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

Date:		**Phone:**		**Birth Date:** *(Required)*	
Name: *(Optional)*				***Unique Participant ID:**	
Street Address:			**City:**		**Zip:**
Email:		**Rural:** (91307,93066,93040)	☐Yes ☐ No ☐ Declined/no stated		
Preferred Language:		**Staff Completing Intake:**			

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

☐ American Indian or Alaska Native	☐ Hawaiian	☐ Other Asian
☐ Asian Indian	☐ Hispanic or Latino	☐ Other Pacific Islander
☐ Black or African American	☐ Japanese	☐ Other Race/Ethnicity
☐ Cambodian	☐ Korean	☐ Samoan
☐ Chinese	☐ Laotian	☐ Vietnamese
☐ Filipino	☐ Middle Eastern or North African	☐ White
☐ Guamanian		☐ 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):

IF MARRIED:	**IF SINGLE:**
☐ At or below Federal Poverty Level *($21,640/year or less)*	☐ At or below Federal Poverty Level *($15,960/year or less)*
☐ Above Federal Poverty Level *($21,641/year or more)*	☐ Above Federal Poverty Level *($15,961/year or more)*
☐ Decline to State	☐ 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
☐ Declined/not stated	☐ Transgender Male to Female	☐ Gay/Lesbian/Same-Gender Loving
	☐ Genderqueer/Gender Non-binary	☐ Questioning/Unsure
	☐ Declined/not stated	☐ Declined/not stated
	☐ Not listed, please specify: _____	☐ Not listed, please specify: _____

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.**	☐ I 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 ☐ Declined/no stated

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.

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:**
Case Opened Date: **Case Closed Date:**	☐ Advice ☐ Limited Representation ☐ Representation