

Date of Registration _____

Name (First, MI, Last): _____

Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

<p>Gender (specify): What is your gender? _____</p> <hr/> <p>Race:</p> <p><input type="checkbox"/> American Indian or Native Alaskan <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Other: _____</p>	<p>Ethnicity:</p> <p><input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino</p> <hr/> <p>Household:</p> <p><input type="checkbox"/> I live alone. <input type="checkbox"/> I live with others.</p>	<p>Income Status: Is your income at or below the following guidelines? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <table border="1"> <thead> <tr> <th># in Home</th> <th>Month / Year</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>\$1,330 / \$15,960</td> </tr> <tr> <td>2</td> <td>\$1,804 / \$21,640</td> </tr> <tr> <td>3</td> <td>\$2,277 / \$27,320</td> </tr> <tr> <td>4</td> <td>\$2,750 / \$33,000</td> </tr> </tbody> </table>	# in Home	Month / Year	1	\$1,330 / \$15,960	2	\$1,804 / \$21,640	3	\$2,277 / \$27,320	4	\$2,750 / \$33,000
# in Home	Month / Year											
1	\$1,330 / \$15,960											
2	\$1,804 / \$21,640											
3	\$2,277 / \$27,320											
4	\$2,750 / \$33,000											

****Malnutrition Screening**

1. Have you recently lost weight without trying?

- No (0)
- Unsure (2)
- Yes

If yes, how much weight have you lost?

- 2-13 pounds (1)
- 14-23 pounds (2)
- 24-33 pounds (3)
- 34 pounds or more (4)
- Unsure (2)

2. Have you been eating poorly because of a decreased appetite?

- No (0)
- Yes (1)

Weight loss score: _____ **Appetite Score:** _____ **MST Score (Total):** _____

Privacy Statement: "The information you are being asked to provide is needed to determine if you are eligible to receive Older Americans Act Services and to comply with federal and state reporting requirements. This information will be stored in a secure electronic database and will not be used for any other purpose. Your information will not be shared with another agency without your permission. This information will not be sold to anyone. You have the right to review your electronic record and request changes to ensure accuracy. You will not be denied most services if you refuse to provide this information. If you have questions regarding this, please ask the aging unit staff."

Nutrition Screening (NSI): Circle your score(s) & add up your total.	No	Yes
I have an illness or condition that made me change the kind and/or amount of food I eat.	0	2
I eat fewer than 2 meals per day.	0	3
I eat few fruits or vegetables or milk products.	0	2
I have 3 or more drinks of beer, liquor or wine almost every day.	0	2
I have tooth or mouth problems that make it hard for me to eat.	0	2
I don't always have enough money to buy the food I need.*	0	4
I eat alone most of the time.	0	1
I take 3 or more different prescribed or over-the-counter drugs a day.	0	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.**	0	2
I am not always physically able to shop, cook, and or feed myself.	0	2

Risk Level: ___ 0-2 Low ___ 3-5 Moderate ___ 6 + High **TOTAL:** _____

Allergies or Special Dietary Needs: _____

*Food Security Screening			
For each of the following statements, please tell me which one is “often true,” “sometimes true” or “never true” for the past 12 months.	Often True	Sometimes True	Never True
1. We (I) worried whether our food would run out before we (I) got money to buy more.	<input type="checkbox"/> Yes*	<input type="checkbox"/> Yes*	<input type="checkbox"/> Yes
2. The food that we (I) bought just didn't last and we (I) didn't have money to get more.	<input type="checkbox"/> Yes*	<input type="checkbox"/> Yes*	<input type="checkbox"/> Yes

Emergency Contact (Last Name, First Name):	
Emergency Contact Relationship:	Emergency Contact Phone:

<i>For Office Use Only</i>	
NSIP Eligible:	NSIP Eligibility Reason (select one):
<input type="checkbox"/> Yes	<input type="checkbox"/> Age 60 and older <input type="checkbox"/> Under age 60 spouse of person age 60+ <input type="checkbox"/> Under age 60 person with disability living with person age 60+ <input type="checkbox"/> Under age 60 person with disability living in dining facility <input type="checkbox"/> Under age 60 Nutrition program volunteer
<input type="checkbox"/> No	<input type="checkbox"/> Under age 60 informal caregiver (connect with NFCSP or AFCSP program) <input type="checkbox"/> NSIP Ineligible