TITLE III INTAKE AND CLIENT REGISTRATION FORM

Date Registered:		Date Updated:	

	Last	First	MI
Name:			

Address:	Bldg #:		Apt/Lot #:	
	State:			

City:		Zip:	
County:		Township:	

Phone:	Rural	YES	NO
Date of Birth:	Gender: (Circle One)	Male	Female

US Citizen? (Circle One)	YES	NO	Number of Persons in Household:				
Low Income? (Circle One)	YES	NO	REFUSED	Medicard Eligibility? (Circle One)	YES	NO	REJECTED

Ethnicity: (Circle One)	N- Not Hispanic or Latino	H- Hispanic or Latino
Primary Race: (Circle One)	B- Black/African American	N- Native Hawaiian or Pacific Islander
	I- American Indian or Alaskan Native	A- Asian
	W- White(Hispanic or Non Hispanic)	
Other Races: (Circle One)	B- Black/African American	N- Native Hawaiian or Pacific Islander
	I- American Indian or Alaskan Native	A- Asian
	W- White(Hispanic or Non Hispanic)	

Eligibility Criteria: (Circle One)	A- Age	S- Spouse of Eligible	D- Disabled (18-59)
	H- Disabled lives in Senior Housing		V- Volunteer
	E- Employee/Staff	O- Guest/Other	G- Caregiver

Status: (Circle One)	Active	Deceased	Inactive	Moved

☐ Limited English proficiency	☐ At Risk of institutional placement

____________________ I give permission for ____________________ to share this information with
Signature Community agencies.

Grey Shaded Boxes must be completed to satisfy Napis requirements.

TITLE III INTAKE AND CLIENT REGISTRATION FORM

Nutritional Assessment

(Must be done prior to receiving Congregate Meals, Home Delivered Meals)

Instructions: Circle the Client's response to each statement.

Statement				
I have an illness or condition that has made me change the kind or amount of food I eat	Yes	No	Unknown	Elects not to answer
I take three or more different prescribed or over-the-counter drugs a day	Yes	No	Unknown	Elects not to answer
I have tooth or mouth problems that make it hard for me to eat.	Yes	No	Unknown	Elects not to answer
Without wanting to, I have lost or gained ten pounds in the last six months.	Yes	No	Unknown	Elects not to answer
** I am not always physically able to shop, cook and/or feed myself.	Yes	No	Unknown	Elects not to answer
I eat less than two meals a day.	Yes	No	Unknown	Elects not to answer
I don't always have enough money to buy the food I need.	Yes	No	Unknown	Elects not to answer
I eat few fruits and vegetables, or milk products.	Yes	No	Unknown	Elects not to answer
I eat alone most of the time.	Yes	No	Unknown	Elects not to answer
I have three or more drinks of beer, liquor or wine almost every day.	Yes	No	Unknown	Elects not to answer

Assessment of Need for Assistance with ADL's and IADL's

(Must be completed prior to receiving Home Delivered Meals)

Instructions: Circle the number or letter that corresponds to the statement (see Key) which most closely describes the clients ability with regard to each Activity of Daily Living (ADL's) and Instrumental Activity of Daily Log (IADL's)

Key:				
	0	Independent/No impairment	A	Needs assistance but refuses
	1	Min. Assist/Mild impairment	D	Does not know if needed
	2	Mod. Assist/Some impairment	E	Elects not to answer
	3	Max. Assist/Total impairment		

Activities of Daily Living (ADL's)

Activity							
Eating:	0	1	2	3	A	D	E
Dressing:	0	1	2	3	A	D	E
Bathing:	0	1	2	3	A	D	E
Toileting:	0	1	2	3	A	D	E
Transferring:*	0	1	2	3	A	D	E
Grooming:	0	1	2	3	A	D	E

*in and out of bed or chair
**Note statement #5 in the Nutritional Risk Assessment and the first and last statements in the IADL Assessment. Clients must be unable to shop, cook and/or feed themselves and require assistance with meal preparation and Transportation to qualify for Home Delivered Meals.

Instrumental Activities of Daily Living (IADL's)

Activity							
**Preparing Meals:	0	1	2	3	A	D	E
Being Alone:	0	1	2	3	A	D	E
Medication Management:	0	1	2	3	A	D	E
Money Management:	0	1	2	3	A	D	E
Telephone Use:	0	1	2	3	A	D	E
Heavy Housework:	0	1	2	3	A	D	E
Light Housework:	0	1	2	3	A	D	E
**Transportation:	0	1	2	3	A	D	E

TITLE III INTAKE AND CLIENT REGISTRATION FORM

Emergency Contact and Caregiver Information

Doctor's Name:						
Phone:			Date of Last Visit:			
Emergency Contact:				Phone:		
Address:						
City:		State:		Zip:		
Relationship: (Circle One)	Husband	Wife	Son/Son in Law	Daughter/Daughter In Law	Other	Non-Relative
Emergency Contact:				Phone:		
Address:						
City:		State:		Zip:		
Relationship: (Circle One)	Husband	Wife	Son/Son in Law	Daughter/Daughter In Law	Other	Non-Relative

If client is a Caregiver, you must complete the section below.

FAMILY CAREGIVER INFORMATION

FCG Eligibility: (Circle all that apply)	FCG Over 60	FCG Under 60	Grand Parent Over 55	Enter # of Grand Children In next box	Enter total # of disabled persons 19-59 Receiving care

ENTER INFORMATION BELOW FOR EACH OF THE 60+ PERSON(s) FOR WHOM THIS CLIENT PROVIDES CARE(i.e., the recipient(s) of the Caregiver's Assistance) (Use additional page if needed)

Relationship of Caregiver to recipient (Circle One)	Husband	Wife	Son/Son In Law	Daughter/ Daughter in Law	Other	Non-Relative

	Last	First		
Recipient Name:			Date Of Birth:	

Address:		City:			
State:		Zip:		Phone:	

Note: Entering Recipient names in NapisPak allows for cross referencing Caregiver Clients and Recipients who are also in the system as clients.

***Grey Shaded Boxes must be completed to satisfy Napis Requirements- Page 2**