ALU LIKE, Inc.,
Ke Ola Pono No Nā Kūpuna

KUMU KAHI INTAKE FORM

Intake Date:_____ KOPP Staff:_____ Site:_____

Personal Information

☐ Participant ☐ Spouse ☐ Care Recipient ☐ Volunteer

Client ID/SSN:_____Name:_____
[Not on database] First [Middle] Last [Suffix (Sr., Jr., etc)]

Ethnicity:_____ Gender:_____ Date of birth: (mm/dd/yyyy)_____

Mailing Address:_____
City State Zip

Street Address:_____
(if different from above)

Telephone: (H)_____ (W)_____ (C)_____ Email:_____

Verification of age: (circle one)
- Birth Certificate
- Senior bus pass
- Driver's license
- Baptismal certificate
- State ID
- Passport
- Other, specify_____

Verification of Hawaiian ethnicity: (circle one) Attach a clean copy for verification
- Birth certificate #_____
- Other, specify _____

Emergency Contacts

Contact Name #1:_____Relationship:_____

Address:_____
City Island Zip

Telephone number(s):_____

Contact Name #2:_____Relationship:_____

Address:_____
City Island Zip

Telephone number(s):_____

Functional Ability (Write **1** if client can do by self; **2** if needs occasional assistance, or **3** if always needs assistance.)

Instrumental Activities of Daily Living (IADLs)
- ____ Shopping
- ____ Light housework
- ____ Heavy housework
- ____ Taking medication
- ____ Managing finances
- ____ Ability to use phone
- ____ Preparing meals
- ____ Laundry
- ____ Transportation

Activities of Daily Living (ADLs)

Physical Self- Maintenance
- ____ Eating
- ____ Bathing
- ____ Dressing
- ____ Grooming

Physical Ambulation
- ____ Climbing stairs
- ____ Walking inside the home
- ____ Walking outside the home

Health

Have you ever been told you have any of the following? (Check all that apply)

• High blood pressure?	☐ Y ☐ N	• Lung Disease	☐ Y ☐ N
• High cholesterol?	☐ Y ☐ N	• Osteoporosis	☐ Y ☐ N
• Diabetes	☐ Y ☐ N	• Parkinson's Disease	☐ Y ☐ N
• Arthritis	☐ Y ☐ N	• Depression	☐ Y ☐ N
• Gout?	☐ Y ☐ N	• Dementia	☐ Y ☐ N
• Kidney problems?	☐ Y ☐ N	• Cancer	☐ Y ☐ N
• Edema (swollen arms/legs)	☐ Y ☐ N	• Blindness/vision loss	☐ Y ☐ N
• Asthma?	☐ Y ☐ N	• Cataracts or glaucoma?	☐ Y ☐ N
• Heart Disease	☐ Y ☐ N	• Hearing loss	☐ Y ☐ N

- Heart attack? ☐ Y ☐ N If Yes, when?_____
- Stroke? ☐ Y ☐ N If Yes, when?_____
- Food allergies? ☐ Y ☐ N If Yes, what food(s)?_____
- Special diet? ☐ Y ☐ N If yes, what?_____
- Other health conditions? ☐ Y ☐ N If yes, what?_____
- Do you take any medication? ☐ Y ☐ N If yes, how many?_____List medications (include prescriptions, la`au lapa `au, herbs, vitamins, aspirin, etc.)_____
_____
- Are you allergic to any medication? ☐ Y ☐ N If yes, what medication(s)?_____
- Do you need to take medication at lunch? ☐ Y ☐ N _____

Other Services (Write **1** if receives service, **2** if wants reference, **3** if not interested)
- ____ Senior center
- ____ Senior meals program
- ____ Home delivered meals
- ____ Additional food needs
- ____ Activity programs for health
- ____ Legal help
- ____ Help to determine services needed (Case Mgmt.)
- ____ Transportation/escort
- ____ Housing
- ____ Friendly visit/Phone reassurance
- ____ Personal care services
- ____Help with light housework (Chore Services)
- ____ Professional nursing care at home
- ____ Home therapy services
- ____ Counseling services
- ____ Support group

Permission obtained to make referral? ☐ Yes ☐ No

Family Responsibility

Are you a caregiver for a family member or friend? ☐ Yes ☐ No

Would you be interested in receiving caregiver services? (respite, information, assistance, etc.?) ☐ Yes ☐ No

Medical Coverage

Primary medical insurance:_____ Member #:_____

Primary Doctor: Name:_____ Address:_____

Phone:_____ Hospital:_____

Names of other health care people, specialists, healers (RN, nutritionist, chiropractor, kahuna, etc)

_____ _____

_____ _____

Background

• Do you live alone? ☐ Yes ☐ No

• If No, who lives in your home? (Relationship, example - daughter)

_____ _____ _____

_____ _____ _____

_____ _____ _____

What is your marital status? (circle one)

• Single • Married • Domestic Partnership • Separated • Divorced • Widowed

• Other • Decline to state

Site Participants Only:

What days of the week will you be able to regularly come for lunch/activities? (circle all that apply)

Lunch: M T W Th F Activities: M T W Th F

Are you able to provide your own transportation? ☐ Yes ☐ No

If Yes (circle all that apply): • Drive own car • Driven by other • Bus • Walk • Other_____

NUTRITIONAL RISK ASSESSMENT (NRAs)	YES	NO
1. Have you made changes in lifelong eating habits because of health problems? (such as diabetes, high blood pressure, etc.)	2	☐
2. Do you eat fewer than 2 complete meals per day?	3	☐
3. Do you eat fewer than 5 servings (1/2 cup each) of fruit (fruit juice) *or* vegetables every day?	1	☐
4. Do you have fewer than *2 servings of dairy products* (such as milk, yogurt, cheese) or tofu daily?	1	☐
5. Do you have any of the following problems that make it difficult for you to eat? ☐ Biting ☐ Chewing ☐ Swallowing	2	☐
6. Are there times when you do not have enough money to buy the food you need?	4	☐
7. Do you eat most meals alone?	1	☐
8. Do you take 3 *or more* prescribed *or* over the counter medications each day? (Including aspirin, laxatives, antacids, inhalers, herbs, etc.)	1	☐
9. Have you lost or gained 10 pounds in the last 6 months *without* trying? ☐ Loss ☐ Gain	2	☐
10. Are there times when you are not physically able to do one or more of the following? ☐ Shop for food ☐ Cook ☐ Eat on your own	2	☐
11. Do you have 3 or more drinks of beer, wine or liquor almost every day?	2	☐
Total YES		

(High risk score = 6+)

Additional Information

Highest education level completed (circle one)

• K- 5 • 6-8 • 9-11 • HS diploma/GED • College Level • Grad 2yr college • Grad 4 yr college

• Grad school • Unknown

What is your family income? (circle one)

$ 0 - $5,000	$35,001 - $45,000	$ 75,001 - $ 85,000
$ 5,001 - $15,000	$45,001 - $55,000	$ 85,001 - $100,000
$15,001 - $25,000	$55,001 - $65,000	$100,001 - $150,000
$25,001 - $35,000	$65,001 - $75,000	$150,001 +
Unknown		

Income Sources (circle all that apply & include monthly totals)

• Spouse's income/money from family
• Social Security
• SSI (Supplemental security income)
• DHS (welfare check)
• Food stamps
• Retirement or pension (incl. Military)
• Private rental income/property/investments/savings
• Employment wages/salary/business income
• Rent supplement
• Other, please specify_____
• None

Meal Delivery
Complete for Home Delivered Meals Participants

Temporary (<6months) HDM? ☐ Yes ☐ No

Recently released from hospital or rehabilitation facility? ☐ Yes ☐ No

If yes, date or scheduled date _____

Is help available to deliver meals? ☐ Yes ☐ No

If yes, specify_____

Number of days meal needed:_____

Explain_____

What are the plans for days when there is no home delivered meals? _____

_____

Physician Form completed and signed by Doctor? ☐ Yes ☐ No

Date to begin service:_____ Expected length of service:_____

Approval for HDM from Central? ☐ Yes ☐ No Date approved/by: _____

Date first reassessment to take place:_____

SPECIAL INSTRUCTIONS:_____

_____

Kūpuna Caregiver
How many individuals are you caring for? _____
Note: Complete an intake for each eligible care recipient (Native Hawaiian age 60+)

Where does the person you care for live? (Circle)

- With me
- In his/her own home or apartment (within thirty minutes drive from you)
- In his/her own home or apartment (more than a thirty minutes drive from you)
- In a care, foster or group home or other long-term care facility.
- Other - Explain: _____

Is this person your? (Explain relationship) _____

Are you the primary caregiver for this person? ☐ Yes ☐ No

How many unpaid caregiver hours do you provide each week? _____

On average, how many hours of paid help do you receive each week? Include adult day care, home care, etc.____
What type of help did you receive? _____

On average, how many hours of unpaid help do you receive each week? From family, friends, neighbors, volunteers, etc. _____

Are other family members or friends involved in the care provided? ☐ Yes ☐ No
How are others involved? _____

_____

Think about all the help you get from family and friends to look after your care recipient. Please indicate the one response that most identifies your situation. (Circle)

- I receive no help
- I receive about what I need in terms of help
- I receive far less help than I need
- I receive somewhat less help than I need
- I do not need any help

Which functional or health problems cause you the most concern in providing care?

_____

_____

Recommendation and Notes

Service Recommendation: _____

_____

_____

_____

_____

_____

Follow Up & Referrals Provided: _____

_____

_____

_____

Additional Notes: _____

_____

_____

_____

Signature - Complete for all kūpuna participants

I understand that this information will be kept confidential. I give ALU LIKE, Inc. permission to use this information to help plan and provide services for Native Hawaiians and/or for statistical purposes.

_____	_____	_____
Participant Signature	Date	Staff Initial