YORK COUNTY AREA AGENCY ON AGING

REGISTRATION FOR CONGREGATE MEALS AND SENIOR CENTER SERVICES

(Please PRINT or TYPE Information)

1.1.A.1. Date:					**Senior Center PSA# 25**
2. Last Name:	3. First:	4. Middle:	5. Suffix:	6. Nickname:	7. Date of Birth:

8a. Current gender identity:	8b. Gender assigned at birth:	8c. Sexual orientation:	9. Registrant's Ethnicity:
☐ Female ☐ Male ☐ Non-binary ☐ Transgender female (male to female) ☐ Transgender male (female to male) ☐ Choose not to disclose ☐ Something else not named:	☐Female ☐Male ☐Something else not named: ☐Choose not to disclose	☐ Straight or Heterosexual ☐ Bisexual ☐ Lesbian, Gay or Homosexual ☐ Don't Know ☐ Something else not named: ☐ Choose not to disclose	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

10. Registrant's Race:	11. Last 4 digits of Social Security #:	12. Is the registrant's annual income less than 100% of the current Federal Poverty Income Guidelines (FPIG)?	13a. Does the registrant have a Medicaid number?
☐ American Indian/Native Alaskan ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Non-minority (White, non-Hispanic) ☐ Unknown ☐ Other	xxx-xx-_____	☐ Yes ☐ No ☐ Unknown The current Federal Poverty Guidelines are: $13,590 for one (1) person annually; $18,310 for 2. (Add $4,720 for each additional person in the household)	☐ Yes ☐ No ☐ Pending 13b. If Yes, what is the number? _____

14a. Does the registrant have Medicare?	15a. Does the registrant have other insurance?	16. Check all benefits the registrant is currently receiving:	
☐ Yes 14b. Medicare # _____ ☐ No	☐ Yes: 15b. Name of insurance: _____ ☐ No	☐ Food Stamps ☐ LIHEAP ☐ Medicaid ☐ PACE	☐ Section 8 ☐ Subsidized Transit ☐ Tax & Rent Rebates ☐ Weatherization ☐ Other:

1.C. Registrant Demographics: 1a. Are you homeless? ☐ Yes ☐ No If yes, answer questions a – c	1b. Do you have a place to stay tonight? ☐ Yes ☐ No	1c. Do you have a place to stay long-term? ☐ Yes ☐ No	1d. Explain homeless situation: ☐ Cannot afford housing ☐ Evicted ☐ Housing not available ☐ Voluntary Other:

2. Type of **PERMANENT** residence in which you reside:	3. What is your **PERMANENT** living arrangement?	4. What is your marital status?	**Veteran Questions**
☐ Apartment ☐ Domiciliary Care ☐ Group Home ☐ Own Home ☐ Personal Care Home ☐ Relative's Home ☐ Rehab Facility ☐ State Institution Other::	☐ Lives Alone ☐ Lives with Spouse Only ☐ Lives with Children, but not spouse ☐ Lives with other Family Members ☐ Other:	☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed Other: If married, when is your anniversary? _____	5a. Are you a Veteran? ☐ Yes Branch: _____ ☐ No 5b. Are you a spouse or widow of a veteran? ☐ Yes ☐ No 5c. Do you receive Veteran's benefits? ☐ Yes ☐ No

6a. Do you require communication assistance? ☐ Yes ☐ No	6b. If **Yes**, select which assistance is required: ☐ Assistive Technology ☐ Interpreter	☐ Large Print ☐ Picture Book	☐ Unable to Communicate ☐ Unknown Other:_____

7a. Do you use sign language as your **PRIMARY** language? ☐ Yes – 7b. Specify type used: _____ ☐ No	8. What is your **PRIMARY** language? ☐ English ☐ Russian ☐ Spanish ☐ Other: _____	9. Are you considered disabled? ☐ Yes ☐ No

1.D. Registrant's Permanent Residential Address Information

2a. County:		2b. Street Address:	
2d. Municipality (Township/Borough):		2c. Second Line Street Address:	
2e. City:	2f. State:	2g. Zip Code:	
4. Does the registrant reside in a rural area? ☐ Yes ☐ No	5a. Primary Phone #:	5b. Mobile Phone #:	5c. Other Phone #:

5d. Email Address:	6. Voter Registration: ☐ Already registered ☐ Not interested	☐ Info requested ☐ Does not meet voter requirements

1.E. Mailing Address (If different than street address):

1a. Postal Address 1st Line:			
1b. 2nd Line:	1c. City:	1d. State:	1e. Zip Code:

1.F.1. Emergency Contact's Name & 2. Relationship:

Physician's Name:	3. Emergency Contact's Phone Number:	4. Emergency Contact's Other Phone #:

2.A. Dietary Issues:

1. Do you generally have a good appetite? ☐ Yes ☐ No	2. Do you use a dietary supplement? ☐ Yes ☐ No	3. Do you have any food allergies? ☐ Yes ☐ No If yes, list:
4. Do you have a special diet for medical reasons? ☐ Yes ☐ No If yes, list:		5. Do you have a special diet for religious/cultural reasons? ☐ Yes ☐ No If yes, list:

2.B. Nutritional Risk Information

1. Has there been a change in your lifelong eating habits because of health problems? ☐ Yes ☐ No If yes, explain:	2. Do you eat fewer than 2 meals per day? ☐ Yes ☐ No If yes, explain:	3.Do you eat fewer than 2 services of dairy products every day? ☐ Yes ☐ No	4. Do you eat fewer than 5 services of fruits or vegetables each day? ☐ Yes ☐ No
5. Do you have 3 or more drinks of beer, liquor or wine almost every day? ☐ Yes ☐ No	6. Do you have trouble eating due to problems with chewing/swallowing? ☐ Yes ☐ No	7. Do you **not have** enough money to buy food needed? ☐ Yes ☐ No	8. Do you eat alone most of the time? ☐ Yes ☐ No
9. Do you take 3 or more prescribed or over-the-counter drugs per day? ☐ Yes ☐ No	10. Have you lost or gained at least 10 pounds or more in the last **6 months**? ☐ Yes ☐ No	11. Are you **not always** able to physically shop, cook and/or feed yourself (or to get someone to do it for you)? ☐ Yes ☐ No	