



Elder Intake Form

Please send completed form to: sodonnell@littlebrothersmn.org or Sandy O'Donnell, LBFE, 1845 E Lake Street, Minneapolis, MN 55407
Phone: 612.721.1400 | Fax: 612.721.5848



Contact Information		RP ID#:
Name:		
Address (street, building, apt #)		
City, zip code, county:		
Housing Type:	<input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Senior Living <input type="checkbox"/> Other	
Phone number:		
E-mail address:		
Birthdate - Age:		
Referral Information		
Referral Date:		
Referral Type:		
<input type="checkbox"/> Self <input type="checkbox"/> Family Friend <input type="checkbox"/> Social service <input type="checkbox"/> Medical <input type="checkbox"/> Housing <input type="checkbox"/> Other:		
Second party referrals only--		
Referral name and title/relationship		
Referral agency/address (if any)		
Referral phone/email		
Does elder know he/she is being referred to LBFE?		
How heard about LBFE?		
Notes: _____		
EMERGENCY CONTACT (Name/relationship/phone number):		

Demographic information
What gender do you self-identify as: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Intersex <input type="checkbox"/> Other
Familial Status/Family/Friendships: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered/Significant Other <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Divorced <input type="checkbox"/> Separated _____
How often do you see family or friends? _____
Notes: _____

Place of Worship (optional): _____

Language(s) Spoken: _____

(optional) Race: Asian American/Pacific Islander African Black/African American
 Hispanic American/Latin Hmong/Laotian Native American/American Indian/First Nations
 White/European American Other/mixed ethnicity

Annual Income: \$

Source of Income (SSI, VA, S.S., Retirement, etc.):

Transportation: Drives Own Car Metro Mobility Public Transp. N/A-Homebound

Personal Mobility: Wheelchair Scooter Walker

Veteran? No Yes Branch/Length of Service _____

Health and Insurance

Physical Health: Poor Fair Good Excellent

Mental Health: Poor Fair Good Excellent

Environmental Health: Poor Fair Good Excellent

Chronic or significant issues/surgeries:

Diet and Food Assistance

Financial Assistance: SNAP (Food Stamps) Other _____

Cooks Own Meals: Yes No Sometimes

Meals: Meals On Wheels Congregate Dining Other

Special Diet (Ethnic, Allergies, etc.) _____

Non-LBFE Services/Affiliations

	# days/week	#hrs/week
<input type="checkbox"/> Adult Day	_____	_____
<input type="checkbox"/> ILS	_____	_____
<input type="checkbox"/> PCA	_____	_____
<input type="checkbox"/> HHA	_____	_____
<input type="checkbox"/> Arhms	_____	_____
<input type="checkbox"/> Nurse	_____	_____
<input type="checkbox"/> Homemaker	_____	_____

	# days/week	#hrs/week
<input type="checkbox"/> Senior Center	_____	_____
<input type="checkbox"/> Church/Faith	_____	_____
<input type="checkbox"/> Other	_____	_____
Description:	_____	
<input type="checkbox"/> Other	_____	_____
Description:	_____	