

**YORK COUNTY AREA AGENCY ON AGING  
REGISTRATION FOR CONGREGATE MEALS AND SENIOR CENTER SERVICES**

(Please Print or Type Information)

<b>Date:</b>	<b>Senior Center:</b>
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**REGISTRANT INFORMATION:**

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

<b>Street Address:</b>	<b>Last Four Digits of Social Security #:</b> XXX-XX-	<b>Telephone #:</b> ( ) -
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<b>Municipality (Township or Borough):</b>	<b>City:</b>	<b>State:</b>	<b>ZIP Code:</b>
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**Mailing Address (if different than street address):**

<b>Emergency Contact Name:</b>	<b>Emergency Contact Address:</b>	<b>Emergency Contact Telephone #:</b> ( ) -
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<b>Physician Name:</b>	<b>Physician Address:</b>	<b>Physician Telephone #:</b> ( ) -
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**REGISTRANT CHARACTERISTICS:**

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

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

<b>Income:</b>	<b>ACCESS Card?</b>
<input type="checkbox"/> Above Poverty <input type="checkbox"/> Below Poverty	<input type="checkbox"/> Yes <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 and \$15,930 for two (2) persons (add \$4,160 for each additional person in household).*

<b>Registrant is Frail:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Registrant is Disabled:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Registrant Lives Alone:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Registrant has Adequate Housing:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Check all mobility aids, if any, that registrant uses:</b>		
<input type="checkbox"/> Manual Wheelchair	<input type="checkbox"/> Walker	<input type="checkbox"/> Other (describe below)
<input type="checkbox"/> Electric Wheelchair	<input type="checkbox"/> Cane	
<input type="checkbox"/> Power Scooter	<input type="checkbox"/> Guide Dog	
<b>Registrant needs an escort:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Registrant disability/disabilities Senior Center needs to be aware of: (describe below)</b>		
<b>Registrant is nutritionally at risk:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Complete Nutritional Risk Questionnaire below</b>		
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.		
<b>Registrant Signature</b>		<b>Date</b>

## 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 two (2) meals per day.	3
I eat few fruits or 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
<b>TOTAL</b>	

**Total Your Nutritional Score. If it is:**

**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.**