

New York State Office for the Aging/Monroe County Office for the Aging

Please Complete ALL of the Form and PRINT Clearly

Ask your Senior Center Coordinator/Senior Center Staff for any help needed to answer the questions below

Date Completed: _____ (must be updated annually and uploaded to the Statewide Database)

Last Name: _____ First Name: _____ Middle Initial: _____

Gender: _____ Date of Birth: ____/____/____ (This is to certify that you are 60 or more years of age)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home Mobile Work (____)____-____ Phone: Home Mobile Work (____)____-____

Email Address: _____ If new, how did you hear about us? _____

Marital Status: Married Domestic Partner or Significant Other Single
 Widowed Separated Divorced

Frail: Yes No Disabled: Yes No Veteran: Yes No

Lives With: Alone Child(ren) Domestic Partner Only Domestic Partner & Others Parent/Guardian
 Non-Relatives in a Community Based Setting Non-Relatives in a facility/Institution Setting
 Non-Relatives (excludes spouse) Spouse Only Spouse and Others Others (not listed)

Race*: American Indian/Alaska Native Asian Black/African American White-Hispanic White
 Native Hawaiian/Other Pacific Islander * (Please note you can select multiple)

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Poverty Income Guidelines 2025

HOUSEHOLD SIZE	100%		125%		150%		185%	
	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly
1	15,650	1,304	19,563	1,630	23,475	1,956	28,953	2,413
2	21,150	1,763	26,438	2,203	31,725	2,644	39,128	3,261
3	26,650	2,221	33,313	2,776	39,975	3,331	49,303	4,109
4	32,150	2,679	40,188	3,349	48,225	4,019	59,478	4,956

For each additional person, add : **5,500 annual amount** **6,875 annual amount** **8,250 annual amount** **10,175 annual amount**

Poverty Levels: <100% 100-124% 125-149% 150- 184% 185+

Low Income Minority: Yes No Do you have health Insurance? Yes No

Limited English Proficient: Yes No Primary Language: _____

Interpreter Requested: Yes No

Emergency Contact Name: _____

Relationship to Emergency Contact: _____

Phone: Home Mobile Work (____)____-____ Phone: Home Mobile Work (____)____-____

Nutrition Screen Initiative (NSI)	NO	YES	Points
I have an illness or condition that made me change the kind and/or amount of food I eat	<input type="checkbox"/>	<input type="checkbox"/>	2
I eat fewer than 2 meals per day	<input type="checkbox"/>	<input type="checkbox"/>	3
I eat few fruits or vegetables or milk products	<input type="checkbox"/>	<input type="checkbox"/>	2
I have 3 or more drinks of beer, liquor, or wine almost every day	<input type="checkbox"/>	<input type="checkbox"/>	2
I have tooth or mouth problems that make it hard for me to eat	<input type="checkbox"/>	<input type="checkbox"/>	2
I don't always have enough money to buy the food I need	<input type="checkbox"/>	<input type="checkbox"/>	4
I eat alone most of the time	<input type="checkbox"/>	<input type="checkbox"/>	1
I take 3 or more different prescribed or over-the-counter drugs a day	<input type="checkbox"/>	<input type="checkbox"/>	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months	<input type="checkbox"/>	<input type="checkbox"/>	2
I am not always physically able to shop, cook, and/or feed myself	<input type="checkbox"/>	<input type="checkbox"/>	2

Total: _____

A score of 6 or more means you are at a high nutritional risk.

Would you like a referral to speak with a Registered Dietitian for Nutrition Counseling? Yes No

(Note, this is a contribution based service and no eligible person can be turned away for failure or refusal to contribute)

Have you visited a health professional to discuss these concerns? Yes No

Informed Consent to Capture and Record Personal Information

I hereby consent to my personal information contained in this Registration Form, being saved in the Client Data System maintained by the New York State Office for the Aging and used by the local Office for the Aging. I understand that my information will not be shared with other agencies without my permission. I understand that the information on this form may be sent to the State and Federal government to improve services offered and better meet my needs.

Signature

Date

Print Type of Service(s) Requested: Senior Center Recreation Meal with Nutrition Education

Other (describe): _____

Please use additional consent forms to refer to Transportation, Nutrition Counseling and Other services.

(Form: Consent to Refer) or share information in cases of Emergency (Form: Consent to Share).

ATTESTATION (To be completed by worker)

I attest that informed consent, as indicated, was obtained from the above individual, who provided his/her signature above. All appropriate processes were followed, and consent was provided voluntarily.

Worker Signature

Date

Worker Name (Print)

Informed Consent to Refer and Share Personal Information

I request and consent that _____, (Senior Center) may release all requested records, including but not limited to, personal information, health information, and any other information concerning me that I have provided to _____, (Senior Center) to the following entities: _____

I understand that this information will be provided so they can make referrals for service that I may need, or for the purposes identified as follows:

I understand what information will be released, the need for the information, and that there are laws and regulations protecting the confidentiality of this information.

I understand that signing this authorization is voluntary but that refusal to do so may limit options available to me.

I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and in such an event may no longer be protected by federal or state law. **Client Initial** _____

Informed Consent to Share Certain Information in the event of a Disaster or Emergency

In the event of a disaster or emergency, I consent to the release of information about services I receive, my housing situation and who I live with, medical equipment or services needed daily, prescription medications taken daily, special dietary needs, special communication needs, blindness or other visual impairments, and information about my general condition and mobility.

I understand that this information will only be given to those who will use it to respond to an emergency, such as government agencies, law enforcement, or those acting on their behalf when and if there is a disaster or emergency situation.

I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and in such an event

I consent to actions above where I have initialed. The authorizations provided shall not expire unless revoked.

Signature of individual or legal representative

Date

Individual name (Print): _____

If legal representative, provide name and relationship to individual

ATTESTATION (To be completed by worker)

I attest that informed consent, as indicated, was obtained from the above individual, who provided his/her signature above. All appropriate processes were followed, and consent was provided voluntarily.

Worker Signature

Date

Worker Name (Print)

may no longer be protected by federal or state law. Client Initial _____