YORK COUNTY AREA AGENCY ON AGING
REGISTRATION FOR CONGREGATE MEALS AND SENIOR CENTER SERVICES

(Please Print or Type Information)

Date:		**Senior Center:**	

REGISTRANT INFORMATION:

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

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:	**Emergency Contact Address:**	**Emergency Contact Telephone #:** ( ) -

Physician Name:	**Physician Address:**	**Physician 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**

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 $11,770 for one (1) person and $15,930 for two (2) persons (add $4,160 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 below)
Registrant needs an escort:	☐ Yes ☐ No	
Registrant 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 Signature		**Date**

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 total nutritional 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 or 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 nutritional 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.