COUNTY of VENTURA
Human Services Agency
Area Agency on Aging

Title III B Legal Assistance – Client Intake Form FY2024-2025 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:** *(Required)*	
Name: *(Optional)*		***Unique Participant ID:**			
Street Address:		**City:**		**ZIP:**	
Email:		**Rural:** (91307, 93066, 93040)	☐Yes ☐ No ☐ Decline to State ☐Missing		
Staff Completing Intake:					

RACE – PLEASE CHOOSE (X) ONE:

☐ American Indian or Alaska Native	☐ Filipino	☐ Laotian	☐ Samoan	**Ethnicity:**
☐ Asian Indian	☐ Guamanian	☐ Asian Indian	☐ Vietnamese	☐ Not Hispanic/ Latino
☐ Black or African American	☐ Hawaiian	☐ Other Asian	☐ White	☐ Hispanic/ Latino
☐ Cambodian	☐ Japanese	☐ Other Pacific Islander	☐ Decline to State	☐ Decline to State
☐ Chinese	☐ Korean		☐ Missing	☐ Missing

MARITAL STATUS: ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single (Never Married) ☐ Widowed ☐ Decline to State ☐Missing

VETERAN STATUS:

☐ **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.**

- ☐ Have you ever served in the United States military?
- ☐ 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?
- ☐ No
- ☐ Decline to State
- ☐ Missing

Preferred Language:

Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626

Client Lives: ☐ Alone ☐ Not Alone ☐ Decline to State ☐Missing

Applicant's Income Level (approximate):

IF MARRIED:
- ☐ At or below Federal Poverty Level *($20,440/year or less)*
- ☐ Above Federal Poverty Level *($20,441/year or more)*
- ☐ Decline to State

IF SINGLE:
- ☐ At or below Federal Poverty Level *($15,060/year or less)*
- ☐ Above Federal Poverty Level *($15,061/year or more)*
- ☐ Decline to State

What was your sex at birth?	**What is your Gender?**	**How do you describe your sexual orientation or sexual identity?**
☐ Female	☐ Female ☐ Male	☐ Straight/Heterosexual
☐ Male	☐ Transgender Female to Male	☐ Bisexual
☐ Decline to State	☐ Transgender Male to Female	☐ Gay/Lesbian/Same-Gender Loving
☐ Missing	☐ Genderqueer/Gender Non-binary	☐ Questioning/Unsure
	☐ Decline to State	☐ Decline to State
	☐ Missing	☐ Missing
	☐ Not listed, please specify:	☐ Not listed, please specify:

Case Information:	**Case Type- Check All That Apply:**
	Income: ☐
	Health Care: ☐
	(Long Term Care: ☐
	(Nutrition: ☐
	Housing: ☐
	Utilities: ☐

Abuse/Neglect:	☐
Protection Services:	☐
Age Discrimination:	☐
Other/Miscellaneous:	☐
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: ☐ Advice ☐ Limited Representation ☐ Representation
Case Opened Date: Case Closed Date:	