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):

Region Code:

Provider Code:

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.
- Family Caregiver Support Program (all codes in **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.
- HCCBG In-home Aide Respite **(235, 236, 237, 238)**, Group Respite **(309)**, and Institutional Respite **(210)** – enter information for the hands-on recipient of services (not the caregiver) in Section I, IV, V (if appropriate), VI (if appropriate), and VII.
- 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 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 client became inactive for the reason stated below: _____)

Enter reason for making client inactive below. Make a client inactive only if the person is thought to be permanently leaving the service system.

If the client is a caregiver receiving FCSP or Project C.A.R.E. services and the reason for making the client inactive relates more to the care recipient's status, check the box for "Care Recipient."

Reason for making client inactive applies to: *Client/Caregiver* ☐ OR *Care Recipient* ☐

☐ Moved to adult care home/assisted living
☐ Alternative living arrangement
☐ Death
☐ Hospitalization (not expected to return)
☐ Nursing home placement
☐ Moved out of service area
☐ Improved function/Need eliminated
☐ Service not needed/wanted
☐ Illness (not expected to return)
☐ Other (Specify): _____

2. Legal Name, Last First MI Suffix

4. Last 4 digits SSN

Not for data entry -- name person likes to be called, if different from legal name on SS card:

5. Date of Birth

☐ *Check if special eligibility*

3. Street Address

Mailing Address ☐ Same as street address

6. Phone #

☐ No phone

City State Zip County

7. Sex *(check one)*

☐ Female
☐ Male

8. At or Below Poverty Level? *(check one)*

☐ Yes
☐ No

9. Marital Status *(check one)*

☐ Single (never married)
☐ Married
☐ Single (divorced/widowed)
☐ Refused to answer

10. Household Size *(check one)*

☐ Lives alone ☐ Group/shared home
☐ 2 in home ☐ Refused to answer
☐ 3 or more in home

11. Race

	Check the one race with which client most identifies:	*Check all that apply:*
Black or African-American	☐	☐
Asian	☐	☐
American Indian or Alaska Native	☐	☐
White	☐	☐
Native Hawaiian or other Pacific Islander	☐	☐
Unknown/refused	☐	

12. Ethnicity *(Are you of Hispanic or Latino origin?)*

☐ Not Hispanic or Latino ☐ Unreported
☐ Hispanic Puerto Rican ☐ Hispanic Cuban
☐ Hispanic Mexican American ☐ Hispanic Other

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

Name of Emergency Contact: _____ ☐ *Refused to provide emergency contact information*

Day phone no.: _____ Evening phone no.: _____

14. 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 then complete Section IV for care recipient.

Section II: Required only for clients of HCCBG congregate meals, home-deliverd 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?	☐ Yes ☐ No	☐
b. How many meals do you eat per day?	#	☐
c. How many servings of fruit per day?	#	☐
d. How many servings of vegetables per day?	#	☐
e. How many servings of milk/dairy products per day?	#	☐
f. How many drinks of beer, liquor, or wine do you have every day or almost every day?	#	☐
g. Do you have tooth/mouth problems that make it hard for you to eat?	☐ Yes ☐ No	☐
h. Do you always have enough money or food stamps to buy the food you need?	☐ Yes ☐ No	☐
i. How many meals do you eat alone daily?	#	☐
j. How many prescribed drugs do you take per day?	#	☐
k. How many over-the-counter drugs do you take per day?	#	☐
l. Have you lost 10 or more pounds in the past 6 months without trying?	☐ Yes ☐ No	☐
m. Have you gained 10 or pounds in the past 6 months without trying?	☐ Yes ☐ No	☐
n. Are you physically able to shop for yourself?	☐ Yes ☐ No	☐
o. Are you physically able to cook for yourself?	☐ Yes ☐ No	☐
p. Are you physically able to feed yourself?	☐ Yes ☐ No	☐

Section III: Complete for the care recipient (not caregiver) if services are funded by Family Caregiver Support Program and/or 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 #** ☐ No phone		**Date of Birth** ____ ____ _____ MM DD YYYY
Mailing Address		☐ Same as street address		
City	State	Zip		**Sex** ☐ Female ☐ 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	☐	☐	☐	☐	☐	☐
b. Shop for personal items	☐	☐	☐	☐	☐	☐
c. Manage own medications	☐	☐	☐	☐	☐	☐
d. Manage own money (pay bills)	☐	☐	☐	☐	☐	☐
e. Use telephone	☐	☐	☐	☐	☐	☐
f. Do heavy housework	☐	☐	☐	☐	☐	☐
g. Do light cleaning	☐	☐	☐	☐	☐	☐
h. Transportation ability	☐	☐	☐	☐	☐	☐
Total "no" column = IADL impairments						

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

	1	2	3	4	5
27.Primary caregiver's self-reported health on scale of 1 (poor) to 5 (excellent) *(choose one)*	☐	☐	☐	☐	☐
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.)*	☐	☐	☐	☐	☐

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/dismissed 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: _____

Provider Use Only – inital below if no changes:

Registration Update ____/____/____ Staff Initials _____
Registration Update ____/____/____ Staff Initials _____
Registration Update ____/____/____ Staff Initials _____

Provider Use Only – inital below if no changes:

Registration Update ____/____/____ Staff Initials _____
Registration Update ____/____/____ Staff Initials _____
Registration Update ____/____/____ Staff Initials _____