

CLIENT REGISTRATION FORM • DAAS 101 (Short Form)

NC Department of Health and Human Services, Division of Aging and Adult Services

Section I: Required for all clients

This Short Form of the DAAS-101 Client Registration Form may only be used to register congregate meal and transportation clients. Complete all applicable information below.

- 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.

Service Code(s):	Region Code:	Provider Code:
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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 the information that needs to be changed)

Inactive (Date inactive and not expected to return: _____)

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 #
City	State	<input type="checkbox"/> No phone
Zip	County	

7. Sex <i>(check one)</i>	8. At or Below Poverty Level? <i>(check one)</i>	9. Marital Status <i>(check one)</i>	10. Household Size <i>(check one)</i>
<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Single (never married) <input type="checkbox"/> Married <input type="checkbox"/> Single (divorced/widowed) <input type="checkbox"/> Refused to answer	<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

11. Race	12. Ethnicity <i>(Are you of Hispanic or Latino origin?)</i>
<i>Check the one race with which client most identifies:</i>	<i>Check all that apply:</i>
Black or African-American <input type="checkbox"/>	<input type="checkbox"/> Not Hispanic or Latino
Asian <input type="checkbox"/>	<input type="checkbox"/> Unreported
American Indian or Alaska Native <input type="checkbox"/>	<input type="checkbox"/> Hispanic Puerto Rican
White <input type="checkbox"/>	<input type="checkbox"/> Hispanic Cuban
Native Hawaiian or other Pacific Islander <input type="checkbox"/>	<input type="checkbox"/> Hispanic Mexican American
Unknown/refused <input type="checkbox"/>	<input type="checkbox"/> Hispanic Other
	13. Primary language spoken in the home: <i>(see 30 language options in CRF instructions manual)</i>

14. Client/CG's Overall Functional Status: Well At risk High risk

(Do not complete this field 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 congregate meals, congregate liquid nutritional supplement, or NSIP-only congregate meals.

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 VII: REQUIRED FOR ALL CLIENTS

I, the client, understand that 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 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 _____

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Registration Update ___/___/___ Staff Initials _____
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