Alabama Department of Senior Services
FY20 Participant Enrollment Form
Title III Services

_____
Name of AAA (office use)

_____
Name of Senior Center (office use)

_____
Enrollment Date

STEP 1: Page 1 required for all programs. STEP 2: Nutrition programs only. STEP 3-5: Staff only. ***ALL*** of this information ***must be updated annually.***

PARTICIPANT INFORMATION: **Please ask for assistance if needed in completing this form**		
Last Name:	First Name:	MI:
Street Address:	Mailing Address (If different):	
City: State: Zip:	City: State: Zip:	
County:	Home Phone: ( ) Other Phone: ( )	
Email address:		
Birthdate: ____/____/_____ MM DD YYYY	Gender: ☐ Male ☐ Female	
Race: ☐ Caucasian/White ☐ Asian ☐ African-American/Black ☐ Native Hawaiian ☐ Alaska Native ☐ Pacific Islander ☐ American Indian ☐ Other	**Ethnicity:** ☐ Not Hispanic/Latino ☐ Hispanic/Latino	
Do you live alone? ☐ Yes ☐ No	☐ **Dementia-related diagnosis**	
Income Range: Is your gross monthly income above $1,041? ☐ Yes ☐ No		
EMERGENCY CONTACT INFORMATION: Please provide name of a person to contact in an emergency.		
Name: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____	Relationship to participant: ☐ Spouse ☐ Other Relative ☐ Friend ☐ Neighbor	
Primary Physician: _____ Physician Phone: _____		

ADLs/IADLs: Do you need help with any of the following?

		Yes	No	Comments
ADLS	Eating			
	Transferring in and out of bed or chair			
	Walking			
	Dressing			
	Bathing			
	Toileting			
IADLS	Doing heavy housework			
	Doing light housework			
	Preparing meals			
	Shopping for personal items			
	Managing money			
	Medication management			
	Using telephone			
	Access to public/private transportation?			

Statement of Confidentiality: The information recorded on this form is required for the statistical and reporting requirements for State and Community Programs under the Older Americans Act of 1965, as amended [Public Law 8973], and is not to be used for any other purpose in any form which could identify the individual without the individual's knowledge of the specific use and the individual's specific authorization for such use.

STEP 2: **Nutritional Health**: Please answer the following nutrition questions for congregate, home-delivered meals, and nutrition counseling:

(2) ☐ Y ☐ N 1. Have you changed the amount or kinds of food you eat because of illness or health condition?
(3) ☐ Y ☐ N 2. Do you eat fewer than 2 meals a day?
(1) ☐ Y ☐ N 3. Do you eat fewer than 3 fruits or vegetables a day?
(1) ☐ Y ☐ N 4. Do you eat fewer than 2 servings of dairy products a day? (Milk, yogurt, cheese)
(2) ☐ Y ☐ N 5. Do you have 2 or more drinks of beer, liquor, or wine almost every day?
(2) ☐ Y ☐ N 6. Do you have any tooth or mouth problems that make it hard to eat?
(4) ☐ Y ☐ N 7. Do you sometimes not have enough money for the food you need?
(1) ☐ Y ☐ N 8. Do you eat alone most of the time?
(1) ☐ Y ☐ N 9. Do you take 3 or more kinds of medicines a day? (include over the counter & prescription medicines)
(2) ☐ Y ☐ N 10. Without wanting to, have you lost or gained 10 pounds or more in the past 6 months?
(2) ☐ Y ☐ N 11. Do you have any physical problems that make it difficult for you to shop, cook, or feed yourself?

☐ ◀ **Nutrition Risk Score** of 6 or greater suggests "High" Nutrition Risk.

☐ Y ☐ N Do you want a referral to a Registered Dietitian Nutritionist for Nutrition Counseling?

DO NOT WRITE BELOW THIS LINE

STEP 3: Nutrition Staff

To be completed by staff:

1. Approved Congregate Meals:
- ☐ Hot Meals
- ☐ Frozen
- ☐ Liquid Meal Replacement
- ☐ Shelf Stable

2. Approved Home-Delivered Meals:
- ☐ Hot Meals
- ☐ Frozen Meals (pick up at center)
- ☐ Frozen Meals (participant delivery by vendor)
- ☐ Shelf Stable
- ☐ Breakfast
- ☐ Liquid Meal Replacement (pick up at center)
- ☐ Liquid Meal Replacement (participant delivery by vendor)

3. If this participant is approved for liquid meal replacement, does the Agency have a doctor's order on file? ☐ Yes ☐ No

4. If this participant is eligible for Title III-C Nutrition Services, identify why:
- ☐ Age 60 and older
- ☐ Spouse of eligible participant
- ☐ Volunteers at mealtime
- ☐ Individual with disability living with eligible participant
- ☐ Individual with disability living in public, low-income housing where a senior center is located
- ☐ 60+ caregiver

Date Approved: _____ Staff: _____

STEP 4: Notes/Comments:

_____

_____

_____

STEP 5:

AIMS #:_____ **Date Entered:** _____ **Staff Initials:** _____