**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-Binary  Transgender Female (male  to female)  Transgender Male (female  to male)  Choose not to disclose  Something 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  Unknown  The 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 No  If 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  Other  If married, when is your anniversary? \_\_\_\_\_\_\_\_\_\_ | | | **Veteran Questions:**  **5a. Are you a veteran?**  Yes  Branch? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  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 No  If yes, please explain:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **2. Do you eat fewer than 2 meals per day?**  Yes No  If 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 | |