

CLIENT REGISTRATION FORM

LEGAL NAME (First/Last): _____

NICKNAME: _____ MALE FEMALE

DATE OF BIRTH: ____ / ____ / ____ PHONE NUMBER: (____) _____

PHYSICAL ADDRESS: _____ MAILING ADDRESS: _____
(If Different) _____

No Current Address/Residence

EMERGENCY CONTACT INFORMATION:

NAME 1 (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (____) _____ WORK OR CELL PHONE: (____) _____

NAME 2 (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (____) _____ WORK OR CELL PHONE: (____) _____

ETHNICITY

HISPANIC OR LATINO

NON-HISPANIC OR LATINO

RACE

WHITE, CAUCASIAN HISPANIC

AMERICAN INDIAN / ALASKAN NATIVE

ASIAN BLACK / AFRICAN AMERICAN

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

OTHER _____

If you do not speak English, what is your primary language? _____

DO YOU:

1. LIVE ALONE?..... Yes No

2. HAVE A DISABILITY? Yes No

3. CONSIDER YOURSELF FRAIL?..... Yes No

ARE YOU:

1. UNABLE TO LEAVE YOUR HOME WITHOUT ASSISTANCE (Homebound)?..... Yes No

2. A VETERAN / SERVED IN ARMED FORCES? Yes No

3. ON STATE MEDICAID? Yes No

4. A CAREGIVER? Yes No

IF YES, for whom do you provide care?

Spouse Child, Age 0-18 Adult Child, 18+

Parent Family Member Other _____

I was provided the *Notice of Privacy Practices*

YOUR INCOME IS:

(The Service Provider will supply you with the current Federal Poverty Guidelines and 300% SSI amount.)

Please provide an answer on both lines:

BELOW POVERTY **OR** ABOVE POVERTY

BELOW 300% SSI **OR** ABOVE 300% SSI

Client Signature _____ Date _____
(Initial or Revised Registration)

Client Signature – 2nd year _____ Date _____
(I certify that my information has not changed.)

FOR OFFICE USE ONLY

Services Registered For: _____ New to This Service? Y N

_____ Y N

Nutrition Risk Assessment Score: _____

Client ID: _____

Site/Notes: _____

Your Name (Please Print) _____

Date _____

DETERMINE YOUR NUTRITIONAL HEALTH

Circle each that applies to your nutritional habits.	YES
1. I have an illness or condition that made me change the kind and/or amount of food I eat.	2 points
2. I eat fewer than 2 meals per day.	3 points
3. I eat few fruits or vegetables, or milk products.	2 points
4. I have 3 or more drinks of beer, liquor or wine almost every day.	2 points
5. I have tooth or mouth problems that make it hard for me to eat.	2 points
6. I don't always have enough money to buy the food I need.	4 points
7. I eat alone most of the time.	1 point
8. I take 3 or more different prescribed or over-the-counter drugs a day.	1 point
9. Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2 points
10. I am not always physically able to shop, cook and/or feed myself.	2 points
<i>Total Your Nutritional Score</i>	

If your score is . . .

0—2 **Good! Recheck your nutritional score in 6 months.**

If it's . . .

3—5 **You are at moderate nutritional risk.**

See what can be done to improve your eating habits and lifestyle. Refer to the attached handout for helpful tips. Recheck your nutritional score in 3 months.

6 or more **You are at high nutritional risk.**

Bring this checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

**U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
2019 FEDERAL POVERTY GUIDELINES**

Size of family unit	Federal Poverty Guidelines <i>48 Contiguous States and D.C.</i>	
	Annual Income	Monthly Income
1	\$ 12,490	\$1,040.83
2	\$ 16,910	\$1,409.17
3	\$ 21,330	\$1,777.50
4	\$ 25,750	\$2,145.83

Social Security Administration:

Supplemental Security Income (SSI) – 300% 1 Person Household	\$2,313
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