

CLIENT REGISTRATION FORM • DAAS 101 (Long Form)
 NC Department of Health and Human Services, Division of Aging and Adult Services

Section I: Required for all clients

Service Code(s):	Complete all sections of this form identified for the applicable service codes. • HCCBG congregate nutrition (180), NSIP-only congregate meals (181), congregate liquid nutritional supplement (182) – complete Sections I, II, and VII only. • HCCBG general (250) or medical (033) transportation – complete Sections I and VII only.
Region Code:	• HCCBG respite services [in-home aide respite (235, 236, 237, 238), group respite (309), and institutional respite (210)], Family Caregiver Support Program (all FCSP codes in service categories 820, 830, 840, 850 except 821, 822, 831, 841, 851, 861), and Project C.A.R.E. – enter information for caregiver in Sections I, VI, and VII and for care recipient in Sections III, IV, and V.
Provider Code:	• HCCBG care management (610), home-delivered meals (020), NSIP-only home-delivered meals (021), home-delivered liquid nutritional supplement (022) – complete Sections I, II, IV, V (if appropriate), VI (if appropriate), and VII. • For all other HCCBG services, complete Sections I, IV, V (if appropriate), VI (if appropriate), and VII.

1. Client Status: Check the appropriate box(es). Enter the date of client status change.

New Registration/Activate (Date: _____)
 Waiting for Service (complete Section I for unit-based services only): (Date: _____)
 Enter waiting for service codes: _____
 Change of information (Date: _____) (Complete Section 1 – Items 2, 4, 5, plus information that needs to be changed)
 Inactive (Date that provider believes the reason for inactivation became effective: _____)
Enter reason for inactivating the client record. If the care recipient is the client, mark the client reason. If the caregiver (CG) is the client, mark the client reason unless the reason for CG terminating services relates more to the care recipient (CR), in which case mark the CR reason.

<input type="checkbox"/> Client/CG moved to adult care home/assisted living <input type="checkbox"/> Client/CG has alternative living arrangement <input type="checkbox"/> Client/CG death <input type="checkbox"/> Client/CG hospitalization (not expected to return) <input type="checkbox"/> Client/CG nursing home placement <input type="checkbox"/> Client/CG moved out of service area <input type="checkbox"/> Client/CG has improved function/need eliminated <input type="checkbox"/> Service not needed/wanted by client/CG <input type="checkbox"/> Client/CG illness (not expected to return) <input type="checkbox"/> Other (Specify): _____	<input type="checkbox"/> CR moved to adult care home/assisted living <input type="checkbox"/> CR has alternative living arrangement <input type="checkbox"/> CR death <input type="checkbox"/> CR hospitalization (not expected to return) <input type="checkbox"/> CR nursing home placement <input type="checkbox"/> CR moved out of service area <input type="checkbox"/> CR has improved function/need eliminated <input type="checkbox"/> Service not needed/wanted by CR <input type="checkbox"/> CR illness (not expected to return) <input type="checkbox"/> Other (Specify): _____
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2. Name, Last	First	MI	Suffix	4. Last 4 digits SSN
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3. Street Address	5. Date of Birth
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Mailing Address	<input type="checkbox"/> Same as street address	6. Phone #
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City	State	Zip	County	<input type="checkbox"/> No phone
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7. Sex (check one) <input type="checkbox"/> Female <input type="checkbox"/> Male	8. At or Below Poverty Level? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No	9. Marital Status (check one) <input type="checkbox"/> Single (never married) <input type="checkbox"/> Married <input type="checkbox"/> Single (divorced/widowed) <input type="checkbox"/> Refused to answer	10. Household Size (check one) <input type="checkbox"/> Lives alone <input type="checkbox"/> 2 in home <input type="checkbox"/> 3 or more in home <input type="checkbox"/> Group/shared home <input type="checkbox"/> Refused to answer
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11. Race Check the one race with which client most identifies:	Check all that apply:	12. Ethnicity (Are you of Hispanic or Latino origin?) <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic Puerto Rican <input type="checkbox"/> Hispanic Mexican American <input type="checkbox"/> Unreported <input type="checkbox"/> Hispanic Cuban <input type="checkbox"/> Hispanic Other
Black or African-American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Unknown/refused <input type="checkbox"/>		

13. Primary language spoken in the home: (see 30 language options in CRF instructions manual)

14. Client/CG's Overall Functional Status: Well At risk High risk
 (Do not complete Q14 if Section IV is required, except under the following circumstances. When the caregiver is registered as the client, use this field for the caregiver's functional status and complete Section IV for the care recipient. See form instructions.)

Section II: Required only for clients of HCCBG congregate meals, home-delivered meals, liquid nutritional supplement meals, NSIP-only meals, or care management services.

15. Nutrition Health Score		Refused to Answer
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 per day?	#	<input type="checkbox"/>
d. How many servings of vegetables per day?	#	<input type="checkbox"/>
e. How many servings of milk/dairy products 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 III: Complete on the care recipient (not caregiver) for HCCBG respite (in-home aide respite, group respite and institutional respite), Family Caregiver Support Program services, and Project C.A.R.E.

CARE RECIPIENT #1 (For additional service recipients, attach an additional DAAS-101, Section III, IV, and V.)

16. Name, Last		First	M.I.	SUFFIX	Last 4 Digits SSN (or zeros) _____	
Street Address			Phone # <input type="checkbox"/> No phone		Date of Birth ____/____/____	
Mailing Address			<input type="checkbox"/> Same as street address			
City		State	Zip		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	

17. Is care recipient a person with severe disabilities? Yes No

18. Does care recipient live in same household as caregiver? Yes No

19. Care recipient marital status: single (never married) single (divorced/widowed)
(check one) married refused to answer

Section IV: Complete for all clients unless the client is the caregiver, in which case complete Section IV for the care recipient. The only exception is that Section IV is not required for FCSP services involving minor relative children.

20. Does client (care recipient) have significant memory loss or confusion? Yes No

21. Number of IADL (Instrumental Activities of Daily Living)	Client (or care recipient) can carry out the following tasks without help.		If the answer to items a-h in question #21 or items a-f #22 is "no," then select one of the following:			
	YES	NO	Client (or care recipient) cannot do and has <u>someone unpaid</u> who assists.	Client (or care recipient) cannot do and has <u>someone paid</u> who assists.	Client (or care recipient) cannot do and has <u>both unpaid & paid</u> assistance.	Client (or care recipient) has <u>no one</u> who assists.
a. Prepare meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Shop for personal items	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Manage own medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Manage own money (pay bills)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Use telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Do heavy housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Do light cleaning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Transportation ability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total "no" column = IADL impairments						

22. Number of ADL (Activities of Daily Living)						
a. Eat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Get dressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Bathe self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Use the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Transfer into/out of bed/chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Ambulate (walk or move about the house without anyone's help)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total "no" column = IADL impairments						

23. How many unpaid caregivers involved in care including primary caregiver? Enter # _____
(If answer to this question is "0," skip to Section VII.)

Section V: Complete for HCCBG respite, FCSP, and others responding with "1" or more in Q23.

24. How many hours per day of help, care, or supervision does care recipient need?

a. # of daily hours needed _____ b. If not daily, # of hours per week needed _____

25. How many hours per day of help, care, or supervision does primary caregiver provide?

a. # of daily hours provided _____ b. If not daily, #of hours per week provided _____

26. Primary caregiver's relationship to care recipient: (check one)

- wife sister mother aunt other relative
 husband brother father uncle non-relative
 daughter/daughter-in-law niece grandmother granddaughter/granddaughter-in-law
 son/son-in-law nephew grandfather grandson/grandson-in-law

Section VI: Complete for all caregivers. Questions 27-30 should be answered only by caregiver.

27. Primary caregiver's self-reported health on scale of

1 (poor) to 5 (excellent) (choose one)

1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. Primary caregiver: How stressful for you is caregiving on a scale

from 1 (not at all/very low) to 5 (very high) (choose one.)

1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. Primary caregiver's paid employment status:

- Full-time Part-time Quit due to caregiving Is not/was not working
 Retired early due to caregiving Retired/full benefits Lost job/dismitted due to caregiving

30. Is the primary caregiver a long distance caregiver?

Yes No

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:** _____

EMERGENCY CONTACT PERSON: Name: _____

Phone (day): _____ - _____ - _____ (evening): _____ - _____ - _____

Refused to provide emergency contact information

Provider Use Only – initial below if no changes:

Registration Update ___/___/___ Staff Initials _____
 Registration Update ___/___/___ Staff Initials _____
 Registration Update ___/___/___ Staff Initials _____

Provider Use Only – initial below if no changes:

Registration Update ___/___/___ Staff Initials _____
 Registration Update ___/___/___ Staff Initials _____
 Registration Update ___/___/___ Staff Initials _____