**YORK COUNTY AREA AGENCY ON AGING**

**REGISTRATION FOR CONGREGATE MEALS AND SENIOR CENTER SERVICES**

**(Please PRINT or TYPE information)**

**1.1.A.1. Date HERITAGE SENIOR CENTER PSA#25\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **2. Last Name** | **3. First Name** | **4. Middle** | **5. Suffix** | **6. Nickname** | **7. Date of Birth** |
| **8a. Current Gender Identity**Female Male Non-BinaryTransgender Female (male to female) Transgender Male (female to male) Choose not to discloseSomething else not named | **8b. Gender assigned at birth**Female  Male  Something else not named  Choose not to disclose | **8c. Sexual Orientation** Straight or  Heterosexual Bisexual Lesbian, Gay or  Homosexual Don’t Know Choose not to  disclose | **9. Registrant’s Ethnicity** Hispanic or Latino Not Hispanic or Latino Unknown  |
| **10. Registrant’s Race**American Indian/Native Alaskan Asian Black/African American Native Hawaiian/Other Pacific Islander Non-Minority (White Non- Hispanic) Unknown Other | **11. Last 4 digits of Social**  **Security #****XXX-XX-\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **12. Is the Registrant’s****Annual income less than 100% of the current Federal Poverty Income Guidelines (FPIG)?**Yes No UnknownThe current Federal Poverty Guidelines are #13,590 for one (1) person annually; $18,310 for 2 (Add $4,720 for each additional person in household) | **13a. Does the Registrant have a Medicaid number?** Yes No Pending**13b. If Yes, what is the** **number?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **14a. Does the registrant have Medicare?** Yes **14b. Medicare #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No  | **15a. Does registrant have other insurance?** Yes**15b. Name of insurance****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **No** | **16. Check all benefits currently receiving** Food Stamps LIHEAP Medicaid PACE | **the registrant is**  Section 8 Subsidized Transit Tax & Rent Rebates Weatherization Other |
| **1.C. Registrant Demographics** **1a. Are you homeless?** Yes NoIf yes, answer questions b-d | **1b. Do you have a place to stay tonight?**Yes  No | **1c. do you have a place to stay long term?** Yes No | **1d. Explain homeless situation:** Cannot afford housing Evicted Housing not available Voluntary Other: |
| **2. Type of PERMANENT residence in which you reside**Apartment Domiciliary Care Group Home Own home Personal Care Home Relative’s Home Rehab Facility State Institution Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **13. What is your PERMANENT living arrangement?**Lives Alone Lives with Spouse ONLY Lives with children but not  spouse Lives with other Family Members Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **14. What is your marital status?**Single Married Divorced Legally Separated Widowed OtherIf married, when is your anniversary? \_\_\_\_\_\_\_\_\_\_ | **Veteran Questions:****5a. Are you a veteran?**YesBranch? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**5b. Are you a spouse or widow of a veteran?** Yes No**5c. Do you receive veteran’s benefits?** Yes No |
| **6a. Do you require communication assistance?**Yes No | **6b. If YES, select which assistance is required:** Assistive Technology Interpreter | Large Print Picture Book Unable to Communicate |  Unknown Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **17a. Do you use sign language as your PRIMARY language?**Yes No**17b. If yes, specify type used****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **18. What is your PRIMARY language?**English Russian Spanish Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **19. Are you considered disabled?**Yes No |  |

**1D. Registrant’s Permanent Residential Address Information**

**2a. County 2b. Street Address**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2c. Municipality (Township or Borough) 2d Second Line Street Address**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2e. City 2f. State 2g. Zip Code**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4. Does the registrant reside in a rural area? 5a. Primary Phone# 5b. Mobile Phone # 5c. Other Phone #**

Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5d. Email Address 6. Voter Registration**

Already Registered Information Requested

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Not Interested Does not meet voter requirements

**1E. Mailing Address (if different than street address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1F. 1. Emergency Contact Name and 2. Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. Emergency Contact Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. Emergency Contact Other Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2.A. DIETARY ISSUES:**

|  |  |  |  |
| --- | --- | --- | --- |
| **1. Do you generally have a good appetite?**Yes No | **2. Do you use a dietary supplement?**Yes No | **3. Do you have any food allergies?**Yes No | If Yes, please list: |
| **4. Do you have a special diet for medical reasons?**Yes No | If Yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **5. Do you have a special diet for religious/cultural reasons?**Yes No | If Yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**2.B. Nutritional Risk Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **1. Has there been a change in your lifelong eating habits because of health problems?**Yes NoIf yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **2. Do you eat fewer than 2 meals per day?**Yes NoIf yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **3. Do you ear fewer than 2 services of dairy products every day?**Yes No | **4. Do you eat fewer than 5 services of fruits or vegetables each day?**Yes No |
| **5. Do you have 3 or more drinks of beer, liquor or wine almost every day?**Yes No | **6. Do you have trouble eating due to problems with chewing/swallowing?** Yes No | **7. Do you NOT HAVE enough money to buy food needed?**Yes No | **8. Do you eat alone most of the time?** Yes No |
| **9. Do you take 3 or more prescribed or over-the-counter drugs per day?**Yes No | **10. Have you lost or gained at least 10 pounds or more in the last 6 months?** Yes No | **11. Are you NOT ALWAYS able to physically shop, cook, and feed yourself or to get someone to do it for you?**Yes No |