Title III Program Registration

Select registration form type: ☐ Intake/non in-home services ☑ Congregate
☐ In-home services ☐ Notes ☐ Referral

Service site: _____ Date: _____ ☐ Participant has AD*vantage*

Participant Information — Reassessment ☐

Eligibility category, check all that apply: **AIM ID#** _____

☐ 60 years of age and older ☐ Spouse ☐ Volunteer
☐ Under 60 years of age with a disability ☐ Caregiver: Relation: _____
☐ Senior Raising Children ☐ Care recipient
☐ Care recipient under 18 years of age

Income below poverty level? ☐ Yes ☐ No **Lives in rural area?** ☐ Yes ☑ No

Participant name (last, first, middle) _____ Date of birth _____ Age _____ Gender: ☐ Female ☐ Male

Street address _____ Mailing address _____

City _____ State OK ZIP code _____ County _____

Home phone _____ Cell phone _____ Veteran? ☐ Yes ☐ No Veteran's spouse? ☐ Yes ☐ No

Emergency contact name and relationship _____ Emergency contact phone number _____

Race, check all that apply: ☐ American Indian/Alaska Native ☐ Asian
☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White

Ethnicity: Hispanic or Latino? ☐ Yes ☐ No Primary Language: ☐ English ☐ Other: _____

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Spouse or partner's name: _____

Lives in: ☐ House ☐ Apartment ☐ Senior housing ☐ Other: _____

Housing: ☐ Own ☐ Rent ☐ Other: _____

Lives: ☐ Alone ☐ With spouse
☐ Spouse/child *U18 ☐ Spouse/child *18+ with a disability
☐ Child(ren) *U18 ☐ Relative child(ren) *18+ with a disability
☐ Other: _____

*U18 (Under 18 years of age) & 18+ w/disability - Refer to Caregiver Program

Number in household: _____

Name: _____ AIM ID#: _____

Nutrition Screening Checklist

1. Have you made any changes in lifelong eating habits because of health problems?	☐ Yes (2)	☐ No (0)
2. Do you eat less than 2 meals per day?	☐ Yes (3)	☐ No (0)
3. Do you eat fewer than two servings of fruits, vegetables or milk products daily?	☐ Yes (2)	☐ No (0)
4. Do you have three or more drinks of beer, liquor or wine almost every day?	☐ Yes (2)	☐ No (0)
5. Do you have tooth or mouth problems that make it hard to eat?	☐ Yes (2)	☐ No (0)
6. Are there times when you don't have enough money to buy the food you need?	☐ Yes (4)	☐ No (0)
7. Do you eat alone most of the time?	☐ Yes (1)	☐ No (0)
8. Do you take three or more different prescribed or over-the-counter drugs per day?	☐ Yes (1)	☐ No (0)
9. Without wanting to, have you lost or gained ten pounds in the past six months?	☐ Yes, +10 (2) ☐ Yes, -10 (2)	☐ No (0)
10. Are there times when you are not physically able to shop, cook, or feed yourself?	☐ Yes (2)	☐ No (0)
Total Nutrition Score (Q.1-10): _____		
Refer to registered dietitian/nutritionist for nutrition counseling if Total Nutrition Score is **six or more.*		
11. Do you have a chronic (ongoing) medical condition?	☐ Yes	☐ No
If yes, list: _____		
12. Is it difficult to cover the cost of your medications each month?	☐ Yes	☐ No
13. Have you been released from the hospital or long term care (LTC) facility in the last ten days?	☐ Yes	☐ No
14. During the last two weeks, have you often been bothered by		
a. Having little interest or pleasure in doing things?	☐ Yes**	☐ No
b. Feeling down, sad, or hopeless?	☐ Yes**	☐ No
** See Nutrition Screening checklist section within User's Guide		

Name: _____ AIM ID#: _____

Consent for Release of Information and Referral

Information Use - Read to Participant

The information provided on this form is for program intake and registration purposes. It is used to help identify additional services to benefit you, the participant and to create statistical reports. This information is not released to anyone other than the referenced parties in a way that identifies you unless a separate consent to release information is signed.

Name: _____ Unique ID/AIM _____

I authorize _____ to release information contained herein to the following:
agency name

Provider agency or individual	Phone number	Services	Client initials

Identified Needs and Requested Referrals

☐ Caregiver services ☐ Chore services ☐ Congregate meals
☐ Evidence Based Health Promotion ☐ Home-delivered meals
☐ Homemaker services ☐ Legal assistance ☐ Outreach
☐ Registered dietician (RD) ☐ Transportation
☐ Other: _____
_____
_____

Signature

- I understand that my signature is applicable to all addendums necessary to complete this assessment. I understand that my information will only be released to other service agencies for the purpose of assisting me in obtaining their services and benefits for which I may be eligible.
- DHS Aging Services makes no distinction on the grounds of race, sex, religion, or national origin in the provision of services in accordance with the Civil Rights Act of 1964 and its amendments.
- This grant of authority shall last to the next review.
- I understand I cannot receive both AD*vantage* waiver meals and Home delivered meals/ Congregate meals.
- The interviewer explained the Older Americans Act Title III suggested donation. ☐Yes ☐No

_____ _____
Participant or ☐ legal representative signature Date

Name: _____ AIM ID#: _____

Program Use Only

_____ _____
Interviewer name | Interviewer title

TCCSNP _____ 918-835-4160
Agency name | Phone number

Same _____ _____ _____
Receiving agency | Phone number | Fax phone number

Amanda Dobyns _____ _____
AIM data entered by | Date entered | Service start date

Referral sent to registered dietician? ☐ Yes ☐ No Date sent: _____

Comments

Signature

_____ _____
Interviewer signature | Date

Nutrition Consult Referral

Assessment Date: _____

Name _____ Client ID _____ HB CONG

Address _____ Phone Number _____

_____ Site Name _____

We have a Registered Dietitian (RD) available to talk with you and or your caregiver about any nutritional questions or concerns you may have. Please check all items you would like to talk to the dietician about. If more than one, please indicate your Primary or Main concern with a "P".

Nutrition Health Score _____

____ Heart Healthy Eating
____ PRE-Diabetes
____ Weight Gain
____ High Blood Pressure
____ High Cholesterol
____ Chronic kidney disease
____ Dietary Supplements/Herbs
____ Lactose intolerance
____ Low blood sugar (hypoglycemia)
____ Diabetes
____ Weight Loss
____ Weight Management
____ Cancer
____ Problems Chewing or Swallowing
____ Heartburn, problems with spicy foods
____ Gluten Sensitivity/Celiac disease
____ Congestive Heart Failure
____ Intolerance or allergies to foods: (eggs, milk products, peanuts, seafood, etc)
____ You are at risk for or have had a heart attack
____ Other problem: _____

____ Yes, I would like to talk with the dietitian in person.
____ Yes, I would like to talk with the dietitian on the phone
____ No, I would not like to talk with the dietitian at this time

The best time to contact me is:
_____

While the nutrition project is required to send a referral to the dietician if I score a 6 or higher on my nutrition screening, I understand the dietitian will only contact me if I have marked that I would like to talk to him.

You have my permission to share the information on this form with the dietician.

Signature: _____

_____ Person Making the Referral

_____ Contact Information

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