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| **The DAAS-101 Client Registration Short Form may only be used to register Congregate Nutrition and Transportation clients. Complete all applicable information relative to Congregate Nutrition and/or Transportation.** | | | | | | | | | | | | |
| * COMPLETE SECTIONS I, II and VII ONLY for codes **(180)-**Congregate Nutrition, **(181)**-Congregate Nutrition-NSIP, and **(182)**-Congregate Nutrition Supplemental Meals. | | | | | | | | | | | | |
| * COMPLETE SECTIONS I and VII ONLY for codes **(250)**-Transportation, **(033)**-Transportation (Medical) and **(252)**-Transportation-Pilot Bus Pass Program. | | | | | | | | | | | | |
| **Service Codes:** Click or tap here to enter text. | | | | **Region Code:** Click or tap here to enter text. | | | | | | | **Provider Code:** Click or tap here to enter text. | |
| ***CLIENT STATUS: Check the Appropriate box(es) and enter the date.*** | | | | | | | | | | | | |
| **New Registration** | | | | | | | | | DATE: Click or tap to enter a date. | | | |
| **Activation** | | | | | | | | | DATE: Click or tap to enter a date. | | | |
| **Waiting for Service** *[Complete Section I ONLY]* | | | | | | | | | DATE: Click or tap to enter a date.  *(enter 3 service codes):* Click or tap here to enter text. | | | |
| **Change of Information** | | | | | | | | | DATE: Click or tap here to enter text.  *(complete Section I when a change is needed for any client information)* | | | |
| **Inactive** – DATE: Click or tap to enter a date. *(check box below) (make inactive only if permanently leaving ARMS)*  *If client is a caregiver receiving FCSP/Project C.A.R.E. services and the client inactive reason relates more to CR status, check Care Recipient box.*  Reason for making client inactive applies to: ☐ Client/Caregiver ☐ Care Recipient | | | | | | | | | | | | |
| Moved to adult care home/assisted living  Alternative living arrangement  Death  Hospitalization (not expected to return)  Nursing home placement | | | | | | | | | Moved out of service area  Improved function/Need eliminated  Service not needed/wanted  Illness (not expected to return)  Other (specify): Click or tap here to enter text. | | | |
| **SECTION I: CLIENT/CAREGIVER INFORMATION (Required for *ALL* Clients/For FCSP the Caregiver is the Client)** | | | | | | | | | | | | |
| **Legal Name:** Last Click or tap here to enter text. | | | | | | | First Click or tap here to enter text. | | | | | M.I. Click or tap here to enter text. |
| Suffix Click or tap here to enter text. | | | **Last 4 Digits SSN:** Click or tap here to enter text. | | | | | | | | | **Phone:** Click or tap here to enter text.  ☐ No phone |
| **Address** Click or tap here to enter text.  **County:** Click or tap here to enter text. | | | | | | **Email** Click or tap here to enter text. | | | | | | **DOB:** Click or tap here to enter text.  *Check if special eligibility* |
| **City:** Click or tap here to enter text. | | | | | **State:** Click or tap here to enter text. | | | | | | | **Zip:** Click or tap here to enter text. |
| **Sex**  *(check one)*  Female  Male | **At/Below Poverty Level?**  *(check one)*  Yes  No | **Marital Status** *(check one)*  Single  Divorced  Married  Widowed  Separated  Partnered  Client Refused  Unknown | | | | | | | | **Household Status** *(check one)*  Lives alone  Lives with Other  Unknown  Client Refused  Lives in Long Term Care (LTC) facility [Legal Assistance is the only service to collect "Lives in Long Term Care (LTC) facility"] | | |
| **Race** (Check all that apply)  Black or African American  White  Asian or Asian American  Native Hawaiian or Pacific Islander  American Indian or Alaska Native  Refused/Unknown/Not Reported | | | | | | | | **Ethnicity (Are you of Hispanic or Latino Origin?)**  Hispanic or Latino  Not Hispanic or Latino  Unreported/Missing/Client Refused | | | | |
| **Primary Language Spoken:** English Spanish  Other Click or tap here to enter text. [*see languages in Client Registration Form (CRF) manual]* | | | | |
| **Name of Emergency Contact:** Click or tap here to enter text.  Refused to provide  Cell#: Click or tap here to enter text. Home#: Click or tap here to enter text. Day#: Click or tap here to enter text. | | | | | | | | | | | | |
| **Caregiver’s Overall Functional Status:**  Well  At risk  High risk  ***(When the CAREGIVER IS REGISTERED AS THE CLIENT, use this field for the CAREGIVER’S SELF-REPORTED functional status and complete Section IV for Care Recipient.) If SECTION IV is required, SKIP THIS QUESTION. ARMS will automatically calculate the Caregiver’s Overall Functional Status when SECTION IV is entered.*** | | | | | | | | | | | | |

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| **SECTION VII: Required for *ALL* Clients** |
| I, the client, understand the information contained on this form will be kept confidential unless disclosure is required by court order or for authorized federal, state or local program reporting and monitoring. I understand that any entitlement I may have to Social Security benefits or other federal or state sponsored benefits shall not be affected by the provision of the aforementioned information. My signature authorizes the providing agency to begin the service(s) requested. |
| **DATE:** Click or tap to enter a date. **CLIENT/CAREGIVER SIGNATURE:** Click or tap here to enter text.  **DATE:** Click or tap to enter a date. **AGENCY EMPLOYEE SIGNATURE:** Click or tap here to enter text. |
| **Provider Use Only – initial below after re-assessment:**  Registration Update: Click or tap to enter a date. Staff Initials Click or tap here to enter text.  Registration Update: Click or tap to enter a date. Staff Initials Click or tap here to enter text.  Registration Update: Click or tap to enter a date. Staff Initials Click or tap here to enter text. |
| **NOTES/COMMENTS:**  Click or tap here to enter text. |

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| **SECTION II: Required *ONLY* for clients of HCCBG Congregate Nutrition, Congregate Nutrition Supplemental Meals, NSIP (only Congregate Nutrition meals).** | | |
| **Nutrition Health Score** | | |
| **Assessment Date:** Click or tap to enter a date. | **Response** | **Refuse** |
| 1. Do you have an illness or condition that made you change the kind and/or amount of food you eat? | Yes  No |  |
| 1. How many meals do you eat per day? | Click or tap here to enter text. |  |
| 1. How many servings of fruit do you eat per day? | Click or tap here to enter text. |  |
| 1. How many servings of vegetables do you eat per day? | Click or tap here to enter text. |  |
| 1. How many servings of milk/dairy products do you consume per day? | Click or tap here to enter text. |  |
| 1. How many drinks of beer, liquor, or wine do you have every day or almost every day? | Click or tap here to enter text. |  |
| 1. Do you have tooth/mouth problems that make it hard for you to eat? | Yes  No |  |
| 1. Do you always have enough money or food stamps to buy the food you need? | Yes  No |  |
| 1. How many meals do you eat alone daily? | Click or tap here to enter text. |  |
| 1. How many prescribed drugs do you take per day? | Click or tap here to enter text. |  |
| 1. How many over-the-counter drugs do you take per day? | Click or tap here to enter text. |  |
| 1. Have you lost 10 or more pounds in the past 6 months without trying? | Yes  No |  |
| 1. Have you gained 10 or pounds in the past 6 months without trying? | Yes  No |  |
| 1. Are you physically able to shop for yourself? | Yes  No |  |
| 1. Are you physically able to cook for yourself? | Yes  No |  |
| 1. Are you physically able to feed yourself? | Yes  No |  |