NAPIS REPORTING FORM for Congregate/HDM Participation Statistics

All clients eligible to receive services under the Older Americans Act programs must fill out this form.

INFORMATION CONFIDENTIAL	**ID#**	AAA	Center Name:

Client's Name: _____ (Last) _____ (First) _____ (Middle) _____ (Nickname)

Date of Birth (mm-dd-yyyy):_____ E-mail Address (optional) _____

Address: _____ (Number and Street) _____ (City) _____ (State) _____ (Zip Code)

County: Phone ( ) Rural: [ ] Yes [ ] No

Initial Contact: Primary/Emergency

Name: (Check box at right to identify this person)

_____ (Last) _____ (First) _____ (Middle)

Relationship: _____

Address: *(Number and Street Name)*

_____

City: _____

State: _____ Zip Code: _____ Phone: (___)_____

[ ] Participant
[ ] Primary Emergency Contact
[ ] Physician Contact
[ ] Social Support Contact
[ ] Family Contact
[ ] Friend Contact
[ ] Next of Kin Contact
[ ] Neighbor Contact
[ ] Veterans A&A
[ ] Personal Contact
[ ] Caller
[ ] Primary Caregiver

Homeless? [ ] No [ ] Yes ***(3)(4)(5)(26)***

Income Information: [ ]High [ ]Medium [ ]At Poverty [ ]Below Poverty Level ***(22) (24) (26*** [ ]Unknown
[ ] Decline to state Would client/family like to meet with a financial planner? [ ] No [ ] Yes

Is the client considered to be frail or disabled/functionally impaired? **[ ] No [ ] Yes Why?**

Assistance Needed (describe):

DEMOGRAPHICS:

Gender: [ ] Male [ ] Female

Race/Ethnic Background: *(Check all that apply.)*

[ ] American Indian or Alaska Native
[ ] Asian
[ ] Black/African-American
[ ] White (Alone) – Hispanic
[ ] Native Hawaiian or Other Pacific Islander
[ ] White (Alone) – Non Hispanic
[ ] Other Race
[ ] Multiple Race
[ ] Declined to state [ ] Unknown

Ethnicity:

[ ] Hispanic/Latino
[ ] Latin not Hispanic/Latino
[ ] Ethnicity Unknown

If under 60, Reason for Service:

[ ] Spouse
[ ] Meal Volunteer
[ ] Lives in Elder Housing
[ ] Disabled
[ ] Living with Client
[ ] Other

Select one answer below:

[ ] Client lives alone.
[ ] Client lives with spouse.
[ ] Client lives with family.
[ ] Client lives with other(s).
[ ] Not disclosed
[ ] Not relative

Primary (Main) Language: _____

English Fluency: [ ] Fluent ***(0)***
[ ] Limited ***(1)***
[ ] Needs translation ***(3) (11)***

DETERMINE YOUR NUTRITIONAL HEALTH

Read the statements below. Circle the number under "Yes" in the first column for those that apply to you. For each "yes" answer, score the number in the box. Total your nutritional score, turn it in. This document will be kept for your personal reference. Use the second and third columns for subsequent reassessments according to the instructions on the bottom of this page. ***DAAS 1/31/2006***

			3-Month Check-up		6-Month Check-up	
Dates						
	Yes	No	Yes	No	Yes	No
I (or someone close to me) have an illness or condition that has caused me to change the amount and/or kind of food I eat. **I**	2		2		2	
I eat fewer than 2 meals per day. **II**	3		3		3	
I eat very few fruits or vegetables a day. **III**	1		1		1	
I eat/drink very few milk products (*i.e.* milk, yogurt, cheese) a day. **III**	1		1		1	
I drink less than 5 cups (8 oz) of fluid a day (*i.e.* water, juice, tea **III**	1		1		1	
I have 3 or more drinks of beer, wine, or liquor almost every day. **IV**	1		1		1	
I have tooth or mouth problems that make it hard for me to eat. **V**	2		2		2	
I don't always have enough money to buy the food I need. **VI**	4		4		4	
I eat alone most of the time. **VII**	1		1		1	
I take 3 or more different prescribed or over-the-counter drugs a day. **VIII**	1		1		1	
Without wanting to, I have lost or gained 10 pounds in the last 6 months. **IX**	2		2		2	
I am not always physically able to shop, cook and/or feed myself. **X**	2		2		2	
TOTAL						

Resource: *American Academy of Physicians, The American Dietetic Association, National Council on the Aging*

If you checked "yes" in any column, or would like more information about the specified topic, ask for a copy of the corresponding brochure.

0-2 GOOD! The warning signs of poor nutritional health are often overlooked. Please review these warning signs. Copies are available for the asking. Recheck your score in one year.

3-5 YOU ARE AT MODERATE RISK FOR MALNUTRITION. Seek what can be done to improve your eating habits and lifestyle. Contact the Office on Aging, senior nutrition program, senior citizens center, or health department. Ask for written materials and register for the next nutrition education/counseling session at your closest senior citizens center. More in-depth analysis including checklists for intervention support within your community may also be available. You may re-check your score in six months to see how much you have improved. Let the Nutrition Program personnel or your case manager know how you are doing!

6 or YOU ARE AT HIGH RISK FOR MALNUTRITION! Complete a Level 1 Screen and refer to the appropriate health care or social service professional in your area or, call your closest hospital's Senior Health Center and make an appointment for a nutrition assessment. In most cases, Medicare, Medicare Supplement, or third-party payment will cover the costs with a nominal co-payment. A team of qualified health care professionals, including a registered dietitian, will be available to follow up with you to find ways to improve your nutritional health.

Remember that these warning signs suggest risk but do not represent diagnosis of any condition.

Your Name: _____ Date(month/day/year): _____