Home Delivered Meal Program Registration Please complete this form to the best of your ability. Shaded areas are for office use only.							
Contact Date	Status	AAA Reg		ibility Category	□ Volunteer	NAPIS ID Number	
Caregiver Disabled under 60 Section A. Basic Demographics							
Last Name: First Nam						Middle Initial:	
Lives in Rural Area (Circle One):			Gender:	□ Female	□ Male	Date of Birth:	
□ Yes □ No				□ Unspecified		/ /	
Address:				Address #2:			
City: Sta		State:	Zip Code:			County:	
Home Phone: Mobile Pho			one:		Work Phone:		
()							
		Se	ction B. S	ocial History			
Race (Circle one): □ American Indian/Alaskan □ Asian				Ethnicity (Circle one) More Races Hispanic or Latino			
Household Size (Circle One): I live alone.				I live with others.			
Section C. Financial							
I live aloneand my monthly income is between (circle one)							
Under \$990 \$991-\$1,485 \$1,486-\$1,980 More than \$1,980							
□ <u>I live with my spouse</u> and our <u>monthly</u> income is between (circle one)							
Under \$1,335 \$1,336-\$2,003 \$2,004-\$2,670 More than \$2,670							
Section D. Contacts							
Emergency Phone: Emergency Contact Name					Eme	rgency Contact Relationship	
Section E. Nutrition Risk Assessment							
Have you changed the way you eat due to illness or medical condition?				Are there times when you don't have enough money to buy the food you need?			
Yes No				Yes No			
Do you eat less than 2 meals a day?				Do you eat alor	Do you eat alone most of the time?		
Yes No					Yes	No	
Do you eat few fruits or vegetables or milk products?				Do you take 3 or more prescribed or over-the-counter drugs each day?			
Yes No					Yes	No	
Do you have 3 or m	liquor or wi	-	Have you lost or gained 10 pounds in the last 6 months without wanting to?				
every day?	Yes	No			Ig to? Yes	No	

Do you have tooth or mouth problems that make it hard to eat?	Are there times when you are not physically able to shop, cook or feed yourself?					
Yes No	Yes No					
Section F. Activities of Daily Living						
Can you walk around inside without any help?	Can you bathe or shower without any help?					
Yes No	Yes No					
Can you sit up or move around in bed without any help?	Can you use the toilet without any help?					
Yes No	Yes No					
Can you comb your hair, shave, wash your face, or	Can you dress without any help?					
brush your teeth without any help?						
Yes No	Yes No					
Can you get in and out of bed or chair without any help?	Can you manage eating without any help?					
Yes No	Yes No					
Section G. Independent Activities of Daily Living						
Can you answer the telephone or make a phone call	Can you do heavy house cleaning, like yard work and					
without help?	laundry, without any help?					
Yes No	Yes No					
Can you shop for food and other things you need without help?	Can you take your medications without help?					
Yes No	Yes No					
Can you prepare meals for yourself without help?	Can you handle your own money, like keeping track of bills without help?					
Yes No	Yes No					
Can you do light housekeeping, like dusting or	Can you use public transportation or drive beyond					
sweeping, without help?	walking distances without help?					
Yes No	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 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.						

Signature: _____ Today's Date: _____

MBA 2/16