

CLIENT REGISTRATION FORMS

ADSD Grant Funding

Older Americans Act, Titles III-B, III-C, III-D, III-E
Independent Living Grant (ILG), State Volunteer and State Transportation

[ADSD General Service Specifications](#), Item 5: Programs shall update registration forms for all active clients in the first quarter of the fiscal year and complete registration forms on new clients as they enter the program. Any deviation from this schedule must be approved by ADSD. Clients must sign and date the registration form indicating that the information provided is correct.

Visit the General Service Specifications for additional information on client registration, SAMS data entry, Notice of Privacy Practices, etc.

The three client registration forms that follow are labeled as #1, #2 and #3 in the footer.

- Form #1 is for programs not addressed in forms #2 and #3.
- Form #2 is for the Title III-C Congregate Meal program.
- Form #3 is for programs that can be reimbursed under Medicaid, Medicare or other insurance.
 - ADSD funds are to be used as a last resort.
 - Search Medicaid Services Manual:
<http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/>
 - Search Medicare: <https://www.medicare.gov>

Agencies that are funded for multiple services by ADSD may use the registration form that collects information needed for all services.

Agencies may use a non-ADSD registration form if the form contains the same data elements as the ADSD registration form for the specific program(s).

The gray section at the bottom of each form may be changed to fit the needs of a specific program.

CLIENT REGISTRATION FORM

LEGAL NAME (First/Last): _____

NICKNAME: _____ MALE FEMALE

DATE OF BIRTH: _____ / _____ / _____ PHONE NUMBER: (_____) _____

PHYSICAL ADDRESS: _____ MAILING ADDRESS: _____

ADDRESS: _____ (If Different) _____

No Current Address/Residence

EMERGENCY CONTACT INFORMATION (Attach additional papers if more than one person):

NAME (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (_____) _____ WORK OR CELL PHONE: (_____) _____

ETHNICITY

HISPANIC OR LATINO

NON-HISPANIC OR LATINO

RACE

WHITE, CAUCASIAN HISPANIC

AMERICAN INDIAN / ALASKAN NATIVE

ASIAN BLACK / AFRICAN AMERICAN

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

OTHER _____

If you do not speak English, what is your primary language? _____

YOUR INCOME IS:

Please provide an answer on **both** lines:

BELOW POVERTY **OR** ABOVE POVERTY

And is also,

BELOW 300% SSI **OR** ABOVE 300% SSI

(The Service Provider will supply you with the current Federal Poverty Guidelines and 300% SSI amount.)

Activities of Daily Living (ADLs)

Without assistance, I am unable to:

Bathe Get Dressed

Eat Use the Bathroom

Walk Transfer In or Out of a Bed or Chair

None – I can perform these activities

DO YOU:

1. LIVE ALONE?..... Yes No

2. HAVE A DISABILITY? Yes No

3. CONSIDER YOURSELF FRAIL? Yes No

ARE YOU:

1. UNABLE TO LEAVE YOUR HOME WITHOUT ASSISTANCE (Homebound)?..... Yes No

2. A VETERAN / SERVED IN ARMED FORCES? Yes No

3. ON STATE MEDICAID? Yes No

4. A CAREGIVER? Yes No

IF YES, for whom do you provide care?

Spouse Child, Age 0-18 Adult Child, 18+

Parent Family Member Other _____

Instrumental Activities of Daily Living (IADLs)

Without assistance, I am unable to:

Prepare Meals Do Light Housework

Take Medication Do Heavy Housework

Manage Money Use the Telephone

Shop Use Transportation Services

None – I can perform these activities

I was provided the *Notice of Privacy Practices*

Client Signature _____ Date _____

(Initial or Revised Registration)

Client Signature – 2nd year _____ Date _____

(I certify that my information has not changed.)

FOR OFFICE USE ONLY

Services Registered For: _____

New to This Service? Y N

Nutrition Risk Assessment Score (HD Meals): _____

Site: _____

Notes: _____

CLIENT REGISTRATION FORM

LEGAL NAME (First/Last): _____

NICKNAME: _____ MALE FEMALE

DATE OF BIRTH: _____ / _____ / _____ PHONE NUMBER: (_____) _____

PHYSICAL ADDRESS: _____ MAILING ADDRESS: _____
(If Different) _____

No Current Address/Residence

EMERGENCY CONTACT INFORMATION:

NAME 1 (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (_____) _____ WORK OR CELL PHONE:(_____) _____

NAME 2 (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (_____) _____ WORK OR CELL PHONE:(_____) _____

ETHNICITY

- HISPANIC OR LATINO
- NON-HISPANIC OR LATINO

RACE

- WHITE, CAUCASIAN HISPANIC
- AMERICAN INDIAN / ALASKAN NATIVE
- ASIAN BLACK / AFRICAN AMERICAN
- NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- OTHER _____

If you do not speak English, what is your primary language? _____

YOUR INCOME IS:

(The Service Provider will supply you with the current Federal Poverty Guidelines and 300% SSI amount.)

Please provide an answer on both lines:

- BELOW POVERTY **OR** ABOVE POVERTY
- BELOW 300% SSI **OR** ABOVE 300% SSI

DO YOU:

- 1. LIVE ALONE?..... Yes No
- 2. HAVE A DISABILITY? Yes No
- 3. CONSIDER YOURSELF FRAIL?..... Yes No

ARE YOU:

- 1. UNABLE TO LEAVE YOUR HOME WITHOUT ASSISTANCE (Homebound)? Yes No
- 2. A VETERAN / SERVED IN ARMED FORCES? Yes No
- 3. ON STATE MEDICAID? Yes No
- 4. A CAREGIVER? Yes No

IF YES, for whom do you provide care?

- Spouse Child, Age 0-18 Adult Child, 18+
- Parent Family Member Other _____

I was provided the *Notice of Privacy Practices*

Client Signature Date
(Initial or Revised Registration)

Client Signature – 2nd year Date
(I certify that my information has not changed.)

FOR OFFICE USE ONLY

Services Registered For: _____ **New to This Service?** _____
 _____ Y N
 _____ Y N

Nutrition Risk Assessment Score: _____
Client ID: _____
Site/Notes: _____

CLIENT REGISTRATION FORM

LEGAL NAME (First/Last): _____

NICKNAME: _____ MALE FEMALE

DATE OF BIRTH: _____ / _____ / _____ PHONE NUMBER: (_____) _____

PHYSICAL ADDRESS: _____ MAILING ADDRESS: _____

No Current Address/Residence (If Different)

EMERGENCY CONTACT INFORMATION (Attach additional papers if more than one person):

NAME (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (_____) _____ WORK OR CELL PHONE: (_____) _____

ETHNICITY

HISPANIC OR LATINO

NON-HISPANIC OR LATINO

RACE

WHITE, CAUCASIAN HISPANIC

AMERICAN INDIAN / ALASKAN NATIVE

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NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

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If you do not speak English, what is your primary language? _____

YOUR INCOME IS:

(The Service Provider will supply you with the current Federal Poverty Guidelines and 300% SSI amount.)

Please provide an answer on both lines:

BELOW POVERTY **OR** ABOVE POVERTY

BELOW 300% SSI **OR** ABOVE 300% SSI

DO YOU:

1. LIVE ALONE?..... Yes No

2. HAVE A DISABILITY? Yes No

3. CONSIDER YOURSELF FRAIL? Yes No

ARE YOU:

1. UNABLE TO LEAVE YOUR HOME WITHOUT ASSISTANCE (Homebound)? Yes No

2. A VETERAN / SERVED IN ARMED FORCES? Yes No

3. ON STATE MEDICAID? Yes No

4. ON MEDICARE? Yes No

IF YES, Which Parts? (check all that apply)

Part A: Hospital Part B: Medical

Part C: HMO (Medicare Advantage)

Part D: Prescriptions

5. A CAREGIVER? Yes No

IF YES, for whom do you provide care?

Spouse Child, Age 0-18 Adult Child, 18+

Parent Family Member Other _____

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Without assistance, I am unable to:

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Manage Money Use the Telephone

Shop Use Transportation Services

None – I can perform these activities

Client Signature (Initial or Revised Registration) _____ Date _____

Client Signature – 2nd year _____ Date _____
(I certify that my information has not changed.)

FOR OFFICE USE ONLY

Services Registered For: _____	New to This Service? <input type="checkbox"/> Y <input type="checkbox"/> N	Other Insurance: _____
<input type="checkbox"/> _____	<input type="checkbox"/> Y <input type="checkbox"/> N	Client ID: _____
		Site/Notes: _____