# Alabama Department of Senior Services
# Title III Services
# FY24 Participant Enrollment Form

_____
*Name of AAA (office use)*

_____
*Name of Senior Center (office use)*

_____
*Enrollment Date*

STEP 1: Page 1 required for all programs. STEP 2: Nutrition programs only. STEP 3-5: Staff only. ***ALL*** information ***must be updated annually*.**

| **PARTICIPANT INFORMATION**: **Please ask for assistance if needed in completing this form** | | | |
|---|---|---|---|
| Last Name: | | First Name: | MI: |
| Street Address: | | Mailing Address (If different): | |
| City: State: Zip: | | City: State: Zip: | |
| County: | | Home Phone: ( ) Other Phone: ( ) | |
| Email address: | | | |
| Birthdate: ____/____/_____ MM DD YYYY | | Gender: ☐ Male ☐ Female | |
| **Race:** ☐ Caucasian/White ☐ Asian ☐ African-American/Black ☐ Native Hawaiian | ☐ Alaska Native ☐ Pacific Islander ☐ American Indian ☐ Other | **Ethnicity:** ☐ Not Hispanic/Latino ☐ Hispanic/Latino | |
| **Do you live alone?** ☐ Yes ☐ No | | ☐ **Dementia-related diagnosis** | |
| **Income Range:** Is your gross monthly income above $1,215 ☐ Yes ☐ No | | | |
| **EMERGENCY CONTACT INFORMATION**: Please provide name of a person to contact in an emergency. | | | |
| Name: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____ | | Relationship to participant: ☐ Spouse ☐ Friend | ☐ Other Relative ☐ Neighbor |
| Primary Physician: _____ Physician Phone: _____ | | | |

**ADLs/IADLs:** Do you need help with any of the following?

| | | Yes | No | Comments |
|---|---|---|---|---|
| ADLS | Eating | | | |
| | Transferring in and out of bed or chair | | | |
| | Walking | | | |
| | Dressing | | | |
| | Bathing | | | |
| | Toileting | | | |
| IADLS | Doing heavy housework | | | |
| | Doing light housework | | | |
| | Preparing meals | | | |
| | Shopping for personal items | | | |
| | Managing money | | | |
| | Medication management | | | |
| | Using telephone | | | |
| | Access to public/private transportation? | | | |

**Statement of Confidentiality:** The information recorded on this form is required for the statistical and reporting requirements for State and Community Programs under the Older Americans Act of 1965, as amended [Public Law 8973], and is not to be used for any other purpose in any form which could identify the individual without the individual's knowledge of the specific use and the individual's specific authorization for such use.

STEP 2: **Nutritional Health**: Please answer the following nutrition questions for congregate, home-delivered meals, and nutrition counseling:

(2) ☐ Y ☐ N 1. Have you changed the amount or kinds of food you eat because of illness or health condition?
(3) ☐ Y ☐ N 2. Do you eat fewer than 2 meals a day?
(1) ☐ Y ☐ N 3. Do you eat fewer than 3 fruits or vegetables a day?
(1) ☐ Y ☐ N 4. Do you eat fewer than 2 servings of dairy products a day? (Milk, yogurt, cheese)
(2) ☐ Y ☐ N 5. Do you have 2 or more drinks of beer, liquor, or wine almost every day?
(2) ☐ Y ☐ N 6. Do you have any tooth or mouth problems that make it hard to eat?
(4) ☐ Y ☐ N 7. Do you sometimes not have enough money for the food you need?
(1) ☐ Y ☐ N 8. Do you eat alone most of the time?
(1) ☐ Y ☐ N 9. Do you take 3 or more kinds of medicines a day? (include over the counter & prescription medicines)
(2) ☐ Y ☐ N 10. Without wanting to, have you lost or gained 10 pounds or more in the past 6 months?
(2) ☐ Y ☐ N 11. Do you have any physical problems that make it difficult for you to shop, cook, or feed yourself?

☐ ◀ **Nutrition Risk Score** of 6 or greater suggests "High" Nutrition Risk.

☐ Y ☐ N Do you want a referral to a Registered Dietitian Nutritionist for Nutrition Counseling?

**DO NOT WRITE BELOW THIS LINE**

STEP 3: Nutrition Staff

***To be completed by staff:***

**1. Approved Congregate Meals:**
☐ Hot Meals
☐ Frozen
☐ Shelf Stable

**2. Approved Home-Delivered Meals:**
☐ Hot Meals
☐ Frozen Meals (senior center delivered)
☐ Frozen Meals (food vendor delivery D2D)
☐ Frozen Breakfast (senior center delivered)
☐ Frozen Breakfast (food vendor delivery D2D)
☐ Shelf Stable

**3.** Liquid Nutrition Supplement (approved and provided by AAA with local funds or Title III cash allocations)
Congregate ☐ Yes ☐ No Homebound ☐ Yes ☐ No

**4.** If this participant is eligible for Title III-C Nutrition Services, identify why:
☐ Age 60 and older
☐ Spouse of eligible participant
☐ Volunteers at mealtime
☐ Individual with disability living with eligible participant
☐ Individual with disability living in public, low-income housing where a senior center is located
☐ 60+ caregiver

Date Approved: _____ Staff: _____

STEP 4: Name and address of alternate deliver if for home-delivered meal or Notes and Comments:

_____
_____
_____

STEP 5:
**AIMS #:** _____ **Date Entered:** _____ **Staff Initials:** _____