

**CLIENT REGISTRATION FORM • DAAS 101**

**NC Department of Health and Human Services - Division of Aging and Adult Services**

- COMPLETE SECTIONS I, II and VII ONLY for codes **(180)**-Congregate Nutrition, **(181)**-Congregate Nutrition-NSIP, and **(182)**-Congregate Nutrition Supplemental Meals.
- COMPLETE SECTIONS I and VII ONLY for codes **(250)**-Transportation, **(033)**-Transportation (Medical) and (252) Transportation-Pilot Bus Pass Program.
- COMPLETE SECTIONS I, VI, and VII for Family Caregiver Support Program/Project C.A.R.E. (all FCSP codes in series **820, 830, 840, 850** – EXCEPT codes **821, 822, 831, 841, 851, 861**. For Care Recipient complete SECTIONS III, IV and V.
- COMPLETE SECTIONS I, IV, and VII for codes **235, 236, 237, 238**-In-Home Aid Respite, **309**-Group Respite, **210**-Institutional Respite. Enter data for hands-on recipient, not the caregiver. If applicable, complete Sections V and VI.
- COMPLETE SECTIONS I, II, IV, VII for codes **020**-Home Delivered Meals, **021**-Home Delivered Meals-NSIP, **022**-Home Delivered Meals Supplemental, and **610**-Care Management. If applicable, complete Sections V and VI.
- COMPLETE SECTIONS I, IV, and VII for all other HCCBG services. If applicable, complete Sections V and VI.

**Service Codes:** \_\_\_\_\_ **Region Code:** \_\_\_\_\_ **Provider Code:** \_\_\_\_\_

**CLIENT STATUS: Check the Appropriate box(es) and enter the date.**

<input type="checkbox"/> <b>New Registration</b>	DATE: _____
<input type="checkbox"/> <b>Activation</b>	DATE: _____
<input type="checkbox"/> <b>Waiting for Service</b> [Complete Section I ONLY]	DATE: _____ (enter 3 service codes):
<input type="checkbox"/> <b>Change of Information</b>	DATE: _____ (complete Section I when a change is needed for any client information)
<input type="checkbox"/> <b>Inactive</b> – DATE: _____ (check box below) (make inactive only if permanently leaving ARMS) If client is a caregiver receiving FCSP/Project C.A.R.E. services and the client inactive reason relates more to CR status, check Care Recipient box.	
Reason for making client inactive applies to: <input type="checkbox"/> Client/Caregiver <input type="checkbox"/> Care Recipient	
<input type="checkbox"/> Moved to adult care home/assisted living	<input type="checkbox"/> Moved out of service area
<input type="checkbox"/> Alternative living arrangement	<input type="checkbox"/> Improved function/Need eliminated
<input type="checkbox"/> Death	<input type="checkbox"/> Service not needed/wanted
<input type="checkbox"/> Hospitalization (not expected to return)	<input type="checkbox"/> Illness (not expected to return)
<input type="checkbox"/> Nursing home placement	<input type="checkbox"/> Other (specify): _____

**SECTION I: CLIENT/CAREGIVER INFORMATION (Required for ALL Clients/For FCSP the Caregiver is the Client)**

<b>Legal Name:</b> Last _____ First _____ M.I. _____	
Suffix _____	<b>Last 4 Digits SSN:</b> _____ <b>Phone:</b> _____ <input type="checkbox"/> No phone
<b>Address</b> _____	<b>Email</b> _____ <b>DOB:</b> _____
<b>County:</b> _____	<input type="checkbox"/> Check if special eligibility
<b>City:</b> _____	<b>State:</b> _____ <b>Zip:</b> _____

<b>Sex</b> (check one) <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>At/Below Poverty Level?</b> (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Marital Status</b> (check one) <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Partnered <input type="checkbox"/> Client Refused <input type="checkbox"/> Unknown	<b>Household Status</b> (check one) <input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with Other <input type="checkbox"/> Unknown <input type="checkbox"/> Client Refused <input type="checkbox"/> Lives in Long Term Care (LTC) facility [Legal Assistance is the only service to collect "Lives in Long Term Care (LTC) facility"]
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<b>Race</b> (Check all that apply) <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Refused/Unknown/Not Reported	<b>Ethnicity (Are you of Hispanic or Latino Origin?)</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unreported/Missing/Client Refused <b>Primary Language Spoken:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ [see languages in Client Registration Form (CRF) manual]
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**Name of Emergency Contact:** \_\_\_\_\_  Refused to provide  
**Cell#:** \_\_\_\_\_ **Home#:** \_\_\_\_\_ **Day#:** \_\_\_\_\_

**Caregiver's Overall Functional Status:**  Well  At risk  High risk  
*(When the CAREGIVER IS REGISTERED AS THE CLIENT, use this field for the CAREGIVER'S SELF-REPORTED functional status and complete Section IV for Care Recipient.) If SECTION IV is required, SKIP THIS QUESTION. ARMS will automatically calculate the Caregiver's Overall Functional Status when SECTION IV is entered.*

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**SECTION II: Required ONLY for clients of HCCBG Congregate Nutrition, Home-Delivered Meals, Congregate Nutrition Supplemental Meals, Home Delivered Meals Supplemental, NSIP (only meals), and Care Management services.**

**Nutrition Health Score**

<b>Assessment Date:</b>	<b>Response</b>	<b>Refuse</b>
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 do you eat per day?	#	<input type="checkbox"/>
d. How many servings of vegetables do you eat per day?	#	<input type="checkbox"/>
e. How many servings of milk/dairy products do you consume 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"/>

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**SECTION III: Care Recipient Data (not caregiver) for Family Caregiver Support Program/ Project C.A.R.E. services.**

**CARE RECIPIENT #1 (Adult/Child) (For additional Care Recipients, attach an additional DAAS-101, Sections III, IV, and V.)**

Name: Last		First	M.I.
Suffix	Last 4 Digits SSN/zeros:		Phone: <input type="checkbox"/> No phone
Address		DOB:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
City:		State:	Zip:

Is Care Recipient a person with (a) severe disability(ies)?  Yes  No

Does the Care Recipient live in same household as Caregiver?  Yes  No

**Marital Status:**  Single  Married  Separated  Divorced  Partnered  Refused  Widowed  Unknown

**SECTION IV: Client/Care Recipient Data (not caregiver)/ not required for Children Under 18 Receiving Care by FCSP.**

Is the client/care recipient's daily life significantly affected due to memory loss or a cognitive impairment?  Yes  No

Has a doctor/healthcare professional diagnosed care recipient with Alzheimer's disease or a related dementia?  Yes  No

	<b>IADLS</b> (Client/CR can do without help; select Yes/No)				<b>ADLS</b> (Client/CR can do without help; select Yes/No)						
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
Food Preparation	<input type="checkbox"/>	<input type="checkbox"/>	Use Telephone	<input type="checkbox"/>	<input type="checkbox"/>	Feeding	<input type="checkbox"/>	<input type="checkbox"/>	Toileting	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	Dressing	<input type="checkbox"/>	<input type="checkbox"/>	Transferring	<input type="checkbox"/>	<input type="checkbox"/>
Manage Medications	<input type="checkbox"/>	<input type="checkbox"/>	Laundry	<input type="checkbox"/>	<input type="checkbox"/>	Bathing	<input type="checkbox"/>	<input type="checkbox"/>	Continence	<input type="checkbox"/>	<input type="checkbox"/>
Manage Finances	<input type="checkbox"/>	<input type="checkbox"/>	Use Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<b>TOTAL ADL SCORE:</b>					
<b>TOTAL IADL SCORE:</b>											

**Unpaid caregivers (include primary caregiver) \_\_\_\_\_ [ONLY ANSWER for Respite, FCSP, and Project CARE services. Otherwise, enter "0" in ARMS and skip to Section VII on the DAAS-101.]**

**SECTION V: Complete for HCCBG respite, FCSP, and Project C.A.R.E. if "unpaid caregiver" = 1 or more in previous question.**

How many hours of care does Care Recipient need? \_\_\_\_\_  Day  Week

How many hours does Caregiver usually spend providing care for the Care Recipient? \_\_\_\_\_  Day  Week

**Primary Caregiver Relationship to Care Recipient: (ONLY check one)**

- |                                  |                                      |   |  |
|----------------------------------|--------------------------------------|---|--|
| <input type="checkbox"/> Wife    | <input type="checkbox"/> Sister      | <input type="checkbox"/> Non-Relative             | <input type="checkbox"/> Domestic partner, including civil union |
| <input type="checkbox"/> Husband | <input type="checkbox"/> Brother     | <input type="checkbox"/> Other Relative           | <input type="checkbox"/> Older Non-Relative (FCSP)               |
| <input type="checkbox"/> Parent  | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Son/Son-in-Law           | <input type="checkbox"/> Other Older Relative (FCSP)             |
|                                  |                                      | <input type="checkbox"/> Daughter/Daughter-in-Law |  |

Is the primary caregiver a long-distance caregiver?  Yes  No **[If YES, please answer the next questions by listing the NC county or State.]**

- Distance Caregiver** (list NC county \_\_\_\_\_)
- Out of State** (list state \_\_\_\_\_)

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**SECTION VI: Complete for ALL Caregivers**

<b>In general, would you say that the Caregiver's health is:</b>	Excellent (5) <input type="checkbox"/>	Very Good (4) <input type="checkbox"/>	Good (3) <input type="checkbox"/>	Fair (2) <input type="checkbox"/>	Poor (1) <input type="checkbox"/>

<b>How stressful for you is caregiving:</b>	Extremely (5) <input type="checkbox"/>	Very (4) <input type="checkbox"/>	Moderately (3) <input type="checkbox"/>	Slightly (2) <input type="checkbox"/>	Not at all (1) <input type="checkbox"/>

**Primary Caregiver Employment Status:**

Full-time     
  Part-time     
  Quit due to caregiving     
  Is/was not working  
 Retired early due to caregiving     
  Retired     
  Lost job/dismissed due to caregiving  
 Refused     
  Other (please specify) \_\_\_\_\_

**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:** \_\_\_\_\_

**Provider Use Only – initial below after re-assessment:**

Registration Update: \_\_\_\_\_ Staff Initials: \_\_\_\_\_  
 Registration Update: \_\_\_\_\_ Staff Initials: \_\_\_\_\_  
 Registration Update: \_\_\_\_\_ Staff Initials: \_\_\_\_\_

**NOTES/COMMENTS:**