

NATIONAL AGING PROGRAM INFORMATION SYSTEMS (NAPIS) REGISTRATION FORM

Welcome! We're glad you're here. Would you help us by telling us a bit about you? Services are funded in part by the Older Americans Act, a federal program since 1965. Annually we report demographics of participants. All information is confidential - we do not report personal information - only age, gender, race, zip code, poverty etc.

Section 1 – Tell us about YOU

Last	First	MI	Phone # () -	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /		# in Household: <input type="checkbox"/> 1 <input type="checkbox"/> 2+	
Street address:			City	Zip
Mailing address:			City	Zip

MONTHLY HOUSEHOLD INCOME

Single: below \$908 above \$909 Married: below \$1,226 above \$1,227

Ethnicity:

Hispanic/Latino Not Hispanic/Latino

Race: select all that apply

- | | |
|---|--|
| <input type="checkbox"/> White (alone) - Non-Hispanic | <input type="checkbox"/> White – Hispanic |
| <input type="checkbox"/> Amer. Indian/Alaska Native | <input type="checkbox"/> Native Hawaiian/Other Pacific |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Unknown - some other race | |

Section 2 – In case of an emergency - please contact (Optional information)

CONTACT NAME 1:	Phone Number:
<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Friend <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Family <input type="checkbox"/> Neighbor <input type="checkbox"/> Not Related	

CONTACT NAME 2:	Phone Number:
<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Friend <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Family <input type="checkbox"/> Neighbor <input type="checkbox"/> Not Related	

Complete Sections 3 & 4 if you participate in meal nutrition or in-home service.

Section 3 – Nutritional data (Please check all that apply)

- 1) I have an illness/condition and had to change the kind and/or amount of food I eat.
- 2) I eat fewer than 2 meals per day.
- 3) I eat few fruits, vegetables or milk products.
- 4) I have 3 or more drinks of beer, liquor or wine almost every day.

continued on reverse

Nutritional data, continued

- 5) I have tooth or mouth problems that make it hard for me to eat.
- 6) I don't always have enough money to buy the food I need.
- 7) I eat alone most of the time.
- 8) I take 3 or more prescribed or over-the-counter drugs a day.
- 9) Without wanting to, I have lost or gained 10 pounds in the last six months.
- 10) I am not always physically able to shop, cook and/or feed myself.

Section 4 – ADL/IADL Activities of Daily Living <i>Complete if you receive in-home svc</i> (Please mark I - Independent A - Assistance needed D - Dependent on helper)

- | | | |
|--|--|--|
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Toileting | <input type="checkbox"/> Medication Management |
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Transferring* | <input type="checkbox"/> Shopping* |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Food Preparation* | <input type="checkbox"/> Taking Medication |
| <input type="checkbox"/> Eating* | <input type="checkbox"/> Heavy Housework | <input type="checkbox"/> Using Telephones |
| <input type="checkbox"/> Mobility/Walking* | <input type="checkbox"/> Housekeeping | <input type="checkbox"/> Using Transportation* |
| <input type="checkbox"/> Managing Finances | <input type="checkbox"/> Personal Hygiene/Grooming | |

(Optional)

Section 5 - Special Diet Needs (Check all that apply)
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- | | | | |
|--|--|-------------------------------------|--|
| <input type="checkbox"/> Bland | <input type="checkbox"/> Dairy Free | <input type="checkbox"/> Diabetic | <input type="checkbox"/> High Calorie |
| <input type="checkbox"/> High Fiber | <input type="checkbox"/> High Protein | <input type="checkbox"/> Kosher | <input type="checkbox"/> Liquid |
| <input type="checkbox"/> Low Calorie | <input type="checkbox"/> Soft | <input type="checkbox"/> Renal | <input type="checkbox"/> Low Cholesterol |
| <input type="checkbox"/> Low Fat | <input type="checkbox"/> Low Fiber | <input type="checkbox"/> Low Salt | <input type="checkbox"/> Low Sodium |
| <input type="checkbox"/> Low Vitamin K | <input type="checkbox"/> Vegan | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Nasogastric Feeding |
| <input type="checkbox"/> Supplements | <input type="checkbox"/> Wheat/Gluten Free | <input type="checkbox"/> Other | |

Do you have comments you'd like to share?
