



# CLIENT PROGRAM REGISTRATION

DISCOUNT DINE, LUNCH & ACTIVITY CENTERS AND SENIOR COMMUNITY ACTIVITIES

Site Name: \_\_\_\_\_

Start Date: \_\_\_\_\_

## CLIENT INFORMATION

Name: \_\_\_\_\_

Address (street, city, state, zip): \_\_\_\_\_

County: \_\_\_\_\_

Township: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_  Cell

Emergency Contact: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

## CLIENT DEMOGRAPHICS

Date of Birth (MM / DD / YYYY): \_\_\_\_\_

Disabled:  Yes  No

Gender:  Male  Female  Transgender  Gender Non-Confirming  Other  Prefer Not to Identify

Sexual Orientation:  Straight / Heterosexual  Lesbian  Gay  Bisexual  
 Other  Prefer Not to Identify

Marital Status:  
 Divorced  
 Married  
 Separated  
 Single  
 Widowed

Race:  American Indian / Eskimo / Aleut  
 Asian  
 Black / African American  
 Hawaiian / Pacific Islander  
 Two or More Races  
 White

Ethnicity:  Hispanic or Latino  
 Not Hispanic or Latino

Household Composition:  
 Lives Alone  Lives with Spouse  
 Lives with Family (other than spouse)  
 Other

# in Household: \_\_\_\_\_

Did you enlist or serve in the military?  
 Yes  No If yes, which branch? \_\_\_\_\_

Spouse of a military member?  
 Yes  No

Are you part of a tribe?  
 Yes  No  
If yes, which tribe? \_\_\_\_\_

Monthly Income: If single, is your income more or less than \$1,330 per month?  Less  More  
If couple, is your combined income more or less than \$1,803 per month?  Less  More

## CLIENT NUTRITION SCREENING TOOL

Statement	Score (circle if yes)
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
Score (circle): 0 - 2: No risk 3 - 5: Moderate risk 6+: High risk Total Score: _____	

## CLIENT CONSENT AND RELEASE OF LIABILITY

Registration is required each fiscal year. Program funding relies on accurate participation data reported to State and Federal Legislators. No personal information is shared without your consent and all documents are securely shredded. By choosing to take uneaten food home, you agree that you've been provided information about food borne illness and food safety and vaccept all responsibility for food safety. By participating in any AgeWell Services activity, you assume all risks and release and hold harmless AgeWell Services, its staff and partners from any liability related to your participation.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

## FOR AGENCY AND PARTNER STAFF USE ONLY

Eligibility	Programs	Funding Sources	Referral(s)	Enrollment Type
<input type="checkbox"/> 60+ client	<input type="checkbox"/> Discount Dine	<input type="checkbox"/> ACLS Bureau	<input type="checkbox"/> SafeSeniors	<input type="checkbox"/> New Enroll
<input type="checkbox"/> Under 59, spouse of 60+	<input type="checkbox"/> Congregate	<input type="checkbox"/> MCSM	<input type="checkbox"/> STP	<input type="checkbox"/> Re-Enroll
<input type="checkbox"/> Disabled under 59	<input type="checkbox"/> SCA	<input type="checkbox"/> Waiver	<input type="checkbox"/> Other	

Checked for Eligibility (Initial): \_\_\_\_\_ Entered in ServTracker (Initial): \_\_\_\_\_

Key Tag # \_\_\_\_\_