

AgeWell Services Program Registration



- New Enroll AASA
 Re-Enroll Millage
 Waiver

Key Tag # _____

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/
 Do you consider yourself to be transgender or gender non-conforming? Yes No Unknown
Veteran Status: Veteran Veteran Dependent
Monthly Income: Below \$1,215 single Below \$1,643 couple Above \$1,215 single Above \$1,643 couple

Ethnicity:	Household Size:	Marital Status:	Client Sexual Orientation:	Handicapped:
<input type="checkbox"/> White	<input type="checkbox"/> Lives alone	<input type="checkbox"/> Divorced	<input type="checkbox"/> Straight/Heterosexual	<input type="checkbox"/> Yes
<input type="checkbox"/> Asian	<input type="checkbox"/> Lives with spouse	<input type="checkbox"/> Married	<input type="checkbox"/> Lesbian	<input type="checkbox"/> No
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Lives with family	<input type="checkbox"/> Separated	<input type="checkbox"/> Gay	
<input type="checkbox"/> American Indian/Eskimo/Aleut	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Single	<input type="checkbox"/> Bisexual	
<input type="checkbox"/> Hawaiian/Pacific Islander		<input type="checkbox"/> Widowed	<input type="checkbox"/> Prefer not to say	Frail & Disabled
<input type="checkbox"/> Hispanic or Latino			<input type="checkbox"/> Other	<input type="checkbox"/> Yes
<input type="checkbox"/> Tribal			<input type="checkbox"/> No response/Unknown	<input type="checkbox"/> No
<input type="checkbox"/> Multi-racial				

Nutrition Screening Tool for Older Adults	YES	Score	Total Score: 0-2: No risk 3-5: Moderate risk 6+: High risk
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	
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	
I don't always have the money I need to buy the food I need.		4	
I eat alone most of the time.		1	
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 data 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: Congregate Meals Nutrition Education Senior Activities **Start Date:** _____
 EAA Dynamic (bus, van, taxi) Volunteer (paid mileage) **Start Date:** _____
Eligibility: 60+ Participant Under 60, Spouse of 60+ Disabled under 60

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

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 # _____