CLIENT REGISTRATION 10-02 **DATE**_____________________

*
___
First Name **MI** **Last Name**

*
___
Address **City** **State** **Zip**

*(   )______________ * ____________________________ * **Gender**
Telephone No. **Birthdate (Month/day/year)** { } **Female**
{ } **Male**

*_________________ *_________________ *_________________________________
Social Security No. **County** **City/Township**

*______________________________
Household Monthly Income
{ } **Refused Income Information**

***Race**
{ } **American Indian or Alaskan Native**
{ } **Asian**
{ } **Black or African American**
{ } **Native Hawaiian or other Pacific Island**
{ } **White**
{ } **Other Race**
{ } **Refused/Unknown**
{ } **Two or more Races**

***Ethnic Origin**
{ } **Hispanic or Latino**
{ } **No Hispanic or Latino**
{ } **Cambodian**
{ } **Former Soviet Union**
{ } **Vietnamese**

Marital Status
{ } **Divorced**
{ } **Married**
{ } **Separated**
{ } **Single**
{ } **Widowed**

*_____________
No. of Persons in Household

Self Declared Nutrition Risk Assessment:

I have an illness or condition that made me change the kind and/or the amount of food I eat.	{ }	{ }
I eat fewer than 2 meals per day.	{ }	{ }
I eat few fruits and vegetables or milk products.	{ }	{ }
I have 3 or more drinks of beer, liquor or wine almost everyday.	{ }	{ }
I have tooth or mouth problems that make it difficult 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 and/or over-the-counter drugs per day.	{ }	{ }
Without wanting to, I have lost or gained 10 pounds in the past 6 months.	{ }	{ }
I am not always physically able to shop, cook and/or feed myself.	{ }	{ }

Services Provided to Client

Service	Start Date	Funding	End Date	Reason Ended

Disclosure Statement:

The Client Registration Form was developed to assist the Council on Aging to monitor the effectiveness of senior programs offered to the citizens of Ohio. Any client information obtained from this form will be kept confidential and no personal identifying information about a client (i.e. name, address, telephone number, etc.) will be released to the public without the client's prior written consent, or unless otherwise required under federal law.

The data collected (i.e. age, sex race, low-income status, ADL's and IADLS) will be forwarded to the Council on Aging and summarized and reported to the Ohio Department of Aging (ODA) and the Administration on Aging (AOA) in order to keep both state and federal legislators informed on the effectiveness of senior programs (as required by the Older Americans Act reauthorization.) While all clients receiving services under the Older Americans Act are asked to complete the attached form in full, no client may be denied services for refusing to provide any of the information requested, including Social Security Number.

If you have any questions, ask the staff to explain why this is necessary.

*______________________________________ *______________________________

Applicant Signature Date

I have discussed/read/explained the Disclosure Statement with the client.

*______________________________________ *______________________________

Provider Signature Date

Membership Application/Renewal

Anderson Senior Center is a non-profit entity of Senior Independence, a division of the Ohio Presbyterian Retirement Services. Contributions may be tax deductible.

_____New Application _____Renewal Application

_____$20 Individiual/year ______$35 Couple (same address)/year

****************************The above charges are for Anderson Twp. Residents***

Non-Resident

_____$30 Individual/year _____$55 Couple/year

____________________ ____

Birthdate Email Address

_____I will pick up my bi-monthly Newsletter _____Please mail my newsletter