# Delaware Health and Social Services

*Division of Services for Aging and Adults with Physical Disabilities*

***New Client*** ***Update Client***

# Napis Intake

Provider: 259

Assessment Date: ____/___/____

Re-Assessment Date:___/___/____

| | | |
|---|---|---|
| **Last Name:** | **First Name & MI:** | **SSN:** XXX-XX-XXXX |
| **Address 1:** | | **Birth Date:** / / |
| **Address 2:** | | **Sex:** ☐ Male ☐ Female |
| **City:** | **State:** **Zip Code** | **Rural:** ☐ Yes ☐ No |
| **Home Phone:** ( ) | **Work Phone:** ( ) | |
| **Age 60 or Over** (verified by): ☐ License/ID ☐ Medicare Card ☐ Verbal ☐ Other | | |
| **Individual Income Status** (*annual*): ☐ At or Below Poverty ☐ Above Poverty ☐ Refused to Answer ☐ Missing (not provided) | | **Living Arrangements:** ☐ Alone ☐ With Someone |
| **If Under age 60:** (*nutrition only):* ☐ Eligible through Spouse ☐ Social Security Disability ☐ Volunteer | | **Physical Condition:** Frail / Disabled ☐ Yes ☐ No |
| **Ethnic Group** (*Check Only One*): ☐ African American ☐ Hispanic Origin ☐ American Indian/Native Alaskan ☐ Asian/Pacific Islander (Inc.Native Hawaiian) ☐ Non Minority (White, Not of Hispanic Origin) ☐ Other | | |
| **Limited English Speaking:** ☐ Yes ☐ No | | |

**The information provided above is true and correct to the best of my knowledge.**

**Signature of person completing form _____ Date____ /_____/____**

***The above information is pertinent to help provide us with funding sources for your needs.***

Revised 5/15/06