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.

YORK COUNTY AREA AGENCY ON AGING

REGISTRATION FOR CONGREGATE MEALS AND SENIOR CENTER SERVICES

(Please PRINT or TYPE Information)

1.1.A.1. Date:					**Senior Center PSA# 25**
2. Last Name:	3. First:	4. Middle:	5. Suffix:	6. Nickname:	7. Date of Birth:

8a. Current gender identity:	8b. Gender assigned at birth:	8c. Sexual orientation:	9. Registrant's Ethnicity:
☐ Female ☐ Male ☐ Non-binary ☐ Transgender female (male to female) ☐ Transgender male (female to male) ☐ Choose not to disclose ☐ Something else not named:	☐Female ☐Male ☐Something else not named: ☐Choose not to disclose	☐ Straight or Heterosexual ☐ Bisexual ☐ Lesbian, Gay or Homosexual ☐ Don't Know ☐ Something else not named: ☐ Choose not to disclose	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

10. Registrant's Race:	11. Last 4 digits of Social Security #:	12. Is the registrant's annual income less than 100% of the current Federal Poverty Income Guidelines (FPIG)?	13a. Does the registrant have a Medicaid number?
☐ American Indian/Native Alaskan ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Non-minority (White, non-Hispanic) ☐ Unknown ☐ Other	xxx-xx-_____	☐ Yes ☐ No ☐ Unknown The current Federal Poverty Guidelines are: $13,590 for one (1) person annually; $18,310 for 2. (Add $4,720 for each additional person in the household)	☐ Yes ☐ No ☐ Pending 13b. If Yes, what is the number? _____

14a. Does the registrant have Medicare?	15a. Does the registrant have other insurance?	16. Check all benefits the registrant is currently receiving:	
☐ Yes 14b. Medicare # _____ ☐ No	☐ Yes: 15b. Name of insurance: _____ ☐ No	☐ Food Stamps ☐ LIHEAP ☐ Medicaid ☐ PACE	☐ Section 8 ☐ Subsidized Transit ☐ Tax & Rent Rebates ☐ Weatherization ☐ Other:

1.C. Registrant Demographics: 1a. Are you homeless? ☐ Yes ☐ No If yes, answer questions a – c	1b. Do you have a place to stay tonight? ☐ Yes ☐ No	1c. Do you have a place to stay long-term? ☐ Yes ☐ No	1d. Explain homeless situation: ☐ Cannot afford housing ☐ Evicted ☐ Housing not available ☐ Voluntary Other:

2. Type of **PERMANENT** residence in which you reside:	3. What is your **PERMANENT** living arrangement?	4. What is your marital status?	**Veteran Questions**
☐ Apartment ☐ Domiciliary Care ☐ Group Home ☐ Own Home ☐ Personal Care Home ☐ Relative's Home ☐ Rehab Facility ☐ State Institution Other::	☐ Lives Alone ☐ Lives with Spouse Only ☐ Lives with Children, but not spouse ☐ Lives with other Family Members ☐ Other:	☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed Other: If married, when is your anniversary? _____	5a. Are you a Veteran? ☐ Yes Branch: _____ ☐ No 5b. Are you a spouse or widow of a veteran? ☐ Yes ☐ No 5c. Do you receive Veteran's benefits? ☐ Yes ☐ No

6a. Do you require communication assistance? ☐ Yes ☐ No	6b. If **Yes**, select which assistance is required: ☐ Assistive Technology ☐ Interpreter	☐ Large Print ☐ Picture Book	☐ Unable to Communicate ☐ Unknown Other:_____

7a. Do you use sign language as your **PRIMARY** language? ☐ Yes – 7b. Specify type used: _____ ☐ No	8. What is your **PRIMARY** language? ☐ English ☐ Russian ☐ Spanish ☐ Other: _____	9. Are you considered disabled? ☐ Yes ☐ No

1.D. Registrant's Permanent Residential Address Information

2a. County:		2b. Street Address:	
2d. Municipality (Township/Borough):		2c. Second Line Street Address:	
2e. City:	2f. State:	2g. Zip Code:	
4. Does the registrant reside in a rural area? ☐ Yes ☐ No	5a. Primary Phone #:	5b. Mobile Phone #:	5c. Other Phone #:

5d. Email Address:	6. Voter Registration: ☐ Already registered ☐ Not interested	☐ Info requested ☐ Does not meet voter requirements

1.E. Mailing Address (If different than street address):

1a. Postal Address 1st Line:			
1b. 2nd Line:	1c. City:	1d. State:	1e. Zip Code:

1.F.1. Emergency Contact's Name & 2. Relationship:

Physician's Name:	3. Emergency Contact's Phone Number:	4. Emergency Contact's Other Phone #:

2.A. Dietary Issues:

1. Do you generally have a good appetite? ☐ Yes ☐ No	2. Do you use a dietary supplement? ☐ Yes ☐ No	3. Do you have any food allergies? ☐ Yes ☐ No If yes, list:
4. Do you have a special diet for medical reasons? ☐ Yes ☐ No If yes, list:		5. Do you have a special diet for religious/cultural reasons? ☐ Yes ☐ No If yes, list:

2.B. Nutritional Risk Information

1. Has there been a change in your lifelong eating habits because of health problems? ☐ Yes ☐ No If yes, explain:	2. Do you eat fewer than 2 meals per day? ☐ Yes ☐ No If yes, explain:	3.Do you eat fewer than 2 services of dairy products every day? ☐ Yes ☐ No	4. Do you eat fewer than 5 services of fruits or vegetables each day? ☐ Yes ☐ No
5. Do you have 3 or more drinks of beer, liquor or wine almost every day? ☐ Yes ☐ No	6. Do you have trouble eating due to problems with chewing/swallowing? ☐ Yes ☐ No	7. Do you **not have** enough money to buy food needed? ☐ Yes ☐ No	8. Do you eat alone most of the time? ☐ Yes ☐ No
9. Do you take 3 or more prescribed or over-the-counter drugs per day? ☐ Yes ☐ No	10. Have you lost or gained at least 10 pounds or more in the last **6 months**? ☐ Yes ☐ No	11. Are you **not always** able to physically shop, cook and/or feed yourself (or to get someone to do it for you)? ☐ Yes ☐ No	