Clear Form

Kansas Department for Aging and Disability Services Uniform Program Registration

Registration Date: PSA: Select

CUSTOMER INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____

Birth Date: _____ Age: _____ Social Security #: _____ Gender: ☐ Female ☐ Male ☐ Other

Month Day Year

Residence Street Address: _____

Phone: _____ *Street City County State Zip Apt #*

Emergency Contact Name: _____

Emergency Contact Address: _____

Street City County State Zip Phone Alt Phone

Ethnicity	Race	
☐ Hispanic or Latino	☐ American Indian/Alaskan Native	☐ Native Hawaiian or Other Pacific Islander
☐ Not Hispanic or Latino	☐ Asian	☐ White
☐ Ethnicity Missing	☐ Black or African American	

Do you live alone? ☐ Yes ☐ No

Is your income below the poverty level? ☐ Yes ☐ No

Doctor Name: _____

City: _____ Phone: _____

Veteran or Spouse of Veteran ☐ Yes ☐ No

Health conditions/medications: _____

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, check box	Yes	SCORING – If Yes, check box	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		
Do you eat less than 2 servings of dairy products (milk, cheese, yogurt, etc.) daily?	1	Are you physically not always able to grocery shop, cook, and/or feed yourself? (List all that apply)	2
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 drink 3 or more alcoholic beverages daily?	2	Do you feel that you usually do not have enough money to buy the food you need?	4
Do you take 3 or more different prescriptions and/or over-the-counter drugs daily?	1	Have you gained or lost more than 10 pounds in the last 6 months? (List all that apply)	2
Do you have problems with dentures, teeth, or mouth, which make it hard to eat? (List all that apply)	2	Add all YES answers for **Total Nutrition Risk Score**:	0

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 ~~~~~~~~~~~~~~~~~~~~~~~~

KAMIS ID #:

UNMET NEEDS

Service Code	*Availability Code*	*Monthly Units*

PARTICIPANT STATUS FOR MEALS

- ☐ 60+ Person
- ☐ Less than 60 Spouse of 60+ Person
- ☐ Less than 60 disabled Person residing with 60+ Person
- ☐ 60+ non-spouse Caretaker (IIIB Home-delivered meals only)
- ☐ Volunteer
- ☐ 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
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