

**Kansas Department for Aging and Disability Services Uniform Program Registration**

Registration Date: \_\_\_\_\_ PSA: \_\_\_\_\_

**CUSTOMER INFORMATION**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Gender:  Female  Male  
                     *Month Day Year*  Other

Residence Street Address: \_\_\_\_\_  
   *Street City County State Zip Phone*

Emergency Contact Name: \_\_\_\_\_  
 Emergency Contact Address: \_\_\_\_\_  
   *Street City County State Zip Phone Alt Phone*

<b>Ethnicity</b>	<b>Race</b>	
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> Ethnicity Missing	<input type="checkbox"/> Black or African American	

Do you live alone?  Yes  No Is your monthly income below?  Yes  No  
 Doctor Name: \_\_\_\_\_ \$1,133 – Family of 1 or \$1,526 – Family of 2  
 City: \_\_\_\_\_ Phone: \_\_\_\_\_ \$1,919 – Family of 3 or \$2,313 – Family of 4  
 Health conditions/medications: \_\_\_\_\_ Veteran or Spouse of Veteran  Yes  No

**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.

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

**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 #: _____   |                          |                       |                 | <input type="checkbox"/> 60+ Person                                                                                                  | <b>PARTICIPANT STATUS FOR MEALS</b> |            |                            |                     |                   |                 |                       |  |
| <b>UNMET NEEDS</b>  |                          |                       |                 | <input type="checkbox"/> Less than 60 Spouse of 60+ Person                                                                           |                                     |            |                            |                     |                   |                 |                       |  |
| <b>Service Code</b> | <b>Availability Code</b> | <b>Monthly Units</b>  |                 | <input type="checkbox"/> Less than 60 disabled Person residing with 60+ Person                                                       |                                     |            |                            |                     |                   |                 |                       |  |
|                     |                          |                       |                 | <input type="checkbox"/> 60+ non-spouse Caretaker (IIIB Home-delivered meals only)                                                   |                                     |            |                            |                     |                   |                 |                       |  |
|                     |                          |                       |                 | <input type="checkbox"/> Volunteer                                                                                                   |                                     |            |                            |                     |                   |                 |                       |  |
|                     |                          |                       |                 | <input type="checkbox"/> Less than 60 disabled Person residing in housing facility with CMEL site and occupied mostly by 60+ Persons |                                     |            |                            |                     |                   |                 |                       |  |
| <b>PSA</b>          | <b>Service Code</b>      | <b>Funding Source</b> | <b>Disaster</b> | <b>Provider</b>                                                                                                                      | <b>Unit(s)</b>                      | <b>Per</b> | <b>Total Units Monthly</b> | <b>Cost of Unit</b> | <b>Start Date</b> | <b>End Date</b> | <b>Discharge Code</b> |  |
|                     |                          |                       |                 |                                                                                                                                      |                                     |            |                            |                     |                   |                 |                       |  |
|                     |                          |                       |                 |                                                                                                                                      |                                     |            |                            |                     |                   |                 |                       |  |

~~~~~(OPTIONAL) PAGE 2 FOR GRAB AND GO MEAL ELIGIBILITY~~~~~

**PLEASE READ:** Page 2 must be uploaded to UPR Additional Info File Upload region in KAMIS.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Registration Date: \_\_\_\_\_

| How would you rate your knowledge about healthy food and healthy eating? |  | Do you have difficulty with? | Difficulty | No Difficulty |
|--|--|------------------------------|------------|---------------|
| Very poor  |  |                              |            |               |
| Below average  |  | Meal Preparation             |            |               |
| Average  |  | Eating                       |            |               |
| Above average  |  | Shopping for Food            |            |               |
| Excellent  |  | Transportation               |            |               |
|  |  | Walking, Mobility            |            |               |

**What prevents you from attending the congregate meal site? (Beyond food quality, preference)**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

| Level of Agreement with the Following:   | Strongly Disagree | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree |
|--|-------------------|----------|----------------------------|-------|----------------|
| Healthiness of food has little impact on my food choices.                          |                   |          |                            |       |                |
| It is important for me that my daily diet contains a lot of vitamins and minerals. |                   |          |                            |       |                |
| I always follow a healthy and balanced diet.                                       |                   |          |                            |       |                |
| I do not avoid foods, even if they may raise my cholesterol.                       |                   |          |                            |       |                |
| I eat what I like, and I do not worry much about the healthiness of food.          |                   |          |                            |       |                |

| Does anyone help you prepare food or bring food to you? | Yes   |             | No           |            | How often do you leave home? |  |  |  |  |
|---|-------|-------------|--------------|------------|------------------------------|--|--|--|--|
|   | Never | Very Rarely | Occasionally | Frequently | Very Frequently              |  |  |  |  |
|   |       |             |              |            |                              |  |  |  |  |

**Customer Comments:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Reviewer:** Complete bottom section on Page 1 according to nutrition services eligibility.

**Check if emergency/disaster situation**