

YORK COUNTY AREA AGENCY ON AGING

REGISTRATION FOR CONGREGATE MEALS AND SENIOR CENTER SERVICES

(Please **PRINT** or **TYPE** Information) Questions in **BOLD** are required.

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: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Transgender female (male to female) <input type="checkbox"/> Transgender male (female to male) <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Something else not named:	8b. Gender assigned at birth: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Something else not named: <input type="checkbox"/> Choose not to disclose	8c. Sexual orientation: <input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian, Gay or Homosexual <input type="checkbox"/> Don't Know <input type="checkbox"/> Something else not named: <input type="checkbox"/> Choose not to disclose		9. Registrant's Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
10. Registrant's Race: <input type="checkbox"/> American Indian/Native Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Non-minority (White, non-Hispanic) <input type="checkbox"/> Unknown <input type="checkbox"/> Other	11. Last 4 digits of Social Security #: xxx-xx-_____	12. Is the registrant's annual income less than 100% of the current Federal Poverty Income Guidelines (FPIG)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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)		13a. Does the registrant have a Medicaid number? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending 13b. If Yes, what is the number? _____	
14a. Does the registrant have Medicare? <input type="checkbox"/> Yes 14b. Medicare # _____ <input type="checkbox"/> No	15a. Does the registrant have other insurance? <input type="checkbox"/> Yes: 15b. Name of insurance: _____ <input type="checkbox"/> No	16. Check all benefits the registrant is currently receiving: <input type="checkbox"/> Food Stamps <input type="checkbox"/> LIHEAP <input type="checkbox"/> Medicaid <input type="checkbox"/> PACE		<input type="checkbox"/> Section 8 <input type="checkbox"/> Subsidized Transit <input type="checkbox"/> Tax & Rent Rebates <input type="checkbox"/> Weatherization <input type="checkbox"/> Other:	
1.C. Registrant Demographics: 1a. Are you homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No <div style="text-align: center; margin-top: 10px;"> </div> If yes, answer questions a – c	1b. Do you have a place to stay tonight? <input type="checkbox"/> Yes <input type="checkbox"/> No	1c. Do you have a place to stay long-term? <input type="checkbox"/> Yes <input type="checkbox"/> No	1d. Explain homeless situation: <input type="checkbox"/> Cannot afford housing <input type="checkbox"/> Evicted <input type="checkbox"/> Housing not available <input type="checkbox"/> Voluntary Other:		
2. Type of PERMANENT residence in which you reside: <input type="checkbox"/> Apartment <input type="checkbox"/> Domiciliary Care <input type="checkbox"/> Group Home <input type="checkbox"/> Own Home <input type="checkbox"/> Personal Care Home <input type="checkbox"/> Relative's Home <input type="checkbox"/> Rehab Facility <input type="checkbox"/> State Institution Other::	3. What is your PERMANENT living arrangement? <input type="checkbox"/> Lives Alone <input type="checkbox"/> Lives with Spouse Only <input type="checkbox"/> Lives with Children, but not spouse <input type="checkbox"/> Lives with other Family Members <input type="checkbox"/> Other:		4. What is your marital status? <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed Other:	Veteran Questions 5a. Are you a Veteran? <input type="checkbox"/> Yes Branch: _____ <input type="checkbox"/> No 5b. Are you a spouse or widow of a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No 5c. Do you receive Veteran's benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	

6a. Do you require communication assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No		6b. If Yes, select which assistance is required: <input type="checkbox"/> Assistive Technology <input type="checkbox"/> Interpreter		<input type="checkbox"/> Large Print <input type="checkbox"/> Picture Book		<input type="checkbox"/> Unable to Communicate <input type="checkbox"/> Unknown Other: _____	
7. Do you use sign language as your PRIMARY language? <input type="checkbox"/> Yes – 7b. Specify type used: _____ <input type="checkbox"/> No			8. What is your PRIMARY language? <input type="checkbox"/> English <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____			9. Are you considered disabled? <input type="checkbox"/> Yes <input type="checkbox"/> 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:		
3. How would you like to receive your newsletter? <input type="checkbox"/> Email <input type="checkbox"/> US Mail <input type="checkbox"/> Pick up at center			4a. Primary Phone #:		4b. Mobile Phone #:		4c. Other Phone #:
4d. Email Address:			5. Voter Registration: <input type="checkbox"/> Already registered <input type="checkbox"/> Not interested		<input type="checkbox"/> Info requested <input type="checkbox"/> 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:							
Emergency Contact 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		2. Do you use a dietary supplement? <input type="checkbox"/> Yes <input type="checkbox"/> No		3. Do you have any food allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list:			
4. Do you have a special diet for medical reasons? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list:				5. Do you have a special diet for religious/cultural reasons? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list:			
2.B. Nutritional Risk Information							
1. Has there been a change in your lifelong eating habits because of health problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:		2. Do you eat fewer than 2 meals per day? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:		3. Do you eat fewer than 2 servings of dairy products every day? <input type="checkbox"/> Yes <input type="checkbox"/> No		4. Do you eat fewer than 5 servings of fruits or vegetables each day? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Do you have 3 or more drinks of beer, liquor or wine almost every day? <input type="checkbox"/> Yes <input type="checkbox"/> No		6. Do you have trouble eating due to problems with chewing/ swallowing? <input type="checkbox"/> Yes <input type="checkbox"/> No		7. Do you <i>not</i> have enough money to buy food needed? <input type="checkbox"/> Yes <input type="checkbox"/> No		8. Do you eat alone most of the time? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Do you take 3 or more prescribed or over-the-counter drugs per day? <input type="checkbox"/> Yes <input type="checkbox"/> No		10. Have you lost or gained at least 10 pounds or more in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		11. Are you <i>not</i> always able to physically shop, cook and/or feed yourself (or to get someone to do it for you)? <input type="checkbox"/> Yes <input type="checkbox"/> No			