STATE OF ALABAMA
DEPARTMENT OF SENIOR SERVICES
OLDER AMERICANS ACT SERVICES
CLIENT ENROLLMENT FORM

Name of AAA *(office use)*: ____________

Name of Senior Center *(office use)*: ____________

Date: ____________

You ***must*** complete this form to receive the following services provided under the Older Americans Act: Congregate Meals & Transportation (page 1 only), Home-Delivered Meals, Assisted Transportation, Nutrition Counseling, Adult Day Care, Personal Care, Homemaker, Chore, Case Management, Health Promotion, Medication Management, or Cash and Counseling. ***ALL*** of this information ***must be updated each year.***

CLIENT INFORMATION: Please ask for assistance if needed in completing this form		
Last Name:	First Name:	MI:
Birthdate: ___/___/_____ (MM DD YYYY)	Gender: ☐ Male ☐ Female	Rural: ☐ Yes ☐ No
Street Address:	City:	State: Zip:
Mailing Address (If different):		
County: Jefferson	Home Phone: ( )	
Other Phone: ( )	Email address:	

Race:
- ☐ Caucasian/White
- ☐ African-American/Black
- ☐ Alaska Native
- ☐ American Indian
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Pacific Islander

Ethnicity:
- ☐ Not Hispanic/Latino
- ☐ Hispanic/Latino

Household Composition: (check all that apply)
- ☐ Alone
- ☐ With Spouse
- ☐ Family
- ☐ With Other

Number of people living in Household: _____

Income Range:
Estimate your monthly income (net income after taxes). Then, choose one response. (Providing this information will not affect your receiving services).
- ☐ 0-$903
- ☐ $904-$2,707
- ☐ Above $2,707

☐ **Client has dementia-related diagnosis**

Is client a Cash and Counseling client? ☐ Y ☐ N

Suggested Donation: $ 1.50

Nutritional Health: Please answer the following nutrition questions for congregate or home-delivered meals:

(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 less than 2 meals a day?
(1) ☐ Y ☐ N 3. Do you eat less than 3 fruits or vegetables a day?
(1) ☐ Y ☐ N 4. Do you eat less than 2 servings of dairy products a day? (Milk, yogurt, cheese)
(2) ☐ Y ☐ N 5. Do you consume 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 lack money to buy 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. Have you lost or gained 10 pounds or more in the past 6 months without trying? ☐ Lost ☐ Gained
(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**

EMERGENCY CONTACT INFORMATION: Please provide name of a person to contact in an emergency.

Relationship to Client: ☐ Spouse ☐ Other Relative ☐ Friend ☐ Neighbor

Name: ____________ Home Phone: ____________
Address: ____________ Work Phone: ____________
City/State/Zip: ____________ Cell Phone: ____________
Primary Physician: ____________ Physician Phone: ____________

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.

ADLs/IADLs: This information is ***required*** for any Home-Delivered Meals, Assisted Transportation, Homemaker, Personal Care, Adult Day Care, Chore, and Case Management.
Check how much assistance you need with the following activities.

		None	Some	Unable	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				
	Transportation without assistance				

DO NOT WRITE BELOW THIS LINE

To be completed by staff:

AIMS Client No.: ___________ **Enrollment Date:** ___________ **Worker's Initials:** ______

Approved Congregate Meals:
- ☐ Hot Meals
- ☐ Frozen
- ☐ Breakfast
- ☐ Liquid Meal Replacement

Approved Home-Delivered Meals:
- ☐ Hot Meals
- ☐ Frozen Meals (pick up at center)
- ☐ Frozen Meals (client delivery by vendor)
- ☐ Breakfast
- ☐ Liquid Meal Replacement (pick up at center)
- ☐ Liquid Meal Replacement (client delivery by vendor)

1. If this client is approved for liquid meal replacement, does the Agency have a doctor's order on file? ☐ Yes ☐ No

2. If this client is eligible for Title III-C Nutrition Services, identify the reason:
- ☐ Client age 60 and older
- ☐ Spouse of eligible client
- ☐ Volunteers at mealtime
- ☐ Disabled/dependent child living with eligible parent
- ☐ Disabled/client under age 60 and living in public, low-income housing where a a senior center is located

Enrollment Action:
- ☐ New Client
- ☐ Annual Re-enrollment
- ☐ Receiving Client Transfer Date: ___________ Transferred From: ___________
- ☐ Client Termination Date: ___________ Termination Reason: ___________

Notes/Comments: