

Provider Name:	*Unique Participant ID: _____	
Region/Site Name:	Registration/Assessment Date: _____	
*Termination Date: _____ *Reason: _____		
Service Categories(Titles IIIB, IIIC and IIID):		
<input type="checkbox"/> *Personal Care (IIIB) (A,I)	<input type="checkbox"/> *Homemaker (IIIB) (A,I)	<input type="checkbox"/> *Chore (IIIB) (A,I)
<input type="checkbox"/> *Home-Delivered Meals (A,I,N)	<input type="checkbox"/> *Adult Day Care/Health (IIIB) (A,I)	<input type="checkbox"/> *Case Management (IIIB) (A,I, N)
<input type="checkbox"/> *Assisted Transportation (IIIB)	<input type="checkbox"/> *Congregate Meals (N)	<input type="checkbox"/> *Nutrition Counseling (N)
<input type="checkbox"/> Transportation (IIIB)	<input type="checkbox"/> Nutrition Education	<input type="checkbox"/> Other: _____
Notes: Reference the Data Dictionary for allowable "Other" service categories; Requires: A-ADLs, I-IADLs, N-Nutritional Assessments on Page 2		

SECTION 1 (Client)
(Required for All Registered Programs)*

Personal Data (Please Print):					
First Name:					
Middle Initial:					
Last Name:					
*Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to State				
*Birth Date:					
Last 4 Digits Social Security # <i>Optional</i>	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> </tr> </table>				
Home Phone #:	()				
Residential Address:					
Street:					
City:					
*Zip Code:					
Mailing Address:					
Same as Residential? <input type="checkbox"/> Yes – Skip to Next Section					
Street:					
City:					
Zip Code:					
Emergency Contact:	Name: Relationship: Phone #: ()				

*Ethnicity:	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State
*Federal Poverty Level (FPL)	<input type="checkbox"/> Below FPL <input type="checkbox"/> Above FPL <input type="checkbox"/> Declined to State
*Lives Alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
*Rural?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
*Race: (Please Check ONE)	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race	
Asian:	
<input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	
Hawaiian/Other Pacific Islander:	
<input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to State	
Title IIIB Eligibility:	
Are you age 60 or over? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Notes:	

SECTION 2 –ADL and IADL (Activities of Daily Living and Instrumental Activities of Daily Living – Annual Assessment)

** Required for (III-C): Home-Delivered Meals; (III-B): Personal Care, Homemaker, Chore, Adult Day Care, Case Management*

ADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
*Eating						
*Bathing						
*Toileting						
*Transferring In/Out of Bed/Chair						
*Walking						
*Dressing						
Notes:						
IADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
*Meal Preparation						
*Shopping						
*Medication Management						
*Money Management						
*Using Telephone						
*Heavy Housework						
*Light Housework						
*Transportation						
Notes:						

SECTION 3 – Nutritional Assessment (Annual)

** Required for (IIIC): Home-Delivered Meals, Congregate Meals; Nutritional Counseling*

*Nutritional Assessment:	Circle if yes
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits or vegetables or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the past 6 months.	2
I am not always physically able to shop, cook, and/or feed myself.	2
Total Score: (If equal to or greater than 6, the client is at high nutritional risk)	
	<input type="checkbox"/> Declined to State