

YORK COUNTY AREA AGENCY ON AGING

REGISTRATION FOR CONGREGATE MEALS AND SENIOR CENTER SERVICES

(Please **PRINT** or **TYPE** Information)

Date:		Senior Center:	Windy Hill on the Campus
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REGISTRANT INFORMATION:

Last Name:	First:	Middle:	<input type="checkbox"/> Mr.	Birth Date:	
			<input type="checkbox"/> Mrs.	Age:	
		Nickname:	<input type="checkbox"/> Miss	Gender:	<input type="checkbox"/> Female
			<input type="checkbox"/> Ms.		<input type="checkbox"/> Male

Street Address:	Last Four Digits of Social Security #:	Telephone #
	XXX-XX-_____	()-

Municipality: (Township or Borough)	City:	State:	ZIP Code:
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Mailing Address (If different than street address):	
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Emergency Contact Name/ Relationship:	Emergency Contact Address:	Emergency Contact Telephone #:
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Physician's Name:	Physician's Address:	Physician's Telephone #:
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REGISTRANT CHARACTERISTICS:

Ethnicity:	Ethnic Race:	Marital Status:
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Non-Minority (White, non-Hispanic)	<input type="checkbox"/> Single
<input type="checkbox"/> Non-Hispanic or Latino	<input type="checkbox"/> Black/ African American	<input type="checkbox"/> Married
<input type="checkbox"/> Unknown	<input type="checkbox"/> White-Hispanic	<input type="checkbox"/> Legally Separated
	<input type="checkbox"/> Asian	<input type="checkbox"/> Divorced
	<input type="checkbox"/> Native Hawaiian/ Other Pacific Islander	<input type="checkbox"/> Widowed
	<input type="checkbox"/> American Indian/ Native Alaskan	
	<input type="checkbox"/> Other	

Registrant is a Veteran? Yes No Branch _____

Registrant is a spouse, widow or dependent child of a veteran? Yes No

Registrant is receiving Veteran's benefits? Yes No

Income:	ACCESS Card:
<input type="checkbox"/> Above Poverty	<input type="checkbox"/> Yes
<input type="checkbox"/> Below Poverty	<input type="checkbox"/> No

The United States Department of Health and Human Services bases their poverty guidelines on a household's yearly income. The current figures are \$11,770 for one (1) person; \$15,930 for 2. (Add \$4,160 for each additional person in household.)

Registrant is Frail:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Registrant is Disabled:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Registrant Lives Alone:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Registrant has Adequate Housing:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Check all mobility aids, if any, that registrant uses:		
<input type="checkbox"/> Manual Wheelchair	<input type="checkbox"/> Walker	<input type="checkbox"/> Other (Describe)
<input type="checkbox"/> Electric Wheelchair	<input type="checkbox"/> Cane	
<input type="checkbox"/> Power Scooter	<input type="checkbox"/> Guide Dog	
Registrant needs an escort: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Registrant's disability/ disabilities Senior Center needs to be aware of: (Describe below)		
Registrant is nutritionally at risk:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Complete Nutritional Risk Questionnaire below
<i>I authorize the release and/or receipt of information necessary for the delivery of service to me. I hereby certify that the above information is true and correct to the best of my knowledge, information and belief.</i>		
Registrant's Signature:		Date:
Wedding Anniversary Date:		Email address:

DETERMINE Your Nutrition Health Questionnaire

Instructions: Read each statement below to the registrant. Circle the number in the "yes" column for those statements that apply to the registrant. Add all circled numbers for a determined score.

	YES
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than two (2) meals per day.	3
I eat few fruits, vegetables or milk products.	2
I have three (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 do not 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	

Total your Nutritional Score. If it is:

0-2

Good!

3-5

You are at moderate risk.

6 or higher

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. Also, contact YCAA for consumer eligibility for nutrition counseling.

November 7, 2016