

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 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 client made inactive and not expected to return: _____)

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

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

<input type="checkbox"/> Moved to adult care home/assisted living <input type="checkbox"/> Alternative living arrangement <input type="checkbox"/> Death <input type="checkbox"/> Hospitalization (not expected to return) <input type="checkbox"/> Nursing home placement	<input type="checkbox"/> Moved out of service area <input type="checkbox"/> Improved function/Need eliminated <input type="checkbox"/> Service not needed/wanted <input type="checkbox"/> Illness (not expected to return) <input type="checkbox"/> Other (Specify): _____
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2. Legal Name, Last:	First:	MI:	Suffix:	4. Last 4 digits SSN:
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Not for data entry -- name person likes to be called, if different from legal name on SS card:

3. Street Address:	<input type="checkbox"/> Check if special eligibility
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Mailing Address:	<input type="checkbox"/> Same as street address
City:	State:
Zip:	County:

7. Sex (check one) <input type="checkbox"/> Female <input type="checkbox"/> Male	8. At or Below Poverty Level? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No	9. Marital Status (check one) <input type="checkbox"/> Single (never married) <input type="checkbox"/> Married <input type="checkbox"/> Single (divorced/widowed) <input type="checkbox"/> Refused to answer	10. Household Size (check one) <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
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11. Race	12. Ethnicity (Are you of Hispanic or Latino origin?)
<p align="center"><i>Check the one race with which client most identifies:</i></p> <p>Black or African-American <input type="checkbox"/></p> <p>Asian <input type="checkbox"/></p> <p>American Indian or Alaska Native <input type="checkbox"/></p> <p>White <input type="checkbox"/></p> <p>Native Hawaiian or other Pacific Islander <input type="checkbox"/></p> <p>Unknown/refused <input type="checkbox"/></p>	<p align="center"><i>Check all that apply:</i></p> <p><input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unreported</p> <p><input type="checkbox"/> Hispanic Puerto Rican <input type="checkbox"/> Hispanic Cuban</p> <p><input type="checkbox"/> Hispanic Mexican American <input type="checkbox"/> Hispanic Other</p>
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. Client's Overall Functional Status: Well At risk High risk

Enter the client's self-reported overall functional status here. If the client receives other services in addition to congregate nutrition and transportation, use the DAAS-101 Long Form to register the client and complete section IV to report functional status.

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:** _____

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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