Kansas Department for Aging and Disability Services Uniform Program Registration

Registration Date: PSA:

CUSTOMER INFORMATION

First Name: Middle Name: Last Name:

Birth Date: Age: Social Security #: Gender: ☐ Female ☐ Male

Month Day Year

Residence Street Address:

Street City County State Zip Phone

Emergency Contact Name:

Emergency Contact Address:

Street City County State Zip Phone Alt Phone

Ethnicity	Race	
☐ Hispanic or Latino	☐ American Indian/Alaskan Native	☐ Native Hawaiian or Other Pacific Islander
☐ Not Hispanic or Latino	☐ Asian	☐ White Hispanic
☐ Ethnicity Missing	☐ Black or African American	☐ White Non-Hispanic
	☐ Reporting some other race	☐ Reporting 2 or more races

Do you live alone? ☐ Yes ☐ No

Doctor Name:

City: Phone:

Health conditions/medications:

Is your monthly income below? ☐ Yes ☐ No

$1,073 – Family of 1 or $1,452 – Family of 2

$1,830 – Family of 3 or $2,208 – Family of 4

Veteran or Spouse of Veteran ☐ Yes ☐ No

MODIFIED DIETS

Are you following any modified diet(s)? ☐ Yes ☐ No

If yes, mark each type: ☐ Diabetic ☐ Diverticulitis ☐ Ethnic/religious ☐ Low sodium (salt) ☐ Mechanical ☐ Pureed ☐ Renal ☐ Vegetarian ☐ Other _____

NUTRITION RISK SCREEN (This section for Congregate Meals and Nutrition Counseling Only)

Please answer each question below.

SCORING – If Yes, Circle	Yes	SCORING – If Yes, Circle	Yes
Do you eat less than 2 meals daily?	3	Have you made changes in the kind and/or amount of food you eat because of an illness and/or condition?	2
Do you eat less than 2 servings of fruits and vegetables daily?	1		
Do you eat less than 2 servings of dairy products (milk, cheese, yogurt, etc.) daily?	1	Are you physically not always able to grocery shop, cook, and/or feed yourself? (Circle all that apply)	2
Do you usually drink less than 6 glasses of water, milk, or juice daily? # of glasses:	0	Do you eat alone most of the time?	1
		Do you feel that you usually do not have enough money to buy the food you need?	4
Do you drink 3 or more alcoholic beverages daily?	2		
Do you take 3 or more different prescriptions and/or over-the-counter drugs daily?	1	Have you gained or lost more than 10 pounds in the last 6 months? (Circle all that apply)	2
Do you have problems with dentures, teeth, or mouth, which make it hard to eat? (Circle all that apply)	2	Add all YES answers for **Total Nutrition Risk Score**:	

RISK LEVEL: _____0-2: Low **_____3-5:** Moderate **____6 or more:** High nutritional risk; share results with your health care provider.

Release of Information: I consent to the release of the information on this page so I can receive services. I understand the information on this page will be released to Kansas Department for Aging and Disability Services, the Area Agencies on Aging, and service providers as listed below to enable the delivery of services and program monitoring.

Customer/Guardian Signature Date

Reviewer Signature Date

~ COMPLETED BY REVIEWER ~

KAMIS ID #:

UNMET NEEDS

Service Code	*Availability Code*	*Monthly Units*

PARTICIPANT STATUS FOR MEALS

- ☐ 60+ Person
- ☐ Less than 60 Spouse of 60+ Person
- ☐ Less than 60 disabled Person residing with 60+ Person
- ☐ 60+ non-spouse Caretaker (IIIB Home-delivered meals only)
- ☐ Volunteer
- ☐ Less than 60 disabled Person residing in housing facility with CMEL site and occupied mostly by 60+ Persons

PSA	Service Code	Funding Source	Disaster	Provider	Unit(s)	Per	Total Units Monthly	Cost of Unit	Start Date	End Date	Discharge Code