

Form 5 - Consumer Registration Form

Registration:	<input type="checkbox"/> New	<input type="checkbox"/> Update	<input type="checkbox"/> NFCSP/Statewide Respite <small>(Caregivers complete sections I, II, IV, V, VIa, VIb, IX)</small>	<input type="checkbox"/> Includes Service Data <small>(Complete section IX)</small>
I. SAMS Details - Personal				
a.) Consumer Name	First:	Last:		
b.) Date	/ /			
c.) Marital Status	<input type="checkbox"/> Divorced	<input type="checkbox"/> Legally Separated	<input type="checkbox"/> Married	<input type="checkbox"/> Single
	<input type="checkbox"/> Widowed	<input type="checkbox"/> Civil Union	<input type="checkbox"/> Unknown	
d.) Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male			
e.) Birth Date	/ /		f.) SSN (Social Security): 000 - 00 - ____ - ____ - ____	
g.) Default Agency				
II. SAMS Details - Residential Address				
a.) Street 1				
b.) Street 2				c.) County:
d.) Town, Zip Code	Town:	State (if not CT):	Zip Code:	
III. SAMS Details - Characteristics				
a.) Cognitive Impairment	Has Alzheimer's disease or a related dementia. <input type="checkbox"/> Yes (mild) <input type="checkbox"/> No (none) <input type="checkbox"/> Unknown			
b.) Meal Eligibility Type	<input type="checkbox"/> Age 60 and Older	<input type="checkbox"/> Disabled in Elderly Housing	<input type="checkbox"/> Helper/Spouse	<input type="checkbox"/> Not Indicated
	<input type="checkbox"/> Other	<input type="checkbox"/> Tribal Specification	<input type="checkbox"/> Volunteer	
IV. SAMS Details - Care Enrollment/Provider				
a.) Care Enrollment	Level of Care:		Service/Care Program:	
b.) Provider Name				
V. SAMS Details - Caregiver/Care Recipient (only for NFCSP and CT Statewide Respite Care)				
a.) Care Status	<input type="checkbox"/> Care Recipient	Name of Caregiver:		
	<input type="checkbox"/> Caregiver	Name of Care Recipient:		
b.) Relationship	<input type="checkbox"/> Daughter	<input type="checkbox"/> Daughter-in-Law	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Husband
	<input type="checkbox"/> Non-Relative	<input type="checkbox"/> Other Elderly Non-Relative	<input type="checkbox"/> Other Elderly Relative	<input type="checkbox"/> Other Relative
	<input type="checkbox"/> Relationship Missing	<input type="checkbox"/> Son	<input type="checkbox"/> Son-in-Law	<input type="checkbox"/> Wife
VI. Assessment Form - Demographics				
a.) Ethnicity	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Not Hispanic/Latino	<input type="checkbox"/> Unknown	
b.) Race <small>(check all that apply)</small>	<input type="checkbox"/> Native American/Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Missing
	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Non-Minority, White Non-Hispanic		<input type="checkbox"/> Other
	<input type="checkbox"/> White, Hispanic			
c.) Housing	<input type="checkbox"/> Private Home	<input type="checkbox"/> Private Apartment	<input type="checkbox"/> Senior Housing	<input type="checkbox"/> Congregate Housing
	<input type="checkbox"/> Public Housing	<input type="checkbox"/> Residential Care Home	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Assisted Living
	<input type="checkbox"/> Other _____		<input type="checkbox"/> Unknown	

VI. Assessment Form - Demographics (Continued)

d.) Income (1/24/2006) **I live alone and my monthly income is about:**
 Under \$817 (100%) \$818 - \$1,021 (125%) \$1,022 - \$1,225 (150%)
 \$1,226 - \$1,429 (175%) \$1,430 - \$1,633 (200%) \$1,634 or over (over 200%) Unknown

I live with my spouse and our monthly income is about:
 Under \$1,100 (100%) \$1,101 - \$1,375 (125%) \$1,376 - \$1,650 (150%)
 \$1,651 - \$1,925 (175%) \$1,926 - \$2,200 (200%) \$2,201 or over (over 200%) Unknown

e.) In Poverty Yes No Unknown

f.) Living Arrangements Alone With Spouse/Partner With Spouse and Child/Children
 With Child, No Spouse With Other Relatives With Others Unknown

VII. Assessment Form - Functional Status

a.) ADL/IADL **I need help with these activities**
 On each line enter: ___ Eating ___ Dressing ___ Bathing/Washing ___ Using the Toilet
 Y for yes, ___ Getting Out of Bed/Chair ___ Walking ___ Planning/Preparing Meals ___ Shopping
 N for no, or ___ Managing Money ___ Using the Telephone ___ Heavy Housework ___ Light Housework
 U for unknown ___ Taking Medicine ___ Using Transportation

VIII. Assessment Form - Nutrition

	Yes	No	Unknown	
a.) Nutritional Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I have an illness or condition that made me change the kind or amount of food I eat. (2)
For Consumers Receiving:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I eat fewer than 2 meals per day. (3)
case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I eat fewer than 5 fruits and vegetables per day. (1)
congregate meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I eat fewer than 2 servings of milk, cheese or yogurt each day. (1)
home-delivered meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I have problems chewing/swallowing that make it hard for me to eat. (2)
nutrition counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I do not always have enough money or food stamps to buy the food I need. (4)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I take 3 or more different prescription or over-the-counter drugs each day. (1)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I eat alone most of the time. (1)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I have 3 or more drinks of beer, liquor or wine almost every day. (2)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Without wanting to, I have lost or gained 10 pounds in the last 6 months. (2)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I am not always physically able to shop, cook or feed myself. (2)

IX. Service Delivery

a.) Site Name (if applicable): _____

b.) Service Category (if applicable)	c.) Service (sub-service)	d.) Fund Identifier	e.) Number of Units
_____ / _____	_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____	_____ / _____

The confidential information on this form may be used for state, federal and local monitoring, including reporting requirements, program management, public safety and research. The personal identifying information on this form will not be further disclosed or used for any other purpose unless by court order or authorized by the program participant or consumer, or his or her personal representative.

Consumer Signature: _____