

Kansas Department for Aging and Disability Services Uniform Program Registration

Registration Date: _____ PSA: _____

CUSTOMER INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____
 Birth Date: _____ Age: _____ Social Security #: _____ Gender: Female Male
Month Day Year
 Residence Street Address: _____
Street City County State Zip Phone
 Emergency Contact Name: _____
 Emergency Contact Address: _____
Street City County State Zip Phone Alt Phone

Ethnicity	Race	
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Asian	<input type="checkbox"/> White Hispanic
<input type="checkbox"/> Ethnicity Missing	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White Non-Hispanic
	<input type="checkbox"/> Reporting some other race	<input type="checkbox"/> Reporting 2 or more races

Do you live alone? Yes No Is your monthly income below? Yes No
 Doctor Name: _____ \$1,063 – Family of 1 or \$1,437 – Family of 2
 City: _____ Phone: _____ \$1,810 – Family of 3 or \$2,183 – Family of 4
 Health conditions/medications: _____ Veteran or Spouse of Veteran Yes No

MODIFIED DIETS

Are you following any modified diet(s)? Yes No
 If yes, mark each type: Diabetic Diverticulitis Ethnic/religious Low sodium (salt) Mechanical
 Pureed Renal Vegetarian Other _____

NUTRITION RISK SCREEN (This section for Congregate Meals and Nutrition Counseling Only)
 Please answer each question below.

SCORING – If Yes, Circle	Yes	SCORING – If Yes, Circle	Yes
Do you eat less than 2 meals daily?	3	Have you made changes in the kind and/or amount of food you eat because of an illness and/or condition?	2
Do you eat less than 2 servings of fruits and vegetables daily?	1	Are you physically not always able to grocery shop, cook, and/or feed yourself? (Circle all that apply)	
Do you eat less than 2 servings of dairy products (milk, cheese, yogurt, etc.) daily?	1		
Do you usually drink less than 6 glasses of water, milk, or juice daily? # of glasses:	0	Do you eat alone most of the time?	1
		Do you feel that you usually do not have enough money to buy the food you need?	4
Do you drink 3 or more alcoholic beverages daily?	2	Have you gained or lost more than 10 pounds in the last 6 months? (Circle all that apply)	2
Do you take 3 or more different prescriptions and/or over-the-counter drugs daily?	1		
Do you have problems with dentures, teeth, or mouth, which make it hard to eat? (Circle all that apply)	2	Add all <u>YES</u> answers for Total Nutrition Risk Score:	

RISK LEVEL: 0-2: Low 3-5: Moderate 6 or more: High nutritional risk; share results with your health care provider.

Release of Information: I consent to the release of the information on this page so I can receive services. I understand the information on this page will be released to Kansas Department for Aging and Disability Services, the Area Agencies on Aging, and service providers as listed below to enable the delivery of services and program monitoring.
 Customer/Guardian Signature _____ Date _____
 Reviewer Signature _____ Date _____

~~~~~ **COMPLETED BY REVIEWER** ~~~~~

| UNMET NEEDS  |                   |                | PARTICIPANT STATUS FOR MEALS                                                                                                                                                                                                                                                                                                                                                                                                                            |          |         |     |                     |              |            |          |                |
|--------------|-------------------|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------|-----|---------------------|--------------|------------|----------|----------------|
| Service Code | Availability Code | Monthly Units  |                                                                                                                                                                                                                                                                                                                                                                                                                                                         |          |         |     |                     |              |            |          |                |
|              |                   |                | <input type="checkbox"/> 60+ Person<br><input type="checkbox"/> Less than 60 Spouse of 60+ Person<br><input type="checkbox"/> Less than 60 disabled Person residing with 60+ Person<br><input type="checkbox"/> 60+ non-spouse Caretaker (IIIB Home-delivered meals only)<br><input type="checkbox"/> Volunteer<br><input type="checkbox"/> Less than 60 disabled Person residing in housing facility with CMEL site and occupied mostly by 60+ Persons |          |         |     |                     |              |            |          |                |
| PSA          | Service Code      | Funding Source | Disaster                                                                                                                                                                                                                                                                                                                                                                                                                                                | Provider | Unit(s) | Per | Total Units Monthly | Cost of Unit | Start Date | End Date | Discharge Code |
|              |                   |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                         |          |         |     |                     |              |            |          |                |