Participant Registration

☐ **CARE MANAGEMENT**
☐ **CAREGIVER MEALS**

PARTICIPANT INFORMATION

First Name

_____

Middle Initial

_____

Last Name

_____

Birth Date

_____/_____/_____

Age

Address

_____

City

_____

State

_____

ZIP Code

_____

County

_____

Township

_____

Directions (optional)

_____

_____

Telephone

_____

Income status - Is the participant's monthly income below poverty level?

☐ Yes ☐ No

Lives Alone

☐ Yes
☐ No

Household size of participant

☐ Two people in household ☐ Three people in household
☐ Four or more people in household ☐ Unknown

Marital Status

☐ Married ☐ Divorced ☐ Widowed
☐ Separated ☐ Single

Spouse Name

_____

_____

Participant Gender (Assigned at birth)

☐ Female ☐ Other ☐ No response/Unknown
☐ Male ☐ Prefer not to say

Do you consider yourself to be transgender or gender non-conforming?

☐ Yes
☐ No

Participant Sexual Orientation

☐ Straight/Heterosexual ☐ Prefer not to say
☐ Lesbian ☐ Other
☐ Gay ☐ No response/Unknown
☐ Bisexual

Race

☐ White ☐ Native Hawaiian / Pacific Islander
☐ Black ☐ American Indian / Eskimo / Aleut
☐ Asian

Is Participant Multiracial?

☐ Yes ☐ No

Is Participant Hispanic?

☐ Yes ☐ No

Non-English Speaking?

☐ Yes
☐ No

How well does the participant speak English?

☐ Very well ☐ Not at all
☐ Well ☐ Unknown
☐ Not well

Has the participant ever served on active duty in the U.S. Armed Forces, Reserves, or National Guard?

☐ Yes ☐ Unknown
☐ No

Referral Name / Agency

_____

_____

Phone Number

_____

Emergency Contact

_____

Phone Number

_____

Participant has medical equipment (Notify in disaster)

☐ Yes
☐ No

CARE RECIPIENT SERVICES INFORMATION

Cluster I

Care Management

☐ Yes
☐ No

Start Date

_____/_____/_____

Homemaker

☐ Yes
☐ No

Start Date

_____/_____/_____

Chore Services

☐ Yes
☐ No

Start Date

_____/_____/_____

Home Delivered Meals

☐ Yes
☐ No

Start Date

_____/_____/_____

Home Care Assistant

☐ Yes
☐ No

Start Date

_____/_____/_____

Cluster II

Congregate Meals

☐ Yes
☐ No

Start Date

_____/_____/_____

Other (List)

☐ Yes
☐ No

Start Date

_____/_____/_____

Cluster III

Health Screening

☐ Yes
☐ No

Start Date

_____/_____/_____

Home Injury Control

☐ Yes
☐ No

Start Date

_____/_____/_____

Service Coordination

☐ Yes
☐ No

Start Date

_____/_____/_____

Transportation

☐ Yes
☐ No

Start Date

_____/_____/_____

Other

☐ Yes
☐ No

Start Date

_____/_____/_____

NUTRITIONAL HEALTH

Read the statements below. Insert number that applies.

I have had a change in eating habits due to an illness

☐ Yes - 2
☐ No - 0

I eat less than 2 meals per day

☐ Yes - 3
☐ No - 0

I eat few fruits and vegetables, or milk products

- [ ] Yes - 2
- [ ] No - 0

I have 3 or more drinks of beer, liquor or wine every day

- [ ] Yes - 2
- [ ] No - 0

I have tooth or mouth problems that make it hard for me to eat

- [ ] Yes - 2
- [ ] No - 0

I don't always have enough money to buy the food I need

- [ ] Yes - 4
- [ ] No - 0

I eat alone most of the time

- [ ] Yes - 1
- [ ] No - 0

I take 3 or more different prescribed or over-the-counter medications a day

- [ ] Yes - 1
- [ ] No - 0

Without wanting to, I have lost or gained 10 lbs in the last 6 months

- [ ] Yes - 2
- [ ] No - 0

I am not always physically able to shop, cook and/or feed myself

- [ ] Yes - 2
- [ ] No - 0

Total Score =

0-2: No Risk
3-5: Moderate Risk
6 or More: High Nutritional Risk

CARE RECIPIENTS RECEIVING CLUSTER I SERVICES (UPCAP CARE MANGERS ONLY)

Mark all activities that require assistance - ADLs

- [ ] All
- [ ] Eating / Feeding
- [ ] Dressing
- [ ] Bathing
- [ ] Walking
- [ ] Stair Climbing
- [ ] Bed Mobility
- [ ] Toileting
- [ ] Bladder Function
- [ ] Bowel Function
- [ ] Wheeling
- [ ] Transferring
- [ ] Mobility Level
- [ ] None

Mark all activities that require assistance - IADLs

- [ ] All
- [ ] Shopping
- [ ] Handling Finances
- [ ] Heavy Cleaning
- [ ] Light Cleaning
- [ ] Using Public Transportation
- [ ] Using Private Transportation
- [ ] Cooking Meals
- [ ] Reheating Meals
- [ ] Taking Medications
- [ ] Using Phone
- [ ] Doing Laundry
- [ ] Keeping Appointments
- [ ] Heating Home
- [ ] None

Title :

Date

Title :

Date