Semcac Home Delivered Meal Program Registration

Please complete this form to the best of your ability. Shaded areas are for office use only.

Site Name: New Client: ☐ Yes ☐ No

Contact Date		AAA Region 10	**Eligibility Category (Check one):** ☐ Client ☐ Spouse ☐ Volunteer ☐ Disabled under 60-Lives in Bldg	☐ Caregiver

Section A. Basic Demographics

Last Name:	First Name:	Middle Initial:
Household Size ☐ I live alone ☐ I live with others	Gender: ☐ Female ☐ Male ☐ Unspecified	**Date of Birth: (required)** / /

Address:	Address #2:		
City:	State:	Zip Code:	County:
Home Phone: ( ) -	Mobile Phone: ( ) -	Work Phone: ( ) -	

Section B. Social History

Ethnicity (Check one)
☐ Hispanic or Latino
☐ Non-Hispanic

Race (Check all that apply):
☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander
☐ Asian/Asian American
☐ Black/African American
☐ White

Section C. Financial

Please circle one:

I live alone and **my** monthly income is between: (Check one)

$1,255/month or less $1,256 - $1,883/month $1,884 - $2,510/month More than $2,510/month

I live with my Spouse and **our** monthly income is between: (Check one)

$1,703/month or less $1,704 - $2,555/month $2,556 - $3,407/month More than $3,407/month

Section D. Contacts

Emergency Contact Name	Emergency Contact Relationship	Emergency Contact Phone Number ( ) -

Section E. Nutrition Risk Assessment

Have you changed the way you eat due to illness or medical condition? ☐ **Yes** ☐ **No**	Are there times when you don't have enough money to buy the food you need? ☐ **Yes** ☐ **No**
Do you eat less than 2 meals a day? ☐ Yes ☐ No	Do you eat alone most of the time? ☐ Yes ☐ No
Do you eat few fruits or vegetables or milk products? ☐ Yes ☐ No	Do you take 3 or more prescribed or over-the-counter drugs each day? ☐ Yes ☐ No
Do you have 3 or more drinks of beer, liquor or wine almost every day? ☐ Yes ☐ No	Have you lost or gained 10 pounds in the last 6 months without wanting to? ☐ Yes ☐ No
Do you have tooth or mouth problems that make it hard to eat? ☐ Yes ☐ No	Are there times when you are not physically able to shop, cook or feed yourself? ☐ Yes ☐ No

Section F. Activities of Daily Living

Can you walk around inside without any help or assistance devices such as cane/walker/etc? ☐ Yes ☐ No	Can you bathe or shower without any help or assistance devices such as shower bars, chair, seat, etc? ☐ Yes ☐ No
Can you sit up or move around in bed without any help? ☐ Yes ☐ No	Can you use the toilet without any help or assistance devices such as extended height toilet/cane/bars, etc? ☐ Yes ☐ No
Can you comb your hair, shave, wash your face, or brush your teeth without any help? ☐ Yes ☐ No	Can you dress without any help? ☐ Yes ☐ No
Can you get in and out of bed or chair without any help or assistance devices such as cane/walker/lift chair/etc? ☐ Yes ☐ No	Can you manage eating without any help? ☐ Yes ☐ No

Section G. Independent Activities of Daily Living

Can you answer the telephone or make a phone call without help? ☐ Yes ☐ No	Can you do heavy house cleaning, like yard work and laundry, without any help? ☐ Yes ☐ No
Can you shop for food and other things you need without help? ☐ Yes ☐ No	Can you take your medications without help? ☐ Yes ☐ No
Can you prepare meals for yourself without help? ☐ Yes ☐ No	Can you handle your own money, like keeping track of bills without help? ☐ Yes ☐ No
Can you do light house keeping, like dusting or sweeping, without help? ☐ Yes ☐ No	Can you use public transportation or drive beyond walking distances without help? ☐ Yes ☐ No

Section H. Use of Information

I understand that the information I am providing on this form is for registration purposes. The information will be used by Semcac and the Area Agency on Aging and the Minnesota Board on Aging to create statistical reports and may be used by other service providers to help identify other services from which I may benefit, such as follow up to the Nutrition Risk Assessment. This information will not be released to anyone other than the above mentioned parties in a way that will identify me as an individual unless I sign a separate consent for that purpose.
My signature (written or typed) indicates my agreement for this information to be used as indicated above.

Signature: _____ Today's Date: _____

Are you a Veteran: ☐ Yes ☐ No	Do you use EBT/SNAP: ☐ Yes ☐ No

If you would like the donation letter sent to a person <u>other than the MOW client</u>, please complete this section:

Name: _____ Telephone #: _____

Street: _____ PO Box: _____

City: _____ State: _____ Zip Code: _____

MBA 2/2024