MANSFIELD

Form 5 - Consumer Registration Form

Registration: ☐ New or ☐ Update ☐ NFCSP/Statewide Respite (Caregivers complete sections I, II, IV, V, Via, Vib, IX) ☐ Includes Service Data (Complete section IX)

I. SAMS Details - Personal

a.) Consumer Name	First: Last:
b.) Current Date	/ /
c.) Marital Status	☐ Divorced ☐ Legally Separated ☐ Married ☐ Single ☐ Widowed ☐ Civil Union
d.) Gender	☐ Female ☐ Male
e.) Birth Date	/ / f.) SSN (SOCIAL SECURTIY) : 000-00- _____
g.) Default Agency	Senior Resources

II. SAMS Details - Residential Address

a.) Street 1	
b.) Street 2	c.) Phone:
d.) Town, Zip Code	Town: State (if not CT): Zip Code:

III. SAMS Details - Characteristics

a.) Cognitive Impairment	Has Alzheimer's disease or a related dementia. If Known ☐ Yes (mild) ☐ No (none) ☐ Unkown
b.) Meal Eligibility Type	☐ Age 60 and Older ☐ Disabled in Elderly Housing with Meal Site ☐ Spouse ☐ Disabled Living with Elderly Person ☐ Volunteer

IV. SAMS Details - Care Enrollment/Provider

a.) Care Enrollment	Level of Care: _____ Service/Care Program: _____
b.) Provider Name Your agency	THAMES VALLEY COUNCIL FOR COMMUNITY ACTION, INC. (TVCCA)

V. SAMS Details - Caregiver/Care Recipient (only for NFCSP and CT Statewide Respite Care)

a.) Care Status	☐ Care Recipient Name of Caregiver:
	☐ Caregiver Name of Care Recipient:
b.) Relationship	☐ Daughter ☐ Daughter-in-Law ☐ Grandparent ☐ Husband ☐ Non-Relative ☐ Other Elderly Non-Relative ☐ Other Elderly Relative ☐ Other Relative ☐ Relationship Missing ☐ Son ☐ Son-in-Law ☐ Wife

VI Assessment Form - Demographics

a.) Ethnicity	☐ Hispanic/Latino ☐ Not Hispanic/Latino
b.) Race (Check all that apply)	☐ Native American/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Non-Minority, White Non-Hispanic ☐ Other ☐ White, Hispanic
c.) Housing	☐ Private Home ☐ Private Apartment ☐ Senior Housing ☐ Congregate Housing ☐ Public Housing ☐ Residential Care Home ☐ Assisted Living ☐ Other _____ if "other" is checked enter type of housing

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VI Assessment Form - Demographics (Continued)

d.) Income (2/8/2017)

If living with someone other than spouse, use "I live alone..." section at top

I live alone and my monthly income is about:

- ☐ Under $1,012 (100%)
- ☐ $1,0136 - $1,265 (125%)
- ☐ $1,266- $1,518 (150%)
- ☐ $1,519 - $1,770 (175%)
- ☐ $1,771 - $2,023 (200%)
- ☐ $2,024 or over (over 200%)

I live with my spouse and our monthly income is about:

- ☐ Under $1,372 (100%)
- ☐ $1373 - $1,715 (125%)
- ☐ $1,716 - $2,058 (150%)
- ☐ $2,059 - $2,400 (175%)
- ☐ $2,401 - $2,743 (200%)
- ☐ $2,744 or over (over 200%)

e.) In Poverty ☐ Yes ☐ No

f.) Living Arrangements

- ☐ Alone
- ☐ With Spouse/Partner
- ☐ With Spouse and Child/Children
- ☐ With Child, No Spouse
- ☐ With Other Relatives
- ☐ With Others

VII Assessment Form - Functional Status

a.) ADL/IADL - I need help with these activities

On each line enter: Y for yes, N for no

___ Eating	___ Dressing	___ Bathing/Washing	___ Using the Toilet
___ Getting Out of Bed/Chair	___ Walking	___ Planning/Preparing Meals	___ Shopping
___ Managing Money	___ Using the Telephone	___ Heavy Housework	___ Light Housework
___ Taking Medicine	___ Using Transportation		

VIII Assessment Form - Nutrition

a.) Nutritional Risk

For Consumers Receiving: case management, congregate meals, home-delivered meals, nutritional counseling

Yes	No	
☐	☐	I have an illness or condition that made me change the kind/amount of food I eat. (2)
☐	☐	I eat fewer than 2 meals per day. (3)
☐	☐	I eat fewer than 5 fruits and vegetables per day. (1)
☐	☐	I eat fewer than 2 servings of milk, cheese or yogurt each day.(1)
☐	☐	I have problems chewing/swallowing that make it hard for me to eat. (2)
☐	☐	I do not always have enough money or food stamps to buy the food I need. (4)
☐	☐	I take 3 or more different prescription or over-the-counter drugs each day. (1)
☐	☐	I eat alone most of the time. (1)
☐	☐	I have 3 or more drinks of beer, liquor or wine almost every day. (2)
☐	☐	Without wanting to, I have lost or gained 10 pounds in the last 6 months. (2)
☐	☐	I am not always physically able to shop, cook or feed myself. (2)

IX Service Delivery

a.) Site Name (if applicable): _____

b.) Service Category (if applicable)	c.) Service (sub -service)	d.) Fund Identifier	e.) Number of Units
_____ /	CONGREGATE MEAL /	_____ /	_____
_____ /	CONGREGATE NUTRITION ED /	_____ /	_____
_____ /	CONG NUTRITION COUNSEL /	_____ /	_____
_____ /	_____ /	_____ /	_____

The confidential information on this form may be used for state, federal and local monitoring, including reporting requirements, program management, public safety and research. The personal identifying information on this form will not be further disclosed or used for any other purpose unless by court order or authorized by the program participant or consumer, or his or her personal representative.

Consumer Signature: _____