

PARTICIPANT REGISTRATION FORM

CONFIDENTIAL



IDN: _____

FTA Code _____
 AMHT CODE _____
 ADA # _____

****HD meals must include eligibility reason on pg 2.**

SITE: _____

DATE: _____

NAME (Last, First, Middle Initial): _____

PHYSICAL ADDRESS: _____

MAILING ADDRESS: _____ ZIP: _____

CITY, STATE: _____ EMAIL ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

BIRTHDATE: _____ GENDER: MALE _____ FEMALE _____
 GENDER IDENTITY: _____

******* This information is important for Federal funding *******

Ethnicity: Alaskan Native/American Indian Asian Black/African American
 Hispanic Origin Hawaiian/Other Pacific Islander White

DO YOU LIVE ALONE? YES _____ NO _____

ARE YOU A VETERAN? YES _____ NO _____

IS YOUR INCOME ABOVE (**\$1,568-1 person**) or (**\$2,128-Couple**) PER MONTH (Not including Senior Benefits Program and Permanent Fund Dividend)? YES _____ NO _____

SPOUSE'S NAME: _____

EMERGENCY CONTACT: _____ TELEPHONE #: _____

COMPLETE FOR QUALIFIED MEAL GUESTS UNDER 60 ONLY:

PLEASE CHECK :

ARE YOU A MEALTIME VOLUNTEER? YES ___ NO ___

IS YOUR SPOUSE OVER 60? YES ___ NO ___

DO YOU HAVE A DISABILITY AND LIVE IN HOUSING WHICH IS CONNECTED TO THIS SENIOR CENTER? YES ___ NO ___

SITE MANAGER PLEASE CHECK

	Congregate
	Transportation
	Home-Delivered Meals

Reviewed by Management
 By Whom: _____
 Title: _____
 Date: _____

(Please complete Back Side of this Form)

NAME OF PARTICIPANT _____

PARTICIPANT MUST COMPLETE ENTIRE PAGE

A. Nutritional Risk Questions (Circle the number if YES)

I have an illness or condition that made me change the kind and/amount of food I eat.	2
I eat fewer than two (2) meals per day.	3
I eat fewer than (5) servings of fruits & vegetables and 2 milk servings per day.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take three (3) or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained ten (10) pounds in the last six (6) months.	2
I am not always physically able to shop, cook, and/or feed myself.	2
TOTAL NUTRITIONAL SCORE	

Score Guide

0-2 Good! Recheck your nutritional score again in 6 months.

3-5 You are at **Moderate Nutritional Risk**. See what can be done to improve your eating habits and lifestyle. Your senior nutrition program can help. Recheck your nutritional score again in 3 months.

6+ You are at **High Nutritional Risk**. Bring this Checklist the next time you see your doctor, dietician or other qualified health or social service professional. Talk with them about any problems you have. Ask for help to improve your nutritional health.

Remember that Warning Signs suggest risk, but do not represent a diagnosis of any condition.

Do you ever need assistance from another person with any of the following activities? Please check the activity.

<input type="checkbox"/>	Preparing meals
<input type="checkbox"/>	Shopping for personal items
<input type="checkbox"/>	Medication management
<input type="checkbox"/>	Managing money
<input type="checkbox"/>	Using telephone
<input type="checkbox"/>	Doing heavy housework
<input type="checkbox"/>	Doing light housework
<input type="checkbox"/>	Using transportation
<input type="checkbox"/>	Total IADL's

<input type="checkbox"/>	Eating
<input type="checkbox"/>	Dressing
<input type="checkbox"/>	Bathing
<input type="checkbox"/>	Bathroom
<input type="checkbox"/>	Transferring in/out of bed/chair
<input type="checkbox"/>	Walking
<input type="checkbox"/>	Total ADL's

ADL's = Activities of Daily Living

IADL's = Instrumental Activities of Daily Living

Indicate if the participant uses a: walker _____ cane _____ wheelchair _____ crutches _____

Is the participant Homebound? YES _____ NO _____

**** ELIGIBILITY REASON FOR HOME DELIVERED MEALS:** _____

ADDITIONAL COMMENTS? _____

PARTICIPANT REFERRED BY: _____

FORM COMPLETED BY: _____