

**Title III B Legal Assistance – Client Intake Form FY2026-2027**

**CONFIDENTIAL**



**COUNTY of VENTURA**  
Human Services Agency  
Area Agency on Aging

**PROVIDER LOCATION:** \_\_\_\_\_

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

\*Unique Participant ID must begin with PSA18

|                                |  |               |                                   |  |             |
|--------------------------------|--|---------------|-----------------------------------|--|-------------|
| <b>Date:</b>                   |  | <b>Phone:</b> |                                   | <b>Birth Date:</b> <i>(Required)</i>   |             |
| <b>Name:</b> <i>(Optional)</i> |  |               |                                   | <b>*Unique Participant ID:</b>   |             |
| <b>Street Address:</b>         |  |               |                                   | <b>City:</b>   | <b>Zip:</b> |
| <b>Email:</b>                  |  |               | <b>Rural:</b> (91307,93066,93040) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/no stated |             |
| <b>Preferred Language:</b>     |  |               | <b>Staff Completing Intake:</b>   |  |             |

**RACE/ETHNICITY – CHECK ALL THAT APPLY (X):**

|   |  |   |
|---|--|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Hawaiian                        | <input type="checkbox"/> Other Asian            |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Hispanic or Latino              | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Japanese                        | <input type="checkbox"/> Other Race/Ethnicity   |
| <input type="checkbox"/> Cambodian                        | <input type="checkbox"/> Korean                          | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Laotian                         | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Middle Eastern or North African | <input type="checkbox"/> White                  |
| <input type="checkbox"/> Guamanian                        |  | <input type="checkbox"/> Declined/no stated     |

**MARITAL STATUS:**  Divorced  Domestic Partner  Married  Separated  Single (Never Married)  
 Widowed  Declined/no stated

**Client Lives:**  Alone  Not Alone  Declined/no stated

**Applicant’s Income Level (approximate):**

|   |  |
|---|--|
| <p><b>IF MARRIED:</b></p> <input type="checkbox"/> At or below Federal Poverty Level ( <i>\$21,640/year or less</i> )<br><input type="checkbox"/> Above Federal Poverty Level ( <i>\$21,641/year or more</i> )<br><input type="checkbox"/> Decline to State | <p><b>IF SINGLE:</b></p> <input type="checkbox"/> At or below Federal Poverty Level ( <i>\$15,960/year or less</i> )<br><input type="checkbox"/> Above Federal Poverty Level ( <i>\$15,961/year or more</i> )<br><input type="checkbox"/> Decline to State |
|---|--|

|  |  |  |
|--|--|--|
| <b>What was your sex at birth?</b>   | <b>What is your Gender?</b>  | <b>How do you describe your sexual orientation or sexual identity?</b>   |
| <input type="checkbox"/> Female<br><input type="checkbox"/> Male<br><input type="checkbox"/> Declined/not stated | <input type="checkbox"/> Female <input type="checkbox"/> Male<br><input type="checkbox"/> Transgender Female to Male<br><input type="checkbox"/> Transgender Male to Female<br><input type="checkbox"/> Genderqueer/Gender Non-binary<br><input type="checkbox"/> Declined/not stated<br><input type="checkbox"/> Not listed, please specify:<br>_____ | <input type="checkbox"/> Straight/Heterosexual<br><input type="checkbox"/> Bisexual<br><input type="checkbox"/> Gay/Lesbian/Same-Gender Loving<br><input type="checkbox"/> Questioning/Unsure<br><input type="checkbox"/> Declined/not stated<br><input type="checkbox"/> Not listed, please specify:<br>_____ |

**VETERAN STATUS:**

|  |  |
|--|--|
| <p><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.</p> | <p><input type="checkbox"/> I served in the United States military?<br/> <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?<br/> <input type="checkbox"/> No<br/> <input type="checkbox"/> Declined/no stated</p> |
|--|--|

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

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