



Title III B Legal Assistance – Client Intake Form FY2023-2024 **CONFIDENTIAL**

PROVIDER LOCATION: _____

TO RECEIVE LEGAL SERVICES: Person must be aged 60 or older.

*Unique Participant ID must begin with PSA18

Date:		Phone:		Birth Date: <i>(Required)</i>	
Name: <i>(Optional)</i>			*Unique Participant ID:		
Street Address:			City:		ZIP:
Email:			Rural: (91307, 93066, 93040)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing	
Staff Completing Intake:					
RACE – PLEASE CHOOSE (X) ONE:					Ethnicity:
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian <input type="checkbox"/> Samoan <input type="checkbox"/> Asian Indian <input type="checkbox"/> Guamanian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Black or African American <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other Asian <input type="checkbox"/> White <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Other Pacific <input type="checkbox"/> Decline to State <input type="checkbox"/> Chinese <input type="checkbox"/> Korean Islander <input type="checkbox"/> Missing					<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing
MARITAL STATUS:		<input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Widowed <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing			
VETERAN STATUS:		<input type="checkbox"/> Have you ever served in the United States military? <input type="checkbox"/> Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military? <input type="checkbox"/> No <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing		Preferred Language:	
<input type="checkbox"/> I consent to this agency and the California Department of Aging transmitting my name, email address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for 12 months.					
Client Lives:	<input type="checkbox"/> Alone <input type="checkbox"/> Not Alone <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing				
Applicant's Income Level (approximate):					
IF MARRIED:			IF SINGLE:		
<input type="checkbox"/> At or below Federal Poverty Level (\$19,720/year or less) <input type="checkbox"/> Above Federal Poverty Level (\$19,721/year or more) <input type="checkbox"/> Decline to State			<input type="checkbox"/> At or below Federal Poverty Level (\$14,580/year or less) <input type="checkbox"/> Above Federal Poverty Level (\$14,581/year or more) <input type="checkbox"/> Decline to State		
What was your sex at birth?	What is your Gender?		How do you describe your sexual orientation or sexual identity?		
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing <input type="checkbox"/> Not listed, please specify:		<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing <input type="checkbox"/> Not listed, please specify:		
Case Information:			Case Type- Check All That Apply:		
			Income:	<input type="checkbox"/>	
			Health Care:	<input type="checkbox"/>	
			(Long Term Care:	<input type="checkbox"/>	
			(Nutrition:	<input type="checkbox"/>	
			Housing:	<input type="checkbox"/>	
			Utilities:	<input type="checkbox"/>	
			Abuse/Neglect:	<input type="checkbox"/>	
			Protection Services:	<input type="checkbox"/>	

Age Discrimination:		<input type="checkbox"/>
Other/Miscellaneous:		<input type="checkbox"/>
Hours (Units):		
I certify that all statements on this form are true and correct. _____		
Applicant's Signature		
DO NOT WRITE IN THIS BOX – OFFICIAL USE ONLY		
Unique Case ID Number:		Service Level: <input type="checkbox"/> Advice <input type="checkbox"/> Limited Representation
Case Opened Date:	Case Closed Date:	<input type="checkbox"/> Representation