

# 2017 Vision Impairment Intake Form

Updated February 10, 2017

<b>Basic Client Information:</b>				<b>Date of Assessment:</b> / /	
*First Name:		*Last Name:		Middle Initial:	
*Date of Birth: / /		Age:	*Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
What is your primary language?		*What is your race?		*Are you Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Are you visually impaired (cannot be corrected with glasses)? <input type="checkbox"/> Yes <input type="checkbox"/> No				Are you receiving Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many people live in your household?			
What is your monthly income?			What is your monthly household income?		
*If you live alone, is your individual monthly income below \$1,005? <input type="checkbox"/> Yes <input type="checkbox"/> No			*If you have a spouse or partner, is your monthly household income below \$1,353? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you use any assistive devices? <input type="checkbox"/> Yes <input type="checkbox"/> No			If so, which ones? _____		
*Residential Street Address:			Mailing Address - Street/P.O. Box:		
*Apartment or Unit # (if applicable):			Mailing City or Town:		
*Residential City or Town:			Mailing State:		Zip Code:
*Residential State:		Zip Code:	Email Address:		
*County of Residence:					
*Primary Phone # (including area code):			Secondary Phone # (including area code):		
Emergency contact name:			Relationship:		Phone Number:
Are you interested in receiving nutrition counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No					
How did you hear about our services? <input type="checkbox"/> AAA Brochure <input type="checkbox"/> AAA Newsletter <input type="checkbox"/> Channel 9 Senior Source (TV) <input type="checkbox"/> Congregate Meal Site <input type="checkbox"/> From a Current Client <input type="checkbox"/> From a Friend/Relative <input type="checkbox"/> Senior Fair <input type="checkbox"/> Walk-In <input type="checkbox"/> Web Site <input type="checkbox"/> Other _____					
Do you want to hear about other services? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, how can we contact you? <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> Phone		
When is the best time to contact you?			Please tell us what services you would like to receive:		

*I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service provider and I herewith give my consent to do so.*

*(If filled out by assessor or via phone, please have assessor check here and sign below ).*

Signature \_\_\_\_\_

Date \_\_\_\_\_

## 2017 Vision Impairment Form

**Do you have a vision problem?** Yes / No *(please circle one)*

**Do you wear corrective eyewear?** Yes / No *(please circle one)*

**Do you have one of the following eye conditions?** *(check all that apply)*

- Totally Blind
- Legally Blind
- Macular Degeneration Wet/ Dry/ Both *(please circle one)*
- Cataracts
- Glaucoma
- Stroke
- Diabetic Retinopathy
- Retinitis Pigmentosa
- Accident
- Vision Impairment *Describe: \_\_\_\_\_*  
*How long: \_\_\_\_\_*
- Other \_\_\_\_\_

**What do you feel are your vision needs?** *(check all that apply)*

- Regular Eye Examination
- Low-Vision Specialist Appointment
- Corrective Eyewear (glasses, contacts, etc.)
- Assistive Technology Desired Device(s): \_\_\_\_\_
- Adaptive Aids Desired Device(s): \_\_\_\_\_

**Please read the following information concerning this Intake Form and Complaint/Grievance Procedure:**

We are asking you to complete the attached form to the best of your knowledge so we understand how you would like to receive services. Some basic information (\*) is needed to meet compliance with federal and state reporting requirements and to target consumers age 60 and older who have the greatest economic and social need, such as individuals who are low-income minority, frail, and rural. Requests for services are processed as funds allow.

Your income level is not used to qualify you to receive services, but rather as a means to gather demographic data to various entities to show the need for continued funding of services. Nobody will contact you, unless you choose so in order to receive information about services which might be available to you.

If there is not enough room on the application for any of your responses, please attach a separate sheet.

**Complaint/Grievance/Appeal Procedure:**

The purpose of the Complaint/Grievance/Appeal Procedure is

- To ensure fair and equitable treatment of all consumers, eliminate dissatisfaction, resolve problems and
- To establish complaint and appeals procedures that inform the consumers of their rights to complain and receive a written response at the provider level

Any OAA/OCA (Older Americans Act/Older Coloradans Act) eligible consumer who has a complaint/grievance with the organization asking you to fill out this assessment form has the right to file a complaint/grievance with said organization and, if not satisfied with the organization's decision, to appeal that decision with either the local AAA (Area Agency on Aging) or the SUA (State Unit on Aging).

The complete Complaint/Grievance/Appeal Procedure is available upon request by contacting your local AAA and/or the SUA as follows:

Office of Community Access and Independence  
Aging and Adult Services  
1575 Sherman Street, 10<sup>th</sup> Floor  
Denver, CO 80203  
(303) 866-2800 (Main Line)  
(303) 866- 2977 (Fax)  
(888) 866-4243 (Toll Free)

**Contributions:**

Any person receiving services shall have the opportunity to contribute towards the cost of the service. No eligible person shall be denied a service because of their inability and/or choice not to contribute.

**KEEP THIS FORM FOR YOUR RECORDS**

## Instructions about filling out the 2017 Basic Consumer Intake Form:

This Basic Consumer Intake Form is provided as a courtesy to allow the AAAs and their providers to gather the information required by the federal or state government to be entered into Colorado's official data system (currently SAMS). If this information is already obtained by other means, there is no need to fill this Basic Intake Form out again, as long as you have the data to register a client in SAMS, by entering the starred (\*) data elements into the detailed consumer record.

(\*) Any fields with this prefix designate demographic data collected by the federal or state government to support the need for continued funding for the various programs. This data will be de-identified and used in aggregate form to compile statistical information. None of the data is sold to a third party and any personal information will only be used in an effort to better serve the client in providing him/her with services.

There is one additional required field you need to be aware of, which is not on the form, but needs to be checked in the NAPIS section of the consumer record. That field is 'In poverty?'. Please check yes, if the consumer has less than \$1,005 individual or less than \$1,353 household income monthly; mark 'no' otherwise.

Any fields which do not have the (\*) prefix are optional, but help determine in what other ways we might be able to help the client and to get feed-back about which of our outreach programs are successful. Please try to obtain as much information as possible, since we can only help when we know that there is a need.

While we ask you to make an honest effort to gather this basic information, we cannot deny services to clients on the basis of them refusing to provide the requested information, as our programs are not means tested. Since our programs are specifically for the elderly, particularly for persons age 60 or over, the date of birth needs to be filled in. If the client refuses to provide his/her date of birth, please enter January 1 and the year which would make them the age they are stating. Then, indicate in the notes of the consumer detail record that the date of birth is not factual, as the client would not provide it.

This form may be used for the following services (any other services require one of the available assessment forms, rather than just a basic intake):

- Assisted Transportation or Assisted Transportation (State)
- Counseling or Counseling (State)
- Education or Education (State), if the client is registered
- Evidence-based Disease Prevention or Health Promotion or Evidence-based Disease Prevention and Health Promotion (State)
- Information and Assistance or Information or Assistance (State), if the client is registered
- Material Aid or Material Aid (State)
- Nutrition Education or Nutrition Education (State), if the client is registered
- Outreach or Outreach (State), if the client is registered
- Public Information or Public Information (State), if the client is registered
- Reassurance or Reassurance (State)
- Transportation or Transportation (State)

If you have any questions, please contact your local AAA office.