



New to MSC

Registration Form

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

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
 - Caucasian White
 - American Indian/ Alaskan Native
 - Hispanic or Latino
 - Asian
 - Native Hawaiian/Other Pacific Islander
 - Other

Gender: Male Female Unknown/Other

Are you socially isolated? Yes No

Thank you!

Do you live alone? Yes No

Income: Please Check Your Household Gross Monthly Income Range

- Single \$0 - \$1,255**
- Couple \$0- \$1,703**
- My/Our income is above those amounts**

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 _____

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?		

ADL	Independent	Need Assistance
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	Independent	Need Assistance
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 - 12:45 pm)
 Drive-Thru (M-F 10 am – Noon)
 Entertainer (usually M at 1 pm)
 Exercise Class Leader
 Library
 Making Gift Shop Items
 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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