**North Carolina Department of Health and Human Services**

**Division of Aging and Adult Services**

**Adult Services Intake Inquiry**

***This form may be used for Adult Services inquiries other than Adult Protective Services. If there are any concerns for maltreatment an Adult Protective Services Intake Report should be completed.***

**Date**:

**Adult’s Name**: **Adult’s Date of Birth**:

**County Case ID:**  **SIS ID**: 200-

**Type of Contact**:

Face to Face Referral Telephone Contact Written Referral (Postal Mail, Fax, Email, etc.)

**Person’s Other Than Adult Involved in Initial Referral/Contact**:

Agency Facility Family Member Friend Neighbor Physician N/A Other

*(List Names of Person’s Other Than Adult Involved in Initial Referral/Contact Below)*

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**Adult’s Level of Involvement**:

Adult was present and participating.

Adult was present but did not participate.

Adult not present but desires referral/contact.

Adult unaware of contact.

Adult not present but aware of referral/contact.

Uncertain (e.g. telephone contact)

*(Explain further about adult’s level of involvement below.)*

**What is/are the presenting problem(s)?**

**What additional efforts have been made to resolve the problem(s) (duration/efforts/outcomes)?**

**What is the expectation of the person(s) inquiring, including services requested?**

**Urgent?**  Yes  No If yes, explain why:

**Preliminary Information in Functional Domains**:

* **Social**:
* **Environmental**:
* **Economic**:
* **Mental Health**:
* **Activities of Daily Living**:
* **Physical Health**:

**Disposition**:

Aging Information/ Referrals (AAA, Senior Center, Dementia Resources, Referrals to Doctors, etc.)

CAP Information/Referrals

Case Opened for Outreach

Disaster Relief Information/Referrals

Domestic Violence Information Referrals

Food and Nutrition Services Information/Referrals

Housing Resources Information/Referrals

In-Home Aide Service Information/Referrals

Guardianship Information/Referrals

Legal Aide Information/Referrals

Medication Assistance Information/Referrals

Medicaid Information/Referrals

Mental Health Information Referrals

Placement Information/Referrals

Special Assistance Information/Referrals

Special Assistance In-Home Information/Referrals

Substance Use Information/Referrals

Transportation Information/Referrals

Other Health Insurance Information/Referrals (Not Medicaid)

Unable to Assist Client

Other (Explain Below)

Additional Explanation for Other Responses:

**Did anything during the initial interview suggest that the client may live in an environment that may put the social worker at risk?**

Yes  No

**If the above question is answered yes, describe (include source of information and impression of the seriousness of danger)**

**Additional Comments (if needed):**

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| --- | --- |
|  |  |
| Intake Social Worker’s Name |  |
|  |  |
| Intake Social Worker’s Signature | Date |