

CLIENT REGISTRATION FORM

NAME (First/Last): _____ MALE FEMALE
 DATE OF BIRTH: _____ / _____ / _____ PHONE NUMBER: (____) _____
 PHYSICAL ADDRESS: _____ MAILING ADDRESS: _____
 ADDRESS: _____ (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

YOUR INCOME IS:

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

RACE

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

DO YOU LIVE ALONE?

Yes No

ARE YOU DISABLED?

Yes No

ARE YOU FRAIL?

Yes No

ARE YOU HOMEBOUND?

Yes No

ARE YOU A CAREGIVER?

Yes No

If you are a caregiver, who do you care for?

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

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

I was provided the *Notice of Privacy Practices*

WHICH OF THE FOLLOWING ARE YOU UNABLE TO PERFORM WITHOUT ASSISTANCE?

Activities of Daily Living (ADLs):

- Eating Dressing
 Bathing Toileting
 Transferring In/Out of a Bed/Chair
 None – I can perform these activities

Instrumental Activities of Daily Living (IADLs):

- Preparing Meals Light Housework
 Taking Medication Heavy Housework
 Managing Money Using the Telephone
 Shopping Using Transportation Services
 None – I can perform these activities

 Client Signature Date
(Initial or Revised Registration)

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

 Client Signature – 3rd year Date
 (I certify that my information has not changed.)

 Client Signature – 4th 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: _____
Site: _____
Notes: _____

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_____ (If Different) _____

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: (_____) _____

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- DO YOU LIVE ALONE?** Yes No
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Client ID: _____

Notes: _____