# Form 5 - Consumer Registration Form

**Information provided on this form is important for the State of Connecticut to receive federal funds and to continue to provide services to older adults. Please take the time to answer all the questions on this form.**

**Your personal privacy is very important to us. The law prohibits sharing any information you give without a court order or without permission from you or your personal representative EXCEPT for the following: state, federal and local monitoring relative to program reporting requirements; program management, public safety and research. Be assured that your information will only be used as necessary under those provisions.**

***Consumer Signature:*** _____

Registration: ☐ New ☐ Update ☐ NFCSP/Statewide Respite ☐ Caregiver ☐ Includes Service Data
*(Caregivers complete sections I, III, IVc,d, IVf [grandparents])* *(Complete section VIII)*

## I. Add Consumer

a.) Consumer Name:

First: MI: Last:

| b.) Today's Date: | c.) Gender: ☐ Female ☐ Male ☐ Non-Binary ☐ Other | d.) Birth Date: | e.) SSN (Social Secuirty): 000 - 00 - ____ ____ ____ ____ |
|---|---|---|---|

f.) Home Telephone: ( ) g.) Cell Telephone: ( )

h.) Email Address:

i.) Provider Name:

j.) Home Street Address 1:

k.) Home Street Address 2: l.) County: **New Haven County**

m.) Town: n.) State (if not CT) o.) Zip Code:

p.) Care Enrollment: *(office use only)* | Level of Care: | Service/Care Program: **Transportation**

## II. Details - Basic Information

a.) Marital Status: ☐ Currently Married ☐ Divorced ☐ Separated ☐ Single (Never Married) ☐ Widowed

## II. Details - NAPIS

a.) NSIP Eligible: ☐ Yes ☐ No

b.) NSIP Eligiblilty Type: ☐ Age 60 and Older ☐ Disabled in Elderly Housing ☐ Disabled Living with an Elderly Person ☐ Spouse of Person Age 60+ ☐ Volunteer

## II. Details - Other Characteristics

a.) Cognitive Impairment: Has Alzheimer's disease or a related dementia: ☐ No - None ☐ Yes - Early Onset Dementia ☐ Yes - Mild ☐ Yes - Moderate ☐ Yes - Severe

b.) Disabled: ONLY FOR NFCSP CARE RECIPIENTS
Care recipient is between the ages of 18 and 59 and has a disability.
☐ Yes ☐ No

## III. Caregiver Programs ONLY (NFCSP and CSRCP)
## Details - Care Recipient/Caregiver - Add New (only for NFCSP and CT Statewide Respite Care)

| | | |
|---|---|---|
| a.) Care Status: | ❑ Is Caregiver | Name of Care Recipient: |
| | ❑ Is Care Recipient | Name of Caregiver: |

b.) Relationship:

Relationship ALWAYS Means Caregiver's Relationship to the Care Recipient

❑ Brother ❑ Daughter ❑ Daughter-in-Law ❑ Domestic Partner
❑ Father* ❑ Granddaughter ❑ Grandfather* ❑ Grandmother*
❑ Grandson ❑ Husband ❑ Mother* ❑ Non-Relative
❑ Other Relative ❑ Sister ❑ Son ❑ Son-in-Law
❑ Wife

** Must only be checked if the caregiver is age 55 or older and is the primary caregiver for a child under age 18 or an adult child between age 18 - 59 with a disability. Non-relative and Other relative may be checked for these caregivers as well as caregivers of older adults.*

## IV. Assessment Form - Demographics

a.) Primary Language:

Primary language spoken at home:

❍ American Sign Language ❍ Arabic ❍ Cambodian (Khmer) ❍ Chinese
❍ English ❍ French ❍ German ❍ Greek
❍ Gujarati ❍ Haitian Creole ❍ Italian ❍ Korean
❍ Polish ❍ Portuguese ❍ Russian ❍ Spanish
❍ Tactical Sign Lanuage ❍ Turkish ❍ Urdu ❍ Vietnamese
❍ Other _____ *Please Specify*

b.) Speaks English: ❍ Very Well ❍ Well ❍ Not Well ❍ Not At All

c.) Ethnicity: ❍ Hispanic/Latino ❍ Not Hispanic/Latino

d.) Race: (check all that apply)

❑ American Indian/Alaskan Native ❑ Asian/Asian American ❑ Black/African American
❑ Native Hawaiian/Pacific Islander ❑ White

e.) Housing:

❍ Private Home ❍ Private Apartment ❍ Senior Housing ❍ Congregate Housing
❍ Public Housing ❍ Residential Care Home ❍ Nursing Home ❍ Assisted Living
❍ Other _____
*Please Specify*

f.) Income: (2/2021)

**I live alone or with someone other than a spouse and <u>MY</u> monthy income is about:**

❍ At or Below $1,073 *(100%)* ❍ $1,074 - $1,342 *(125%)* ❍ $1,343 - $1,610 *(150%)*
❍ $1,611 - $1,878 *(175%)* ❍ $1,879 - $2,147 *(200%)* ❍ $2,148 or over *(over 200%)*

**I live with my spouse and <u>OUR</u> monthly income is about:**

❍ At or Below $1,452 *(100%)* ❍ $1,453 - $1,815 *(125%)* ❍ $1,816 - $2,178 *(150%)*
❍ $2,179 - $2,540 *(175%)* ❍ $2,541 - $2,903 *(200%)* ❍ $2,904 or over *(over 200%)*

g.) In Poverty: ❍ Yes ❍ No

h.) Living Arrangements:

❍ Alone ❍ With Spouse ❍ With Unmarried Partner ❍ With Spouse/Partner and Child/ren
❍ With Child/ren Only, No Spouse/Partner ❍ With Grandchild/ren ❍ With Other Relatives
❍ With Others

## V. Assessment Form - Functional Status

a.) ADL/IADL:

**I need help with the following ADL activities:**

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Eating | ○ | ○ | Dressing | ○ | ○ | Bathing/Washing |
| ○ | ○ | Using the Toilet | ○ | ○ | Getting Out of Bed/Chair | ○ | ○ | Continence |

**I need help with the following IADL activities:**

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Planning/Preparing Meals | ○ | ○ | Shopping | ○ | ○ | Managing Money |
| ○ | ○ | Using the Telephone | ○ | ○ | Housekeeping | ○ | ○ | Doing Laundry |
| ○ | ○ | Taking Medicine | ○ | ○ | Using Transportation | | | |

## VI. Assessment Form - Nutrition

a.) Nutritional Risk:

| Yes | No | Unknown | |
|---|---|---|---|
| ○ | ○ | ○ | I have an illness or condition that made me change the kind or amount of food I eat. (2) |
| ○ | ○ | ○ | I eat fewer than 2 meals per day. (3) |
| ○ | ○ | ○ | I eat few fruits and vegetables or milk products. (2) |
| ○ | ○ | ○ | I have problems chewing/swallowing that make it hard for me to eat. (2) |
| ○ | ○ | ○ | I do not always have enough money or food stamps to buy the food I need. (4) |
| ○ | ○ | ○ | I take 3 or more different prescription or over-the-counter drugs each day. (1) |
| ○ | ○ | ○ | I eat alone most of the time. (1) |
| ○ | ○ | ○ | I have 3 or more drinks of beer, liquor or wine almost every day. (2) |
| ○ | ○ | ○ | 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 or feed myself. (2) |

## VII. Assessment Form - Service Indicators

In the last 12 months:

1.) If I had groceries available, I was able to use them to prepare a meal:

○ Yes (skip to question 2) ○ No (Please answer 1b below)

1b.) You had someone who could cook for you or helped you cook

○ Yes ○ No

If you answered NO, did you experience this in the last:

○ 1-3 months ○ 4 - 6 months ○ 7 months or more

2.) In the last 12 months have you experienced the following situations because you did not have enough money

a.) Did you or other adults in your household ever skip meals?

○ Yes ○ No

b.) Did you eat less food than you felt you needed?

○ Yes ○ No

c.) Were you ever hungry?

○ Yes ○ No

If you answered YES to ANY of these questions, did you experience this in the last:

○ 1-3 months ○ 4 - 6 months ○ 7 months or more

3.) Have you recently lost weight without trying?

○ Yes ○ No

If YES, how much weight have you lost?

○ 1-13 lbs. ○ 14 - 23 lbs. ○ 24-33 lbs. ○ 34 or more lbs. ○ Unsure

4.) Have you been eating poorly because of a decreased appetite?

Yes No

5.) Have you been hospitalized in the last 12 months?

Yes No

If YES, when were you last in the hospital?

In the last 3 months In the last 4-6 month In the last 7-12 months

## VIII. Service Delivery

a.) Site Name (if applicable): Interfaith Volunteer Care Givers of Greater New Haven

| b.) Service Category (if applicable) | c.) Service (sub-service) | d.) Fund Identifier | e.) Number of Units |
|---|---|---|---|
| | Transportation | Title IIIB | |
| | | | |
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| | | | |