



**TITLE III (with DONATION BOX)
STATE OF ALABAMA
DEPARTMENT OF SENIOR SERVICES
OLDER AMERICANS ACT SERVICES
CLIENT ENROLLMENT FORM**

Name of AAA (office use) _____

Name of Senior Center (office use) _____

Enrollment Date _____

STEP 1:

You **must** complete this form to receive the following services provided under the Older Americans Act: Congregate Meals & Transportation (page 1 only), Home-Delivered Meals, Assisted Transportation, Nutrition Counseling, Adult Day Care, Personal Care, Homemaker, Chore, Case Management, Disease Prevention & Health Promotion, or Cash and Counseling. **ALL** of this information **must be updated each year.**

CLIENT INFORMATION: Please ask for assistance if needed in completing this form

Last Name:		First Name:		MI:	
Birthdate: ____/____/____ MM DD YYYY		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Rural: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Street Address:		City:		State: Zip:	
Mailing Address (If different):					
County:			Home Phone: ()		
Other Phone: ()			Email address:		

- Race:**
- Caucasian/White
 - African-American/Black
 - Alaska Native
 - American Indian
 - Asian
 - Native Hawaiian
 - Pacific Islander

- Ethnicity:**
- Not Hispanic/Latino
 - Hispanic/Latino
- Household Composition:** (check all that apply)
- Alone
 - With Spouse
 - Family
 - With Other

- Income Range:**
- Estimate your monthly income (net income after taxes). Then, choose one response. (Providing this information will not affect your receiving services).
- 0-\$931
 - \$932-\$2,792
 - Above \$2,792

Client has dementia-related diagnosis

Number of people living in Household: _____

Suggested Donation: \$ 1.25

Is client a Cash and Counseling client? Y N

Nutritional Health: Please answer the following nutrition questions for congregate or home-delivered meals:

- (2) Y N 1. Have you changed the amount or kinds of food you eat because of illness or health condition?
- (3) Y N 2. Do you eat less than 2 meals a day?
- (1) Y N 3. Do you eat less than 3 fruits or vegetables a day?
- (1) Y N 4. Do you eat less than 2 servings of dairy products a day? (Milk, yogurt, cheese)
- (2) Y N 5. Do you consume 2 or more drinks of beer, liquor, or wine almost every day?
- (2) Y N 6. Do you have any tooth or mouth problems that make it hard to eat?
- (4) Y N 7. Do you sometimes lack money to buy the food you need?
- (1) Y N 8. Do you eat alone most of the time?
- (1) Y N 9. Do you take 3 or more kinds of medicines a day? (include over the counter & prescription medicines)
- (2) Y N 10. Have you lost or gained 10 pounds or more in the past 6 months without trying? Lost Gained
- (2) Y N 11. Do you have any physical problems that make it difficult for you to shop, cook, or feed yourself?

Nutrition Risk Score

EMERGENCY CONTACT INFORMATION: Please provide name of a person to contact in an emergency.

Relationship to Client: Spouse Other Relative Friend Neighbor

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City/State/Zip: _____ Cell Phone: _____

Primary Physician: _____ Physician Phone: _____

Statement of Confidentiality: The information recorded on this form is required for the statistical and reporting requirements for State and Community Programs under the Older Americans Act of 1965, as amended [Public Law 8973], and is not to be used for any other purpose in any form which could identify the individual without the individual's knowledge of the specific use and the individual's specific authorization for such use.

ADLs/IADLs: This information is required for any Home-Delivered Meals, Assisted Transportation, Homemaker, Personal Care, Adult Day Care, Chore, and Case Management. Check how much assistance you need with the following activities.

	None	Some	Unable	Comments
A D L S	Eating			
	Transferring in and out of bed or chair			
	Walking			
	Dressing			
	Bathing			
I A D L S	Toileting			
	Doing heavy housework			
	Doing light housework			
	Preparing meals			
	Shopping for personal items			
	Managing money			
	Medication management			
	Using telephone			
Transportation				

STEP 2: DO NOT WRITE BELOW THIS LINE

To be completed by staff:

Date: _____

Staff Initials: _____

Approved Congregate Meals:

- Hot Meals
- Frozen
- Breakfast
- Liquid Meal Replacement

Approved Home-Delivered Meals:

- Hot Meals
- Frozen Meals (pick up at center)
- Frozen Meals (client delivery by vendor)
- Breakfast
- Liquid Meal Replacement (pick up at center)
- Liquid Meal Replacement (client delivery by vendor)

1. If this client is approved for liquid meal replacement, does the Agency have a doctor's order on file? Yes No

2. If this client is eligible for Title III-C Nutrition Services, identify the reason:

- Client age 60 and older
- Spouse of eligible client
- Volunteers at mealtime
- Individual with disability living with eligible client
- Individual with disability living in public, low-income housing where a senior center is located

Enrollment Action:

- New Client
- Annual Re-enrollment
- Receiving Client Transfer Date: _____ Transferred From: _____
- Client Termination Date: _____ Termination Reason: _____

Notes/Comments:

STEP 3:

AIMS Client No: _____ **Date Entered:** _____

Staff Initials: _____