

CLIENT REGISTRATION FORM • DAAS 101 (Short Form)

NC Department of Health and Human Services - Division of Aging and Adult Services

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: _____	Region Code: _____	Provider Code: _____
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CLIENT STATUS: Check the Appropriate box(es) and enter the date.

<input type="checkbox"/> New Registration	DATE: _____
<input type="checkbox"/> Activation	DATE: _____
<input type="checkbox"/> Waiting for Service [Complete Section I ONLY]	DATE: _____ (enter 3 service codes):
<input type="checkbox"/> Change of Information	DATE: _____ (complete Section I when a change is needed for any client information)

Inactive – 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

<input type="checkbox"/> Moved to adult care home/assisted living <input type="checkbox"/> Alternative living arrangement <input type="checkbox"/> Death <input type="checkbox"/> Hospitalization (not expected to return) <input type="checkbox"/> Nursing home placement	<input type="checkbox"/> Moved out of service area <input type="checkbox"/> Improved function/Need eliminated <input type="checkbox"/> Service not needed/wanted <input type="checkbox"/> Illness (not expected to return) <input type="checkbox"/> Other (specify): _____
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SECTION I: CLIENT/CAREGIVER INFORMATION (Required for ALL Clients/For FCSP the Caregiver is the Client)

Legal Name: Last _____ First _____ M.I. _____	
Suffix _____	Last 4 Digits SSN: _____ Phone: _____ <input type="checkbox"/> No phone
Address _____	Email _____ DOB: _____ <input type="checkbox"/> Check if special eligibility
County: _____	State: _____ Zip: _____
Sex (check one) <input type="checkbox"/> Female <input type="checkbox"/> Male	At/Below Poverty Level? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No
Marital Status (check one) <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Partnered <input type="checkbox"/> Client Refused <input type="checkbox"/> Unknown	Household Status (check one) <input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with Other <input type="checkbox"/> Unknown <input type="checkbox"/> Client Refused <input type="checkbox"/> 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) <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Refused/Unknown/Not Reported	Ethnicity (Are you of Hispanic or Latino Origin?) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unreported/Missing/Client Refused Primary Language Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ [see languages in Client Registration Form (CRF) manual]
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Name of Emergency Contact: _____ Refused to provide
 Cell#: _____ Home#: _____ Day#: _____

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 II: Required ONLY for clients of HCCBG Congregate Nutrition, Congregate Nutrition Supplemental Meals, NSIP (only Congregate Nutrition meals).

Nutrition Health Score

Assessment Date:	Response	Refuse
a. Do you have an illness or condition that made you change the kind and/or amount of food you eat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
b. How many meals do you eat per day?	#	<input type="checkbox"/>
c. How many servings of fruit do you eat per day?	#	<input type="checkbox"/>
d. How many servings of vegetables do you eat per day?	#	<input type="checkbox"/>
e. How many servings of milk/dairy products do you consume per day?	#	<input type="checkbox"/>
f. How many drinks of beer, liquor, or wine do you have every day or almost every day?	#	<input type="checkbox"/>
g. Do you have tooth/mouth problems that make it hard for you to eat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
h. Do you always have enough money or food stamps to buy the food you need?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
i. How many meals do you eat alone daily?	#	<input type="checkbox"/>
j. How many prescribed drugs do you take per day?	#	<input type="checkbox"/>
k. How many over-the-counter drugs do you take per day?	#	<input type="checkbox"/>
l. Have you lost 10 or more pounds in the past 6 months without trying?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
m. Have you gained 10 or pounds in the past 6 months without trying?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
n. Are you physically able to shop for yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
o. Are you physically able to cook for yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
p. Are you physically able to feed yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

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: _____ **CLIENT/CAREGIVER SIGNATURE:** _____
DATE: _____ **AGENCY EMPLOYEE SIGNATURE:** _____

Provider Use Only – initial below after re-assessment:

Registration Update: _____ Staff Initials: _____
 Registration Update: _____ Staff Initials: _____
 Registration Update: _____ Staff Initials: _____

NOTES/COMMENTS: