

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 I – 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 <input type="checkbox"/> 3 or more	
Street address:		City	Zip
Mailing address:		City	Zip

MONTHLY HOUSEHOLD INCOME

- HH=1: \$981 or below \$982 or above
 HH=2: \$1,328 or below \$1,329 or above
 HH=3: \$1,674 or below \$1,675 or above
 HH=4: \$2,368 or below \$2,369 or above

RACE select all that apply

- Amer. Indian/Alaska Native
 Asian
 Black/African American
 Native Hawaiian/Other Pacific
 White
 Unknown - some other race

ETHNICITY

- Hispanic/Latino
Not Hispanic/Latino

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

Contact Name 1:	Phone #
<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 #
<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 - 5 if you participate in a nutrition or in-home service**Section 3 – Nutritional data** (Please check all that apply)

- I have an illness/condition and had to change the kind and/or amount of food I eat.
 I eat fewer than 2 meals per day.

--continued on reverse--

Nutritional data, continued

- I eat few fruits, vegetables or milk products.
- I have 3 or more drinks of beer, liquor or wine almost every day.
- I have tooth or mouth problems that make it hard for me to eat.
- I don't always have enough money to buy the food I need.
- I eat alone most of the time.
- I take 3 or more prescribed or over-the-counter drugs a day.
- Without wanting to, I have lost or gained 10 pounds in the last six months.
- I am not always physically able to shop, cook and/or feed myself.

Section 4 –Activities of Daily Living* and Instrumental Activities of Daily LivingPlease mark **I** - Independent **A** - Assistance needed **D** - Dependent on helper

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

Section 5 - Special Diet Needs (Check all that apply)

- | | | | | |
|---|--|-------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Bland | <input type="checkbox"/> Clear Liquid | <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"/> Low Carbohydrate | <input type="checkbox"/> Low Cholesterol | <input type="checkbox"/> Low Fat | <input type="checkbox"/> Low Fiber | <input type="checkbox"/> Low Sodium |
| <input type="checkbox"/> Low Vitamin K | <input type="checkbox"/> Nasogastric Feeding | <input type="checkbox"/> Renal | <input type="checkbox"/> Soft | <input type="checkbox"/> Supplements |
| <input type="checkbox"/> Thickened Liquid | <input type="checkbox"/> Vegan | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Wheat/Gluten free | <input type="checkbox"/> Other |

Do you have information or comments you'd like to share?
