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: (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? _____

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**

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**

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.)

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 *(Initial or Revised Registration)* _____ Date _____

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

FOR OFFICE USE ONLY

Services Registered For:
☐ _____
☐ _____

New to This Service?
☐ Y ☐ N
☐ 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

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☐ 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 *(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?***

☐ _____ ☐ 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: _____ (If Different)

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(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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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?
☐ Y ☐ N
☐ Y ☐ N

Other Insurance: _____
Client ID: _____
Site/Notes: _____