☐ **New to MSC**

## Registration Form

Please complete the **front and back** of this form and return to the Grand Forks Senior Center. ND Aging Services **requires** this form for ALL participants.

**Please Print:**

**First Name:** __________________________ **Last Name:** ____________________________ **Middle Initial:**______

**Date of Birth:** ______/______/__________ **If under 60, is your spouse 60+? Yes or No (circle one)**

**Best Phone # to Contact You: (______)** ______________________ **Landline or Cell Phone (circle one)**

**Street Address:** _________________________________________________________________ **Apt #:** _________

**Mailing P.O. Box:** _____________ **City:** ___________________________ **State:** ________ **Zip:** ______________

**County:** _________________________ **Email:** _______________________________________________________

**Race/ Ethnicity:**
- ☐ African American/Black
- ☐ American Indian/ Alaskan Native
- ☐ Asian
- ☐ Caucasian White
- ☐ Hispanic or Latino
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Other

**Gender:** ☐ Male ☐ Female ☐ Unknown/Other

**Are you socially isolated?** ☐ Yes ☐ No

**Do you live alone?** ☐ Yes ☐ No

**Income: Please Check Your Household Gross Monthly Income Range**

☐ **Single** $0 - $1,215 ☐ **Couple** $0- $1,643 ☐ My/Our income is above those amounts

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RELEASE: I understand and agree that the information contained on this form may be released for statistical purposes, and I agree to the release of information for that limited purpose only. I understand that any release of information in identifiable form must be accompanied by a signed consent form and that the information will not be used as an eligibility determination or affect participation as a recipient unless a law has specifically restricted program participation. For Health clients: By signing below I acknowledge and understand that I am to receive "routine" trimming of toenails and/or callus care. I also understand that I will not receive a diagnosis or treatment of any medical conditions.

**SIGNATURE:** ______________________________________________ **DATE:** _______________________

The Grand Forks Senior Center does not discriminate based on age, race, gender, national origin, color, creed, religion, political affiliation, or physical or mental disabilities in its employment practices or the provision of services except where it is a requirement of law.

**OVER**

For office use: Key Tag #: X__ __ __ __ __ __ __ Key tag activated in MSC: Date________ Initial _______

MSC form entered: Date________ Initial _______ Donor Dock entered: Date________ Initial _______

☐ Sit-Down Meals ☐ Drive-Thru ☐ Health ☐ Activities ☐ Resources ☐ Volunteer ☐ Frozen

Well Sky #:______________________________ Assessment entered: Date________ Initial _______

Last updated 07.26.2023

# Nutrition Screening Checklist

| | Yes | No |
|---|---|---|
| 1. Do you have an illness and/or condition that made you change the kind and/or amount of food you eat? | | |
| 2. Do you eat fewer than 2 meals per day? | | |
| 3. The majority of days do you eat **less** than 1 ½ cups to 3 cups of fruits and/or vegetables? | | |
| 4. The majority of days do you eat and/or drink less than 3 cups of dairy products (such as milk, yogurt or cheese)? | | |
| 5. Do you have 3 or more drinks of beer, liquor, and/or wine almost every day? | | |
| 6. Do you have tooth and/or mouth problems that make it hard for you to eat? | | |
| 7. Sometimes you don't have enough money to buy enough food? | | |
| 8. Do you eat alone most of the time? | | |
| 9. Do you take 3 or more different prescribed and/or over-the-counter medications per day? | | |
| 10. Without wanting to, have you lost or gained 10 pounds in the past 6 months? | | |
| 11. Are you sometimes not physically able to shop, cook, and/or feed yourself? | | |
| If you score at a high nutritional risk, do you consent to share this screening data with Dietary Solutions and do you wish to be contacted for free nutritional counseling by them? | | |

| | Independent | Need Assistance |
|---|---|---|
| **ADL** | | |
| 1. What is your ability to bathe/shower yourself? | ______ | ______ |
| 2. What is your ability to dress yourself? | ______ | ______ |
| 3. What is your ability to use the restroom facilities on your own? | ______ | ______ |
| 4. What is your ability to physically transfer on your own? | ______ | ______ |
| 5. Do you have any bowel and/or bladder (incontinence) issues? | ______ | ______ |
| 6. Are you able to feed yourself? | ______ | ______ |
| **IADL** | | |
| 1. Can you use the telephone on your own? | ______ | ______ |
| 2. Can you do your own shopping? | ______ | ______ |
| 3. Are you able to prepare meals? | ______ | ______ |
| 4. Can you do your own housework? | ______ | ______ |
| 5. Can you do your own laundry? | ______ | ______ |
| 6. Can you arrange your own transportation? | ______ | ______ |
| 7. Can you manage your own medications? | ______ | ______ |
| 8. Can you manage your money? | ______ | ______ |

## Interested in volunteering? **Check which areas you would like to volunteer:**

☐ Meals on Wheels out of GFSC (M-F 10:30 am - Noon) ☐ Home Delivered Meals out of Altru (M-F 11 am - 12:30 pm)

☐ Bingo (W, Th 12:30 pm - 3:30 pm) ☐ Board Member ☐ Commodity Pick-up/Delivery

☐ Dining Room (M-F 11:15 am - 12:30 pm) ☐ Drive-Thru (M-F 10 am – Noon) ☐ Entertainer (usually M at 1 pm)

☐ Exercise Class Leader ☐ Library ☐ Making Gift Shop Items

☐ Silvertones Chorus ☐ Silvertones Leader ☐ Special Events

☐ Tech Support for Seniors

**Any other areas of volunteering interest or talents you would like to share?**

| | **Volunteer Information Sent to Activities** |
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