institutionalization ☐ High Cost of Services ☐ Won't Follow Care Plan

☐ On Hold ☐ Service No Longer Needed ☐ Past Active ☐ On Waiting List ☐ Other Reason

NOTES:

Thank you for completing the Universal Intake Form (UIF). As the aging population grows and funding remains limited, it is vital to capture this critical information to reinforce and substantiate the increased demand for older adult services. This information will assist the Los Angeles County Area Agency on Aging (AAA) in identifying unmet needs, effectively developing plans, and better coordinate services to meet your needs.