YORK COUNTY AREA AGENCY ON AGING

REGISTRATION FOR CONGREGATE MEALS AND SENIOR CENTER SERVICES

(Please PRINT or TYPE Information)

Date:		Senior Center:	Windy Hill on the Campus

REGISTRANT INFORMATION:

Last Name:	First:	Middle: Nickname:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Birth Date: Age: Gender:	☐ Female ☐ Male

Street Address:	Last Four Digits of Social Security #: XXX-XX-_____	Telephone # ( )-

Municipality: (Township or Borough)	City:	State:	ZIP Code:

Mailing Address (If different than street address):	

Emergency Contact Name & Relationship:	Emergency Contact Address:	Emergency Contact Telephone #: ( )-

Physician's Name:	Physician's Address:	Physician's Telephone #: ( )-

REGISTRANT CHARACTERISTICS:

Ethnicity:	Ethnic Race:	Marital Status:
☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown	☐ Non-Minority (White, non-Hispanic) ☐ Black/ African American ☐ White-Hispanic ☐ Asian ☐ Native Hawaiian/ Other Pacific Islander ☐ American Indian/ Native Alaskan ☐ Other	☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed

Registrant is a Veteran? ☐ Yes ☐ No Branch_____
Registrant is a spouse, widow or dependent child of a veteran? ☐ Yes ☐ No
Registrant is receiving Veteran's benefits? ☐ Yes ☐ No

Income:	☐ Above Poverty ☐ Below Poverty	ACCESS Card:	☐ Yes ☐ No

The United States Department of Health and Human Services bases their poverty guidelines on a household's yearly income. The current figures are $12,880 for one (1) person; $17,420 for 2. (Add $4,540 for each additional person in household.)

Registrant is Frail:	☐ Yes ☐ No
Registrant is Disabled:	☐ Yes ☐ No
Registrant Lives Alone:	☐ Yes ☐ No
Registrant has Adequate Housing:	☐ Yes ☐ No

Check all mobility aids, if any, that registrant uses:		
☐ Manual Wheelchair ☐ Electric Wheelchair ☐ Power Scooter	☐ Walker ☐ Cane ☐ Guide Dog	☐ Other (Describe)
Registrant needs an escort:	☐ Yes ☐ No	
Registrant's disability/ disabilities Senior Center needs to be aware of: (Describe below)		
Registrant is nutritionally at risk:	☐ Yes ☐ No	**Complete Nutritional Risk Questionnaire below**
I authorize the release and/or receipt of information necessary for the delivery of service to me. I hereby certify that the above information is true and correct to the best of my knowledge, information and belief.		
Registrant's Signature:		**Date:**
Wedding Anniversary Date:		**Email address:**

DETERMINE Your Nutrition Health Questionnaire

Instructions: *Read each statement below to the registrant. Circle the number in the "yes" column for those statements that apply to the registrant. Add all circled numbers for a determined score.*

	YES
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than two (2) meals per day.	3
I eat few fruits, vegetables or milk products.	2
I have three (3) or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I do not always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take three (3) or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained ten (10) pounds in the last six (6) months	2
I am not always physically able to shop, cook, and/or feed myself.	2
TOTAL	

Total your Nutritional Score. If it is:

0-2 **Good!**

3-5 **You are at moderate risk.**

6 or higher **You are at high nutritional risk.** Bring this checklist the next time you see your doctor, dietician, or other qualified health or social service professional. Also, contact YCAAA for consumer eligibility for nutrition counseling.