

Date Completed:

Client Registration Form

First Name:		Last Name:		Mid Init:
Address:			City:	
State:	Zip:	County:	Phone:	
Birth Date:		Gender:	Veteran: ☐ No ☐ Yes	
Email:				
Emergency Contact Name and Relationship:			Emergency Contact Phone:	
Limited ability to read, speak, write or understand English ☐ No ☐ Yes* *Primary Language:		Lives With: ☐ Alone ☐ Child(ren) ☐ Domestic Partner ☐ Domestic Partner & Others ☐ Non-Relative(s) ☐ Non-relative(s) in community-based setting ☐ Non-relative(s) in facility/institution ☐ Others not listed ☐ Parent/Guardian ☐ Relatives ☐ Spouse ☐ Spouse and Others		
Person who is Frail: ☐ No ☐ Yes Person with a Disability: ☐ No ☐ Yes		Any Communication Needs:		
Marital Status: ☐ Divorced ☐ Domestic Partner/Significant Other ☐ Married ☐ Separated ☐ Single ☐ Widowed			Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	
Race (select one or more): ☐ American Indian/Native Alaskan ☐ Asian ⇨ ☐ Black or African American ☐ Middle Eastern ⇨ ☐ Native Hawaiian/Other Pacific Islander ⇨ ☐ North African ⇨ ☐ White - Hispanic ☐ White - Not Hispanic		If Asian: ☐ Asian Indian ☐ Bangladeshi ☐ Chinese ☐ Japanese ☐ Korean ☐ Pakistani ☐ Vietnamese ☐ Prefers not to answer ☐ Other:		
		If Middle Eastern: ☐ Armenian ☐ Iranian ☐ Iraqi ☐ Israeli ☐ Jordanian ☐ Lebanese ☐ Palestinian ☐ Saudi ☐ Syrian ☐ Yemeni ☐ Prefers not to answer ☐ Other:		
		If Native Hawaiian/Other Pacific Islander: ☐ Chamorro ☐ Guamanian ☐ Native Hawaiian ☐ Samoan ☐ Prefers not to answer ☐ Other:		
		If North African: ☐ Algerian ☐ Egyptian ☐ Libyan ☐ Moroccan ☐ Sudanese ☐ Tunisian ☐ Prefers not to answer ☐ Other:		

2026 Poverty Guidelines

Select Income:	<100% ☐		100-124% ☐		125-149% ☐		150-184% ☐		185%+ ☐
HOUSEHOLD SIZE	100%		125%		150%		185%		
	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	
1	15,960	1,330	19,950	1,663	23,940	1,995	29,526	2,461	
2	21,640	1,803	27,050	2,254	32,460	2,705	40,034	3,336	
3	27,320	2,277	34,150	2,846	40,980	3,415	50,542	4,212	
4	33,000	2,750	41,250	3,438	49,500	4,125	61,050	5,088	
For each additional person, add :	5,680 annual amount		7,100 annual amount		8,520 annual amount		11,360 annual amount		

Complete questions below if registering for Meals or Nutrition Counseling

Determining Nutritional Health

Circle the number in the "YES" column for the statements that apply to you.

YES

I have an illness or conditions that made me change the kind and/or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits or vegetables, or milk products.	2
I have 3 or more drinks of beer, liquor, or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook, and/or feed myself.	2
TOTAL SCORE	
<i>A score of 0-2 means Good, recheck at six months.</i>	
<i>A score of 3-5 means you are at moderate nutritional risk and need to see what you can do to improve eating habits and make life-style changes.</i>	
<i>A score of 6 or more means you are at a high nutritional risk. Take the checklist to a doctor, dietitian or qualified health or social service professional and talk to them. Ask for definite ways to improve your nutritional health.</i>	

We can connect you to a dietitian for individualized assistance as part of our services. Do you want a referral to the county Registered Dietitian? Yes ☐ No ☐

Informed Consent to Capture and Record Personal Information

I hereby consent to my personal information contained in this Registration Form being saved in the Client Data System maintained by the New York State Office for the Aging and used by Monroe County Office for the Aging. I understand that my information will not be shared with other agencies without my permission. I understand that the information on this form may be sent to the State and federal government, and is used to improve the services offered and better meet my needs.

Signature

Date

Print

ATTESTATION (To be completed by worker)

I attest that informed consent, as indicated, was obtained from the above individual, who provided his/her signature above. All appropriate processes were followed, and consent was provided voluntarily.

Center Worker Signature

Date

Center Worker Name (Print)