

Form 5 - Consumer Registration Form

Information on this Consumer Registration form is crucial for Connecticut to receive federal funds and maintain services for older adults. Please complete this form and submit the data to the C.T. Bureau of Aging's designated database.

Consumer privacy is paramount. The law strictly prohibits sharing personal information without a court order or consent from the consumer or their legal representative, EXCEPT for state, federal, and local monitoring for program reporting, management, public safety, and research purposes. Rest assured, consumer information will only be used as necessary under these provisions.

Consumer acknowledged (Please initial here to acknowledge the statement above.) [_____]

REGISTRATION: Older Adult New Older Adult Update Caregiver New Caregiver Update Includes Service Delivery Data (Complete section VI)

I. ADD CONSUMER INFORMATION

Consumer Name: First: _____ MI: _____ Last: _____

Today's Date: (mm/dd/yyyy) _____ **Gender:** Female Male Non-Binary Other **Birth Date:** (mm/dd/yyyy) _____

Home phone: _____ **Cell phone:** _____

Email Address: _____

Home Street Address 1: _____

Home Street Address 2: _____ **County:** _____

Town: _____ **State (if not CT) :** _____ **Zip code:** _____

Provider Name: _____

NSIP Eligible (Nutrition Services Incentive Program) Yes No

Eligibility Type: Consumer Age 60 and Older Disabled in Elderly Housing Disabled Living with an Elderly Person Spouse of Person Age 60+ Volunteer Caregiver Age 60 and older

Cognitive Impairment: Has Alzheimer's disease or a related dementia
 None Early Onset Dementia Mild Moderate Severe Unknown

Disability: Yes No Care recipient is between the ages of 18 and 59 and has a disability.

II. CAREGIVER/CARE RECIPIENT STATUS

Care Status: Consumer is Caregiver Consumer is Care Recipient

Name of Care Recipient: _____
Name of Caregiver: _____

Relationship: Caregiver's Relationship to the Care Recipient

Brother Daughter Daughter-in-Law Domestic Partner Father*
 Granddaughter Grandfather* Grandmother* Grandson Husband
 Mother* Non-Relative Other Relative Sister Son
 Son-in-Law Wife

*Must only be checked if the caregiver is age 55 or older and is the primary caregiver for a child under age 18 or an adult child between age 18 - 59 with a disability. Non-Relative and Other Relative may be checked for these caregivers as well as caregivers of older adults.

III. DEMOGRAPHIC INFORMATION - Language and Race/Ethnicity

Primary Language: (Language spoken at home) American Sign Language Arabic Cambodian (Khmer) Chinese English French German Greek Gujarati Haitian Creole Italian Korean Polish Portuguese Russian Spanish Tactical Sign Language Turkish Urdu Vietnamese Other (Please Specify) _____

Speaks English: Very well Well Not Well Not At All

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Race: (Check all that apply) American Indian/Alaskan Native Asian/Asian American Black/African American Middle Eastern/North African Native Hawaiian/Pacific Islander White-Not Hispanic/Latino White-Hispanic/Latino Other

III. DEMOGRAPHIC INFORMATION - Housing, Living Situation and Income

Housing: Private Home Private Apartment Senior Housing
 Congregate Housing Public Housing Residential Care Home
 Nursing Home Assisted Living Other (Please Specify) _____

Living Arrangements: Alone With Spouse With Unmarried Partner
 With Spouse/Partner and Child/ren With Child/ren Only, No Spouse/Partner
 With Grandchild/ren With Other Relatives With Others

Marital Status: Married Divorced Separated Never Married Widowed

Income: **I live alone or with someone other than a spouse and MY monthly income is about:**
*(at/below the 100% FPL is In Poverty, FPL 2024)
 At or Below \$1,255 (100%)* \$1,256-\$1,569 (125%) \$1,570-\$1,883 (150%)
 \$1,884-\$2,196 (175%) \$2,197-\$2,510 (200%) \$2,511 or over (over 200%)
I live with my spouse and OUR monthly income is about:
 At or Below \$1,703 (100%)* \$1,704-\$2,129 (125%) \$2,130-\$2,555 (150%)
 \$2,556-\$2,981 (175%) \$2,982-\$3,407 (200%) \$3,408 or over (over 200%)

IV. ASSISTANCE WITH ACTIVITIES NEEDED

ADLs <small>(Activities of Daily Living)</small>	Yes	No	<input type="checkbox"/> <input type="checkbox"/> Eating	Yes	No	<input type="checkbox"/> <input type="checkbox"/> Dressing	Yes	No	<input type="checkbox"/> <input type="checkbox"/> Bathing/Washing		
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> Using the toilet	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Getting Out of Bed/Chair		<input type="checkbox"/>	<input type="checkbox"/>
IADLs <small>(Instrumental Activities of Daily Living)</small>	Yes	No	<input type="checkbox"/> <input type="checkbox"/> Planning/Preparing Meals	Yes	No	<input type="checkbox"/> <input type="checkbox"/> Shopping					
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> Managing Money	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Using the Telephone	Yes	No	<input type="checkbox"/> <input type="checkbox"/> Walking* <small>(*walking is not part of ADLs/IADLs)</small>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> Housekeeping	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Doing Laundry	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> Taking Medicine	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Using Transportation			

V. NUTRITION RISK - ALL SERVICES EXCEPT CAREGIVERS

The Nutritional Risk Score will be recorded as missing if any of these questions are not answered.

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	I have an illness or condition that made me change the kind or amount of food I eat. (2)
<input type="checkbox"/>	<input type="checkbox"/>	I eat fewer than 2 meals per day. (3)
<input type="checkbox"/>	<input type="checkbox"/>	I eat few fruits and vegetables or dairy products. (2)
<input type="checkbox"/>	<input type="checkbox"/>	I have problems chewing/swallowing that make it hard for me to eat. (2)
<input type="checkbox"/>	<input type="checkbox"/>	I do not always have enough money or food stamps to buy the food I need. (4)
<input type="checkbox"/>	<input type="checkbox"/>	I take 3 or more different prescription or over-the-counter drugs each day. (1)
<input type="checkbox"/>	<input type="checkbox"/>	I eat alone most of the time. (1)
<input type="checkbox"/>	<input type="checkbox"/>	I have 3 or more drinks of beer, liquor or wine almost every day. (2)
<input type="checkbox"/>	<input type="checkbox"/>	Without wanting to, I have lost or gained 10 pounds in the last 6 months. (2)
<input type="checkbox"/>	<input type="checkbox"/>	I am not always physically able to shop, cook or feed myself. (2)

VI. SERVICE DELIVERY (OFFICE USE ONLY; As shown in the WellSky A&D database)

Provider Name	Site / Care Manager (if applicable)	Service (sub-service)	Service Month	Units
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____