Home Delivered Meal Program Registration **Site:**_____

Please complete this form to the best of your ability. **Staff:**_____

Contact Date	Status	AAA Region	Eligibility Category (Check one): ☐ Client ☐ Spouse ☐ Volunteer ☐ Caregiver ☐ Disabled under 60	NAPIS ID Number - -

Section A. Basic Demographics

Last Name:	First Name:	Middle Initial:
Lives in Rural Area (Circle One): Yes No	Gender: ☐ Female ☐ Male ☐ Unspecified	Date of Birth: / /

Address:	Address #2:		
City:	State:	Zip Code:	County:

Home Phone: ( )	Mobile Phone: ( )	Work Phone: ( )

Section B. Social History

Race (Circle one): American Indian/Alaskan Asian White Hispanic White not Hispanic 2 or More Races Black/African American Native Hawaiian/Pacific Islander Other	Ethnicity (Circle one) Hispanic or Latino Non-Hispanic

Household Size (Circle One): I live alone. I live with others.

Section C. Financial

□ I live alone……..and my monthly income is between (circle one)

$1,041/month or less $1,042- $1,561/month $1,562-$2,082/month More than $2,083/month

□ I live with my **spouse**……..and our monthly income is between (circle one)

$1,409/month or less $1,410-$2,114/month $2,115-$2,818/month More than $2,819/month

Section D. Contacts

Emergency Phone: ( )	Emergency Contact Name	Emergency Contact Relationship

Section E. Nutrition Risk Assessment

Have you changed the way you eat due to illness or medical condition? Yes No	Are there times when you don't have enough money to buy the food you need? Yes No
Do you eat less than 2 meals a day? Yes No	Do you eat alone most of the time? Yes No
Do you eat few fruits or vegetables or milk products? Yes No	Do you take 3 or more prescribed or over-the-counter drugs each day? Yes No
Do you have 3 or more drinks of beer, liquor or wine almost every day? Yes No	Have you lost or gained 10 pounds in the last 6 months without wanting to? Yes No
Do you have tooth or mouth problems that make it hard to eat? Yes No	Are there times when you are not physically able to shop, cook or feed yourself? Yes No

OVER

Section F. Activities of Daily Living	
Can you walk around inside without any help? Yes No	Can you bathe or shower without any help? Yes No
Can you sit up or move around in bed without any help? Yes No	Can you use the toilet without any help? Yes No
Can you comb your hair, shave, wash your face, or brush your teeth without any help? Yes No	Can you dress without any help? Yes No
Can you get in and out of bed or chair without any help? Yes No	Can you manage eating without any help? Yes No
Section G. Independent Activities of Daily Living	
Can you answer the telephone or make a phone call without help? Yes No	Can you do heavy house cleaning, like yard work and laundry, without any help? Yes No
Can you shop for food and other things you need without help? Yes No	Can you take your medications without help? Yes No
Can you prepare meals for yourself without help? Yes No	Can you handle your own money, like keeping track of bills without help? Yes No
Can you do light housekeeping, like dusting or sweeping, without help? Yes No	Can you use public transportation or drive beyond walking distances without help? Yes No

Section H. Use of Information

I understand that the information I am providing on this form is for registration purposes. The information will be used by the U.S. Health and Human Services Administration for Community Living (ACL), the Minnesota Board on Aging (MBA) and the local Area Agency on Aging, to create statistical reports. ACL, MBA and/or its assignees may use this information to conduct a study and/or survey of this service. In addition, information provided here, may be used by other service providers to help identify other services from which I may benefit, such as follow up to the Nutrition Risk Assessment. This information will not be released to anyone other than the above mentioned parties in a way that will identify me as an individual unless I sign a separate consent for that purpose.

Signature:_____ Today's Date: _____