Volunteer: Y ❍ N ❍ Interview Date

National Aging Program Information System (NAPIS)

Registration Record Sp: _____ Veteran: ❍ Yes ❍ No

Section 1 - Person Renewal Date:

Client Name: Last First MI

Client ID

Phone number

SSN (Last 4 digits)

Date of Birth

Gender ❍ Male ❍ Female

Primary Language

Number in household

Monthly household income $

❍ Single ❍ Married

❍ $973 and Below ❍ $1311 and Below
❍ $974 to $1216 ❍ $1312 to $ 1639
❍ $1217 to $1945 ❍ $1640 to $2622
❍ $1946 to $2918 ❍ $2623 to $3933
❍ Above $2919 ❍ Above $3934

Race:

❍ Asian
❍ American Indian/Alaska Native
❍ Black/African American
❍ Native Hawaiian/Other Pacific Islander
❍ White
❍ Other
❍ Unknown/Not Reported

Ethnicity:

❍ Hispanic/Latino
❍ Not Hispanic/Latino
❍ Not Reported

Section 2 - Address

Street address:

City: State: Zipcode:

Mailing address (if different)

City: State Zipcode:

Section 3 - Nutrition Risk

Complete this section for clients who receive OAA/OPI case management, **congregate meals**, home delivered meals or nutrition counseling.

(Mark as Yes, No or Undetermined)

_____ 1) I have an illness or condition 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, vegetables or milk products.
_____ 4) I have 3 or more drinks of beer, liquor or wine almost every day.
_____ 5) I have tooth or mouth problems that make it hard for me to eat.
_____ 6) I don't always have enough money to buy the food I need.
_____ 7) I eat alone most of the time.
_____ 8) I take 3 or more prescribed or over-the-counter drugs a day.
_____ 9) Without wanting to, I have lost or gained 10 pounds in the last six months.
_____ 10) I am not always physically able to shop, cook and/or feed myself.

Client name: _____
Last First MI

Section 4 - ADL/IADL

Complete this section for any client who receives OAA/**OPI personal care**, **home care,** chore service, **home delivered meals,** adult day care or case management (Mark as **I** for Independent, **A** for Needs Assistance or **D** for Dependent)

___ Bathing	___ Toileting	___ Medical Management
___ Behavior	___ **Transferring***	___ **Shopping***
___ Dressing	___ **Food preparation***	___ Taking Medication
___ **Eating***	___ Heavy Housework	___ Using Telephone
___ **Mobility/Walking***	___ Housekeeping	___ **Using Transportation***
___ Personal Hygiene/grooming	___ Managing Finances	

Section 5 - Services

Provider name	**Service type**	**Start date**	**End date**	**Site name**

Section 6 - Emergency contact

Contact Name:	❍ Child	❍ Neighbor	❍ Parent
Phone 1	❍ Friend	❍ Not Related	❍ Sibling
Phone 2	❍ Grandchild	❍ Other Family Mbr	❍ Spouse
Contact Name:	❍ Child	❍ Neighbor	❍ Parent
Phone 1	❍ Friend	❍ Not Related	❍ Sibling
Phone 2	❍ Grandchild	❍ Other Family Mbr	❍ Spouse

Section 7 - Special Diet

(Check all that apply)

❍ Bland	❍ Kosher	❍ Low Salt	❍ Renal
❍ High Protein	❍ Low Fiber	❍ Other	❍ Wheat/Gluten Free
❍ Low Fat	❍ Non Applicable	❍ Vegetarian	❍ High Fiber
❍ Nasogastric Feeding	❍ Vegan	❍ High Calorie	❍ Low Cholesterol
❍ Supplements	❍ Diabetic	❍ Low Calorie	❍ Low Vitamin K
❍ Dairy Free	❍ Liquid	❍ Low Sodium	❍ Soft

Comments: _____

Worker Name: _____

Release of Information Agreement Signed: **Y ❍ N ❍**