

## **RED LAND SENIOR CITIZEN'S CENTER**

An Equal Opportunity Organization 736 Wyndamere Road, Lewisberry, PA 17339

Phone: (717)938.4649

(Please <u>PRINT</u> or <u>TYPE</u> information) | Questions in <u>BOLD</u> are required

PERSONAL Age: Too INFORMATION		Today's Date:	D.O.B.	Social	Social Senior Center PSA #2	
		//	/	/ Security # xxx-xx		
Salutation: 1	□ AAr □ AAre I	□Ms. □ Dr. □ Rev. □ Other:				
	□ /VII. □ /VII3. I	ivis. L Di. L kev. L Oillei.				
Name: Last		First	Middle	Suffix	Goes By:	
		11131	Middle	JOHA	COC3 By.	
Address:	Street	City		State	Zip	
<b>Mailing:</b> (If different) _						
	Street	City		State	Zip	
County:			Municipality:			
				Card Id:	n	
Phone Number:		Cell Phone Numb	Cell Phone Number:		CP Alt. Phone Number:	
Email Address:		Does the registra	Does the registrant have Medicare?		If Yes, Medicare #:	
		☐ Yes (see next o				
		☐ No (skip next c	question)			
Gender assigned at birth:  ☐ Female   ☐ Male ☐ Something else not named:		le	Gender Identity:  □ Female   □ Male □ Non-binary □ Transgender Female (male to female)		Sexual Orientation:  Straight or Heterosexual  Bisexual  Lesbian, Gay/Homosexual	
☐ Choose not to disclose		Se Choose not to	<ul><li>□ Transgender Male (female to male)</li><li>□ Choose not to disclose</li><li>□ Something else not named:</li></ul>		☐ Don't know ☐ Choose not to disclose ☐ Something else not named:	
☐ Yes☐ No☐ Unknow The curren	n t Federal Po	al income less than 100% of the come less than 100% of the come less than 100% of the le	590 for one (1) pers	on annually; \$1831	0 for two (2). Add	
Does the registrant have a Medicaid Number?		re a If, Yes, what is the	If, Yes, what is the number?		Does the Registrant have other insurance?  □ Yes: Name of Insurance:	
□ No □ Pending				□ No		
Check all benefits the registrar  Food Stamps LIHEAP Medicaid PACE		□ Section 8 □ Subsidized Tro □ Tax & Rent Re	. •		Are you a veteran?  Pes   No Spouse or widow of a veteran?  Yes   No	
_ · · · · · · _		☐ Other:			Do you receive Veteran's	

		Benetits?	
Living Arrangement:  Lives Alone  Lives with Spouse Only  Lives with Children, but not spouse  Lives with other Family Members  Other:	Type of PERMANENT residence in which you live?  Apartment Domiciliary Care Group Home Own Home Personal Care Home Relative's Home Rehab Facility State Institution Other:	Years living at	□ No same address:
Ethnicity:   Hispanic or Latino  Not Hispanic or Latino  Unknown	Ethnic Race:  American Indian/Native Alaskan  Asian  Black/African American  Native Hawaiian/Other Pacific Islander  Non—Minority (White/Non-Hispanic)  Unknown  Other	Marital Status	:
Emergency Contact			
	Emergency Name:	Nutrition Score	e:
Emergency Phone:			
()			
Emergency Phone 2:			
- ·			
	(Continued on other side)		

1. I have an illness or condition that has made me change the kind and/or amount of food I eat

No 🔻

2. I eat fewer than 2 meals per day



3. I eat few fruits or vegetables or milk products	No	<u> </u>
4. I have 3 or more drinks of beer, liquor, or wine almost every day	No	•
5. I have tooth or mouth problems that make it hard for me to eat	No	Ŧ
6. I don't always have enough money to buy the food I need	No	Ŧ
7. I eat alone most of the time	No	<b>-</b>
8. I take 3 or more different prescribed or over-the-counter drugs per day	No	<b>-</b>
9. Without wanting to, I have lost or gained 10 pounds in the last 6 months	No	Ŧ
10. I am not always physically able to shop, cook, and/or feed myself	No	<b>-</b>

Total Score: