

Form 5 – Consumer Registration Form

Registration	<input type="checkbox"/>	New	<input type="checkbox"/>	Update	<input type="checkbox"/>	NFCSP/Statewide Respite <small>(caregivers complete sections I, II, IV, Via, VIb, IX)</small>	<input type="checkbox"/>	Includes Service Data <small>(complete section IX)</small>
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I. SAMS Details – Personal

a.) Consumer Name	First: _____	Last: _____	
b.) Date:	____ / ____ / ____		
c.) Marital Status	<input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Civil Union <input type="checkbox"/> Unknown		
d.) Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male		
e.) Birth Date	____ / ____ / ____		f.) SSN (Social Security) 000-00-_____
g.) Default Agency	_____		

II. SAMS Details – Residential Address

a.) Street 1	_____		
b.) Street 2	_____		
d.) Town, Zip Code	Town: _____	State (if not CT) _____	Zip Code: _____
c.) County:		_____	

III. SAMS Details – Characteristics

a.) Cognitive Impairment	Has Alzheimer's disease or a related dementia. <input type="checkbox"/> Yes (mild) <input type="checkbox"/> No (none) <input type="checkbox"/> Unknown		
b.) Meal Eligibility Type	<input type="checkbox"/> Age 60 and Older <input type="checkbox"/> Disabled in Elderly Housing <input type="checkbox"/> Helper/Spouse <input type="checkbox"/> Not Indicated		
	<input type="checkbox"/> Other <input type="checkbox"/> Tribal Specification <input type="checkbox"/> Volunteer		

• Start Date: _____	• Referral Source: _____
• Client's Phone #: _____	Emergency Contact _____ Relationship _____ Phone _____
• Physician _____	Phone: _____
• Diagnosis: _____	
• Diet _____	
• Emergency Contact _____	Relationship: _____ Phone# _____
• Meal Type _____	• Frequency _____
• _____	• _____
Hot _____ Cold _____	Receives:
Kosher _____ Box _____	Food Stamps: <input type="checkbox"/>
	Health Insurance <input type="checkbox"/>
	SAGA Cash <input type="checkbox"/>
	SAGA Medical <input type="checkbox"/>

Notes: _____

VI. Assessment Form - Demographics

a.) Ethnicity	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown		
b.) Race Check all that apply	<input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Missing		
	<input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Non-Minority, White, Non-Hispanic <input type="checkbox"/> Other		
	<input type="checkbox"/> White, Hispanic		
c.) Housing	<input type="checkbox"/> Private Home <input type="checkbox"/> Private Apartment <input type="checkbox"/> Senior Housing <input type="checkbox"/> Congregate Housing		
	<input type="checkbox"/> Public Housing <input type="checkbox"/> Residential Care Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Assisted Living		
	<input type="checkbox"/> Other _____		
	<input type="checkbox"/> Unknown		

VI. Assessment Form – Demographics (Continued)

d.) Income (1/24/06) I live alone and my monthly income is about:

<input type="checkbox"/> Under \$817 (100%)	<input type="checkbox"/> \$818-\$1,021 (125%)	<input type="checkbox"/> \$1,022 - \$1,225 (150%)	<input type="checkbox"/> \$1,226-\$1,429 (175%)	<input type="checkbox"/> \$1,430-\$1,633 (200%)	<input type="checkbox"/> \$1634- or over (OVER 200%)	<input type="checkbox"/> Unknown
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I live with my spouse and our monthly income is about:

<input type="checkbox"/> Under \$1,100 (100%)	<input type="checkbox"/> \$1,101-\$1,371(125%)	<input type="checkbox"/> \$1,376-\$1,650(150%)	<input type="checkbox"/> \$1,651-\$1,925(175%)	<input type="checkbox"/> \$1,926-\$2,200(200%)	<input type="checkbox"/> \$2,201 or over (over200%)	<input type="checkbox"/> Unknown
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e.) In Poverty Yes No Unknown

f.) Living Arrangements Alone With Spouse/Partner With Spouse and Child/Children

With Child, No Spouse With Other Relatives With Others Unknown

VII. Assessment Form – Functional Status

a.) ADL/IADL I need help with these activities

On each line enter	— Eating	— Dressing	— Bathing/Washing	— Using the Toilet
Y for yes,	— Getting Out of Bed/Chair	— Walking	— Planning/Preparing Meals	— Shopping
N for no, or	— Managing Money	— Using the Telephone	— Heavy Housework	— Light Housework
U for unknown	— Taking Medicine	— Using Transportation	—	—

VIII. Assessment Form - Nutrition

a.) Nutritional Risk	Yes	No	Unknown	
For Consumers Receiving:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I have an illness or condition that made me change the kind or amount of food I eat. (2)
Case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I eat fewer than 2 meals per day. (3)
Congregate meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I eat fewer than 5 fruits and vegetables per day. (1)
Home-delivered meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I eat fewer than 2 servings of milk, cheese or yogurt each day. (1)
Nutritional counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I have problems chewing/swallowing that make it hard for me to eat. (2)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I do not always have enough money or food stamps to buy the food I need. (4)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I take 3 or more different prescription or over-the-counter drugs each day. (1)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I eat alone most of the time. (1)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I have 3 or more drinks of beer, liquor or wine almost every day. (2)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Without wanting to, I have lost or gained 10 pounds in the last 6 months. (2)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I am not always physically able to shop, cook or feed myself. (2)

IX. Service Delivery

a.) Site Name (if applicable):	_____				
b.) Service Category (if applicable)	c.) Service((sub-service)	d.) Fund Identifier	e.) Number of Units		
_____ /	_____ /	_____ /	_____ /		
_____ /	_____ /	_____ /	_____ /		
_____ /	_____ /	_____ /	_____ /		
_____ /	_____ /	_____ /	_____ /		

The confidential information on this form may be used for state, federal and local monitoring, including reporting requirements, program management, public safety and research. The personal identifying information on this form will not be further disclosed or used for any other purpose unless by court order or authorized by the program participant or consumer, or his or her personal representative.

Consumer Signature: _____