

NAPIS Client Enrollment Form

Applicant Information

First Name: _____ Last Name: _____ Tele No: _____

Address: _____

City: _____ State: _____ Zip Code: _____ - _____

Date of birth: ____/____/____ Gender: M F Social Security # (last 4 digits only): _____

Race: White/Caucasian Black/African American Asian Native Hawaiian or Pacific Islander
American Indian or Alaskan Native Multi-Racial Other

Ethnicity: Hispanic Non-Hispanic

Annual Household Income: \$ _____

Would you consider yourself to be in poverty? Yes: ____ No ____

Do you live alone? Yes: ____ No ____ If no: how many people reside in your household? _____

Do you live in a rural area? Yes: ____ No ____

EMERGENCY CONTACT INFORMATION

First Name: _____ Last Name: _____ Gender: _____

Phone: _____ Cell Phone: _____ Relationship: _____

NUTRITIONAL RISK ASSESSMENT (Congregate Meals Only)

	<u>Points</u>	<u>Check</u>
I have an illness or condition that made me change the kind / or amount of Food I eat.	2	<input type="checkbox"/>
I eat fewer than 2 meals per day.	3	<input type="checkbox"/>
I eat few fruits or vegetables, or milk products.	2	<input type="checkbox"/>
I have 3 or more drinks of beer, liquor or wine almost every day.	2	<input type="checkbox"/>
I have tooth or mouth problems that make it hard for me to eat.	2	<input type="checkbox"/>
I don't always have enough money to buy the food I need.	4	<input type="checkbox"/>
I eat alone most of the time.	1	<input type="checkbox"/>
I take 3 or more different prescribed or over-the-counter drugs a day.	1	<input type="checkbox"/>
Without wanting to, I have lost or gained 10 pounds in the past 6 months.	2	<input type="checkbox"/>
I am not always physically able to shop, cook and /or feed self.	2	<input type="checkbox"/>

Nutritional Risk Score:

At Nutritional Risk Yes: ____ No ____ Date of Nutritional Risk Assessment: : ____/____/____

I do not want information regarding nutrition education. _____

(Score 6+ = High Nutritional Risk)

Office Use Only

Registering for which program(s):

Congregate Meals Senior Center Activities) Name of Center _____
Health Promotion

Signature of person validating form: _____

Date Form Completed: ____/____/____ Age Verification Validated: _____