KIC ELDER MEALS AND WHEELS PARTICIPANT REGISTRATION FORM

CONFIDENTIAL

907-247-RIDE (7433)
Fax 800-865-6310

ADA#_____

IDN#_____

HD meals must include reasons on page 2
LOCATION: KIC – 615 Stedman St., Ketchikan, AK 99901 907-228-9437

NAME (Last, First, Middle Initial): _____

PHYSICAL ADDRESS: _____

MAILING ADDRESS: _____

CITY, STATE: ZIP: _____

HOME PHONE NUMBER: _____CELL PHONE NUMBER: _____

BIRTHDATE: _____/_____/_____ GENDER: MALE_____ FEMALE _____

****This information below is important for Federal Funding*****

ETHNIC RACE (Check 1 box) ❒ Black/African American ❒ Hispanic origin ❒ Alaska Native/American Indian ❒ Native Hawaiian/Other Pacific Islander ❒ Asian ❒ Caucasian/Non-Minority ❒ Other

DO YOU LIVE ALONE? ❒ YES ❒ NO DO YOU HAVE DIABETES? ❒ YES ❒ NO

IS YOUR INCOME ABOVE **($1,133-1 PERSON) OR ($1,532-Couple)** PER MONTH (Not including Senior Benefits Program and Permanent Fund Dividend?) ❒ YES ❒ NO

DO YOU HAVE DISABILITY? ❒ YES ❒ NO ARE YOU 80 YRS OF AGE OR OLDER? ❒ YES ❒ NO

EMERGENCY CONTACT: _____ TELEPHONE #_____

SIGNATURE: _____ *DATE:* _____

QUALIFIED MEAL GUESTS UNDER 55 PLEASE CHECK ☑			**SERVICES REQUESTED PLEASE CHECK ☑**
ARE YOU A MEALTIME VOLUNTEER? ❒ YES ❒ NO		❒	Congregate
IS YOUR SPOUSE OVER 55? ❒ YES ❒ NO		❒	Transportation
DO YOU HAVE A DISABLITY AND LIVE IN LOW INCOME SENIOR HOUSING ❒ YES ❒ NO		❒	Home-Delivered Meals
		❒	Shopping Assistance
		❒	Homemaker/Chore
		❒	Care Coordination
		❒	Adult Day Program
		❒	Other

For Program Office Use Only:
Class: C S V DE MV Status: O N I R M D V MV NR
_____ ADL_____ LADL _____

(Please complete the survey on the back)

KIC CONGREGATE AND HOME DELIVERED MEAL CLIENTS COMPLETE QUESTIONS BELOW

Nutritional Risk Questions	**(Circle the number if YES)**
I have an illness or condition that made me change the kind and/amount of food I eat.	2
I eat fewer than two (2) meals per day.	3
I eat fewer than five (5) servings of fruits & vegetables and 2 milk servings per day.	2
I have three (3) or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take three (3) or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained ten (10) pounds in the last six (6) months.	2
I am not always physically able to shop, cook, and/or feed myself.	2
TOTAL NUTRITIONAL SCORE	

Score Guide

0-2 Good! Recheck your nutritional score again in six (6) months.

3-5 you are at **Moderate Nutritional Risk**. See what can be done to improve your eating habits and lifestyle. Your senior nutrition program can help. Recheck your nutritional score again in three (3) months.

6+ **You are at High Nutritional Risk.** Bring this checklist the next time you see your doctor, dietician or other qualified health or social service professional. Talk with them about any problems you have. Ask for help to improve your nutritional health.

Remember that Warning Signs suggest risk, but do not represent a diagnosis of any condition.

PARTICIPANTS REQUESTING HOME DELIVERED MEALS, ASSISTED RIDES & HOMEMAKER/CHORE SERVICES COMPLETE BELOW

Do you need assistance with any of the following activities? Please check ☑ the activity:

❒ Eating	❒ Preparing meals
❒ Dressing	❒ Shopping for personal items
❒ Bathing	❒ Medication management
❒ Bathroom	❒ Managing money
❒ Transferring in/out of bed/chair	❒ Using telephone
❒ Walking	❒ Doing heavy housework
Total IADL's	❒ Doing light housework
	❒ Using available transportation
	Total IADL's

Is the participant bedridden? ❒ YES ❒ NO

Indicate if the participant uses a: Walker ❒ YES ❒ NO Cane ❒ YES ❒ NO Wheelchair ❒ YES ❒ NO

***REASONS FOR MEALS AT HOME: _____

_____

_____

ADDITIONAL CONCERNS? _____

REFERRED BY: _____

RETURN THIS COMPLETED FORM TO KIC ELDER SERVICES 615 STEDMAN OR FAX TO 800-865-6310