YORK COUNTY AREA AGENCY ON AGING
Registration for Congregate Meals and Senior Center Services

Today's date:	Senior Center Name: Red Land

REGISTRANT INFORMATION

Last Name: First: Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Birth Date: / /	Age:	Gender:

Street address:	City:	State:	Zip Code:

Mailing address if different than street address:	Home phone no.: ( )

Municipality: ❑ Fairview Twp. ❑ Newberry Twp. ❑ Warrington Twp. ❑ Lewisberry Borough ❑ Goldsboro Borough ❑ York Haven Borough ❑Other _____	Last Four Digits of Social Security no.: --- --- --- ---	Email: I would prefer to receive my newsletter via: ❑ Email ❑ US Mail ❑ Pick up at the center

Emergency Contact Name:	Emergency Contact Address:	Emergency Contact Phone No.:
		( )

Physician Name:	Physician Address:	Physician Phone No.:
		( )

REGISTRANT CHARACTERISTICS

Ethnicity:	Ethnic Race:		Marital status: (circle one)
❑ Hispanic or Latino ❑Not Hispanic or Latino ❑ Unknown	❑ Non-Minority (White, non-Hispanic) ❑ Black/African American ❑Native Hawaiian/Other Pacific Islander	❑ White Hispanic ❑ American Indian/Native Alaskan ❑ Asian ❑ Other	Single / Mar / Div / Sep / Wid

Registrant is a veteran? ❑ Yes ❑ No
Registrant is the spouse/widow or dependent child of a veteran? ❑ Yes ❑ No
Registrant is receiving veteran's benefits? ❑ Yes ❑ No

Income: ❑ Above Poverty ❑ Below Poverty	Registrant has an Access Card ❑ Yes ❑ 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 and $15,930 for two (2) persons (add $4,160 for each additional person in household).

Registrant is Frail	❑ Yes	❑ No
Registrant is Disabled	❑ Yes	❑ No
Registrant has Adequate Housing	❑ Yes	❑ No
Registrant Lives Alone	❑ Yes	❑ No

Check all of the mobility aids, if any, that you are using:

❑ Manual Wheelchair ❑ Electric Wheelchair ❑ Power Scooter ❑ Walker ❑ Cane ❑ Guide Dog ❑ Other

Registrant needs an escort ❑ Yes ❑ No

Registrant has effects of their disability which the Senior Center needs to be aware of:
Describe:

Registrant is Nutritionally at Risk: ❑ Yes ❑ No **(Complete nutritional risk questionnaire on reverse side)**

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.

Registrant Signature Date

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 total nutritional 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 2 meals per day.	3
I eat few fruits or vegetables, or milk products.	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 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and/or feed myself.	2

Total Your Nutritional Score. If it's -

0-2 **Good!**

3-5 **You are at moderate nutritional 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 YCAAA for consumer eligibility for nutrition counseling.