GovGuam Association of Retired Persons, Inc. (GGARP)
Servicio Para I ManAmko (SPIMA)
P.O. Box 3057, Hagatna, Guam, 96932 • Tel: (671) 473-1916 • Fax (671) 477-9015

SENIOR CENTER OPERATIONS (SCO)
NOTICE OF SENIOR CITIZEN PARTICIPATION FORM

INSTRUCTIONS: This Form is to be completed by the Manager each time there is a change in the participant's status and submit to SCO office within two (2) business days. After verification of the information is received from the Manager, the Verification of Senior Citizens participation will be issued.

Today's Date:

1. Name (*last, first, middle initial*):	2. Date of Birth (*month, day, year*):
3. Social Security Number:	4. Effective Date of Action (*month, day, year*):

5. Nature of Action Taken (*check appropriate box(es)*):

A. [ ] **NEW PARTICIPANT** (DSC form revised 08-24-06, Emergency Contact and DYNH).

B. [ ] **RE-ENROLLED** (Participant was inactive and is now active).
[ ] At the same Center [ ] Transferred from another Center

Date participant was placed on Inactive status (*month, day, year*): ____________________.

C. [ ] **RECORD CHANGE & SERVICE UPDATE.**

D. [ ] **ANNUAL UPDATE** (Yearly update as required by the RFP).

E. [ ] **TRANSFER** to another Senior Center. (From: ____________ to ________________.
(Client's file from the originating Center to be submitted with this form to SCO Office.)

F. [ ] **INACTIVE** (No participation at the Center for the past thirty (30) calendar days)
Reason: [ ] Off Island [ ] Illness [ ] Admitted to Adult Day Care
[ ] Non-Attendance [ ] Other (specify) ____________________________

G. [ ] **TERMINATION**
Reason: [ ] Death. Date of death (*month, day, year*): ____________________
[ ] Inactive for more than four (4) calendar years.
Enter last Inactive Status Date (*month, day, year*): __________________

6. Submitted by Center Manager (Assistant Center Manager):

Print Name: Signature:

7. Name of Senior Citizen Center:

Revised: 10/99. 06/02. 06/05. 10/05. 08/06

SENIOR CITIZENS AGING SERVICES FY-2007
INTAKE, PROFILE AND REFERRAL (IPR) FORM

INSTRUCTIONS

Title III reporting requirements provide statistical data for management and advocacy initiatives serving as indicators for new and continued funding of programs for seniors. The data collected is used for budget justifications, congressional inquiries, program development and mandated reports for federal, state and local agencies. Information must be accurate for it to be useful in supporting program services.

- FORM: This form is an Intake Profile and Referral (IPR) Form, and not an Assessment Form. Profile characteristics are used in developing new programs to meet the needs of the elderly. Each Service Provider may have their own Assessment Form for their specific programs.

- **DATA RETENTION:** Client data is retained in the main registry until a client remains on Inactive Status for over four (4) years or when a client is deceased.

- **SSN:** If a client does not yet have a Social Security Number (SSN), use 000 as the first three digits for their assigned number. The next two digits should be the month and the last four digits shall be the day and year the client was born. If a client was born on **March 21, 1911**, the SSN would be **000-03-2111**. If born on **November 9, 1933**, the SSN would be **000-11-0933**.

- **INCOME LEVEL:** The Income Level is based on the U.S. Department of Health and Human Services Poverty Guidelines and shall be completed before the Intake, Profile and Referral Form can be processed.

- **REFUSAL TO ANSWER:** Should a client refuse to answer a certain question, leave it blank. In the comments section, list the reason for not answering the question. This does not apply to Income Level.

- **SIGNATURE:** The signature of the client or responsible party is required before services can be provided.

- **SPECIAL ACCOMMODATIONS:** Clients requiring special accommodations shall inform the program in advance of their requirements.

- **SECTION B:**

- **Case Management Services.** Case Management Services Program, at a minimum, conducts an assessment to individuals requesting Adult Day Care Services, In-Home Services and Home-Delivered Meals. Entry into these programs shall not be permitted before an assessment is made and eligibility established by Case Management Services.

- **Transportation Services.** In order to meet demands, clients requesting transportation shall make reservations with the Transportation Services Program at least two (2) working days in advance for service. If the date requested cannot be accommodated, the Transportation Services Program shall recommend an alternate date. Requests for persons using wheelchairs or having a Personal Assistant/Personal Care Attendant shall be made in the same manner, whether for Center participation or to and from medical appointments, etc.

- **Elderly Nutrition Program.** To the extent practicable, meals are adjusted to meet special dietary needs of eligible participants, and shall be supported by a statement from the client's doctor or religious leader stating the necessity for special meals, including nutrition supplements. Mechancial (chopped) or pureed (blendered) meals are not classified as special meals and shall be provided to the client at their request.

FOR ADULT PROTECTIVE SERVICES (APS) REFERRALS PLEASE CONTACT 735-7382/84 OR EMERGENCY RECEIVING HOME AT 653-8855 TWENTY-FOUR HOURS A DAY SEVEN DAYS A WEEK

SENIOR CITIZENS AGING SERVICES FY-2007
INTAKE, PROFILE AND REFERRAL (IPR) FORM
PLEASE PRINT CLEARLY USING BLUE OR BLACK INK

A. CLIENT INFORMATION

Field	
Last Name	
First Name	
Middle Name	
Date of Birth	
Place of Birth	
SSN	
Gender	☐ Male ☐ Female
Village	
Home Address	
Mailing Address	
Ethnicity	
Citizenship	
Day Phone No.	
Night Phone No.	

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Living Arrangement
- ☐ Lives alone
- ☐ Lives with spouse
- ☐ Lives with family
- ☐ Lives with others
- ☐ Lives in Group Home
  Specify: ____________
- ☐ Lives in Institution
  Specify: ____________

Special Needs
- ☐ Language Interpreter
  Specify: ____________
- ☐ Assistive Device(s)
  Specify: ____________
- ☐ None identified at this time.

Mobility Status *(check all that apply)*
- ☐ Drives
- ☐ Walks slowly
- ☐ Walks with assistance
- ☐ Climbs steps with assistance
- ☐ Uses cane/crutches/walker
- ☐ Uses a wheelchair
- ☐ Bedridden
- ☐ Other: ____________

Health Status
- ☐ Excellent
- ☐ Good
- ☐ Poor

Allergies	Specify: ____________ ____________ ____________ ____________ ☐ None known at this time.

Undergoing Treatment
- ☐ Hemodialysis
- ☐ Cancer
- ☐ Physical Therapy
- ☐ Other ____________
- ☐ None at this time

Field	
Heath Insurance	
Policy No.	
Clinic	
Phone No.	
Primary Doctor	
Phone No.	

CLIENT'S NAME: ____________ SSN: ____________ CMS: ____________ SCO: ____________

SENIOR CITIZENS AGING SERVICES FY-2007
INTAKE, PROFILE AND REFERRAL (IPR) FORM

PLEASE PRINT CLEARLY USING BLUE OR BLACK INK.

Income Level

Family Unit Size (FUS)

Is your income less than

Unit Size	Per Month	Per Year	Yes	No
One (1)	$1,020.83	$12,250.00		

Is your combined income less than

Unit Size	Per Month	Per Year	Yes	No
Two (2)	$1,375.00	$16,500.00		

Is your combined income less than

Unit Size	Per Month	Per Year	Yes	No
Three (3)	$1,729.16	$20,750.00		

☐ Four (4) or more in FUS, add $354.16 per month or $4,250.00 per year for each additional member.

$ ______

B. SERVICES REQUESTED

- ☐ Case Management Services
- ☐ Adult Day Care Services
- ☐ In-Home Services
- ☐ Legal Assistance Services
- ☐ National Family Categiver Support Program
- ☐ Senior Center Operations
- ☐ Transportation Services:
  - ☐ Transportation Services
  - ☐ Assisted Transportation
- ☐ Elderly Nutrition Program:
  - ☐ Congregate Meals
  - ☐ Home-Delivered Meals

    Specify Type of Meal
    - ☐ Regular
    - ☐ Mechanical/Chopped
    - ☐ Pureed/Blenderized
    - ☐ Special (*Provide document from client's religious leader or doctor to certify Special Meal request.*)

COMMENTS: ______

______

______

______

C. CAREGIVER INFORMATION

☐ Not Applicable	☐ Caregiver ☐ Paid ☐ Not Paid Paid by: ______
Last Name	
First Name	
Middle Name	
Date of Birth	
Day Phone No.	
Night Phone No.	
Relationship to Client	

D. GUARDIAN/AUTHORIZED REPRESENTATIVE INFORMATION

☐ Guardian

☐ Authorized Representative

☐ Not Applicable

Note: Attach copy of Guardianship or Power of Attorney, as applicable.

Last Name	
First Name	
Middle Name	
Day Phone No.	
Night Phone No.	
Relationship to Client	

E. EMERGENCY CONTACT NUMBER

Last Name	
First Name	
Middle Name	
Day Phone No.	
Night Phone No.	
Relationship to Client	

CLIENT'S NAME: ______ SSN: ______ CMS: ______ SCO: ______

SENIOR CITIZENS AGING SERVICES FY-2007
INTAKE, PROFILE AND REFERRAL (IPR) FORM
PLEASE PRINT CLEARLY USING BLUE OR BLACK INK.

F. HIGH RISK CLIENTS UNDER EMERGENCY DECLARATION

A client is considered High Risk under Emergency Declaration if any of the following exists. This information shall be provided to the client's village mayor in preparation for emergencies.

(check all that apply)

- ☐ Bedridden
- ☐ Requires transportation and/or escort assistance for evacuation to shelter, e.g., those living alone.
- ☐ Requires refrigeration of medication and/or is insulin dependent.
- ☐ Requires oxygen.
- ☐ Lives in substandard housing.
- ☐ Not Applicable

G. ELIGIBILITY & CONSENT OF CLIENT

Individuals age sixty (60) years and older are eligible for Title III programs under the Older Americans Act. This Act also prioritizes services for:

- Persons who are frail, homebound by reason of illness or incapacitating disability, or otherwise isolated; and
- Persons with greatest economic need with particular attention to low-income individuals; persons with greatest social need with particular attention to low-income minority individuals, and those who reside in rural areas.

Voluntary contributions to Title III programs are encouraged and used to expand services. Services may not be denied because the client will not or cannot contribute to the cost of the program.

I CERTIFY THE INFORMATION GIVEN BY ME IS TRUE TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND IT WILL BE KEPT CONFIDENTIAL AND USED ONLY TO HELP ME RECEIVE THE BENEFITS/SERVICES WHICH I MAY BE ENTITLED.

I HEREBY AUTHORIZE THE DISCLOSURE AND RELEASE OF THIS INFORMATION ONLY FOR THE PURPOSES FOR WHICH IT IS INTENDED. THIS AUTHORIZATION MAY BE REVOKED BY THE UNDERSIGNED AT ANY TIME BY GIVING WRITTEN NOTICE TO THE PARTIES AUTHORIZED HEREIN.

Signature of Client or Authorized Representative (AR)	
Date	
Relationship to Client, if AR	

H. INTAKE INFORMATION

Intake Worker	
Signature of Intake Worker	
Date of Intake	
Time of Intake	
Organization	
Contact No.	

IPR Forwarded To

- ☐ Adult Protective Services
- ☐ Case Management Services
- ☐ Elderly Nutrition Program (Congregate Meals)
- ☐ Guam Medicare Assistance Program
- ☐ Legal Assistance Services
- ☐ National Family Caregiver Support Program
- ☐ Ombudsman Services
- ☐ Senior Center Operations
- ☐ Transportation Services

Forwarded By	
Date Forwarded	
Time Forwarded	

I. RECEIVING ORGANIZATION INFO.

IPR Received By	
Date	
Time	

CLIENT'S NAME: ____________________ SSN: ______________ CMS: __________ SCO: __________

SENIOR CITIZENS AGING SERVICES FY-2007
INTAKE, PROFILE AND REFERRAL (IPR) FORM
PLEASE PRINT CLEARLY USING BLUE OR BLACK INK.

IPR Referred To

- ☐ Adult Day Care Services
- ☐ Case Management Services
- ☐ Elderly Nutrition Program – Congregate Meals
- ☐ Elderly Nutrition Program – Home Delivered Meals
- ☐ Guam Medicare Assistance Program (MAP)
- ☐ In-Home Services
- ☐ Legal Assistance Services
- ☐ National Family Caregiver Support Program
- ☐ Senior Citizens Center Operations
- ☐ Transportation Services
- ☐ Other:____________________

Date of Initial Contact with Client	
Time of Initial Contact with Client	

Comments:________________________________

____

J. CLIENT'S HOME

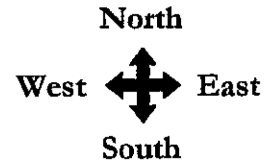
IF MAP IS SENT SEPARATELY, INCLUDE THE CLIENT'S NAME AND SSN AT TOP OF MAP

Does the home have an accessible driveway?	☐ Yes	☐ No
If you use a wheelchair, is there an accessible ramp?	☐ Yes	☐ No

All pets at your home shall be controlled by leash, case, etc. in accordance with P.L. 15-96 and 22-13.

DRAW A MAP TO THE CLIENT'S HOME

(Indicate primary and secondary access roads, type and color of the house, if fenced, landmarks such as adjacent to or across from the village community center, store, bus stop, etc.)



CLIENT'S NAME: ________________ SSN:____________ CMS:________ SCO:________

GovGuam Association of Retired Persons, Inc. (GGARP)
Servicio Para I ManAmko (SPIMA)
P.O. Box 3057, Hagatna, Guam, 96932 • Tel: (671) 477-9014 • Fax (671) 477-9015
SENIOR CENTER OPERATIONS

EMERGENCY CONTACT FORM

Senior Center: ____________________
Today's Date: ____________________

Name: ____ Social Security Number: ____________________

Date of Birth: ______________ Blood Type: ______ Sex: [ ] Male [ ] Female

Clinic: ____ Telephone No: ____________________

Insurance Plan: ________________________________ Policy No: ____________________

Name of Insurance Subscriber: ____________________ Telephone No: ____________________

Other Medical Insurance Policy: ______________ Policy No: ____________________

Home Address (House Number, Street Address, Village): ________________________________

Allergies (If any): ____

Problems List: ____

____

Medications Taken: ____

____

Other Important Information: ____

____

In Case of Emergency, Contact Person: ____
Relationship: ____________________ Work Place: ____________________________________
Telephone No.: ______________ Pager No.: ____________________ Cell Phone: ______________

I hereby authorize the Center Manager or the Medical Doctor to take necessary action to ensure my health and safety during times of emergencies.

Signature: ______________________________________ Date: ____________________

Emergency Number for Police & Ambulance: **911**

Nearest Ambulance Station & Telephone Number: ____________________________________

Name of Village Mayor: ____________________________ Telephone: ____________________

Revised: 08/08/02

The warning signs of poor nutritional health are often overlooked. Use this checklist to find if you or some one you know is at nutritional risk.

DETERMINE YOUR NUTRITIONAL HEALTH

Read the statements below. Circle the number in the column for those that apply to you or someone you know. For each yes answer, score the number in the box. Total your nutritional score.

Date:________________

	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 2 meals per day.	3
I eat few fruits or vegetables, or milk products.	2
I have 3 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 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and/or feed myself.	2
TOTAL	

Total Your Nutritional Score. If it's–

0-2 — **Good!** Recheck your nutritional score in 6 months

3-5 — **You are at moderate nutritional risk.** See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center, or health department can help. Recheck your nutritional score in 3 months.

6 or more — **You are at high nutritional risk.** Bring this check-list the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health .

These materials developed and distributed by the Nutrition Screening Initiative, a project of:

THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

THE AMERICAN DIETETIC ASSOCIATION

NATIONAL COUNCIL ON THE AGING, INC.

Remember that warning signs suggest risk, but do not represent diagnosis of any condition. Turn the page to learn more about the Warning Signs of poor nutritional health.

NAME________________________ DOB________________ CENTER____________________