AgeWell Services Program Registration

☐ New Enroll ☐ Re-Enroll

☐ AASA ☐ Millage ☐ Waiver

Today's Date: ____________ **Meal Site Location:** ____________

Last Name: ____________ **First Name:** ____________ **Middle Initial:** ______

Street Address: ____________ **City:** ____________ **State:** ______

Zip Code: ____________ **County:** ____________ **Township:** ____________

Phone Number: (________) ____________ ☐ Cell ☐ Home ☐ Work

Email Address: ____________ ☐ Home ☐ Work

Emergency Contact Name: ____________ **Relationship:** ____________

Emergency Contact Phone: (________) ____________ **Primary Doctor:** ____________

Date of Birth (MM/DD/YYYY): ____/____/____ **Gender:** ☐ Male ☐ Female ☐ Other ☐ Prefer not to say ☐ No response/Unknown

Do you consider yourself to be transgender or gender non-conforming? ☐ Yes ☐ No

Veteran Status: ☐ Veteran ☐ Veteran Dependent

Monthly Income: ☐ Below $1,041 single ☐ Below $1,414 couple ☐ Above $1,041 single ☐ Above $1,414 couple

Ethnicity:
- ☐ White
- ☐ Asian
- ☐ Black/African American
- ☐ American Indian/Eskimo/Aleut
- ☐ Hawaiian/Pacific Islander
- ☐ Hispanic or Latino
- ☐ Tribal
- ☐ Multi-racial

Household Size:
- ☐ Lives alone
- ☐ Lives with spouse
- ☐ Lives with family
- ☐ Other: ____________

Marital Status:
- ☐ Divorced
- ☐ Married
- ☐ Separated
- ☐ Single
- ☐ Widowed

Client Sexual Orientation:
- ☐ Straight/Heterosexual
- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Prefer not to say
- ☐ Other
- ☐ No response/Unknown

Handicapped:
- ☐ Yes
- ☐ No

Frail & Disabled
- ☐ Yes
- ☐ No

Nutrition Screening Tool for Older Adults	YES	Score	Total Score:
I have an illness or condition that made me change the kind/amount of food I eat.		2	
I eat fewer than 2 meals per day.		3	0-2: No risk
I eat few fruit, vegetable or milk products each day.		2	
I have 3 or more drinks of beer, wine or liquor each day.		2	
I have tooth or mouth problems that make it hard for me to eat.		2	3-5: Moderate risk
I don't always have the money I need to buy the food I need.		4	
I eat alone most of the time.		1	6+: High risk
I take 3 or more different prescribed or over-the-counter drugs a day.		1	
Without wanting to, I have lost or gained 10 pounds in the last 6 months.		2	
I am not always physically able to shop, cook or feed myself.		2	

Registration is required each fiscal year. The funding for this program depends on accurate statistical date for our state & federal legislators. The more we have, the better chances of funding. Only statistical data is used, no personal information is provided without prior consent from you. Documents are shredded. We appreciate the cooperation and support for the meal site program.

If I choose to take any left-over food home that I have not eaten at the center, I accept all liability of food safety issues and have been provided information about food borne illness and food safety.

Signature: ____________________ Date: ____________

I certify that the facts contained in this application are true and complete to the best of my knowledge.

For Office Use Only

Services: / **Start Date:**
- ☐ Congregate Meals ________
- ☐ Nutrition Education ________
- ☐ Senior Activities ________

☐ EAA ________

Transportation: / **Start Date:**
- ☐ Dynamic (bus, van, taxi) ________
- ☐ Volunteer (paid mileage) ________

Eligibility:
- ☐ 60+ Participant
- ☐ Under 60, Spouse of 60+
- ☐ Disabled under 60

________ Office/Coordinator Checked for Eligibility (Initials) ________ Office Entered in System (Initials)

Please See Reverse Side To Fill Out Wellness Medical Form

AgeWell Services Wellness Medical Form

How did you hear about us? ☐ TV ☐ Community Event ☐ Website ☐ Facebook ☐ Friend or Family

Hospital Preference: ______________________________

List Current Medications & Dosage:

____

____

____

____

List Any Medication/Food Allergies:

____

____

____

List Special Health Information including chronic illnesses, surgeries, etc.:

____

____

____

I understand that this information will be used in emergency situations only as a means to provide me with the proper care in case of illness or accident. I understand that all expenses incurred in an emergency situation are my responsibility and not that of AgeWell Services and that it is my responsibility to update this form as changes in my information occur.

I understand that this information is considered very confidential and will not be used for any supplementary purposes. I authorize AgeWell Services to utilize any photographs; personal narrative, interviews or audio and video recording of my participation in any AgeWell Services event for any and all purposes to help promote the program.

☐ Check if you do NOT want photos, etc. used

Email Address (optional): ______________________________

Signature: ______________________________ Date: ______________

For Office Use Only

Name Tag	______________	Orientation	______________
Membership Type	______________	Keytag #	______________