

Consumer Characteristics

Please complete this form annually for Registered Services under the Older Americans Act. Data is critical for Federal Title III and State Funds. Unauthorized use is strictly prohibited. Information is protected by Privacy and Security Agreements. Names and identifiers are not shared. Updated 09/24.

Basic Information Circle One: **HDM** **Congregate** **Transportation**

Name (Last, First, Middle Initial)

Date of Birth

Form Date

Physical Address

City

State

Zip Code

Mailing Address (If different than physical)

City

State

Zip Code

Contact Information

Phone

Email

Emergency Contact

Name

Relationship

Phone

Demographics

Race (Check all that apply)

- ☐ Alaskan Native/American Indian
- ☐ Asian/Asian American
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White/Caucasian
- ☐ Hispanic

Gender

- ☐ Female
- ☐ Male
- ☐ Other

Are you a Veteran?

- ☐ Yes
- ☐ No

**Individuals
in home**

Income

Annual

Monthly

1	\$19,550	\$1,629
2	\$26,430	\$2,203
3	\$33,310	\$2,776
4	\$40,190	\$3,349
5	\$47,070	\$3,923

Are you Diabetic?

- ☐ Yes
- ☐ No

Would you prefer ☐ juice or ☐ milk?

Do you have any food allergies?

- ☐ Yes
- ☐ No

If Yes, Please Describe _____

**Is household income above income
guide?**

- ☐ Yes
- ☐ No

Do you live alone?

- ☐ Yes
- ☐ No

Consumer Characteristics (Continued)

Ability and Assistance

If you use personal or stand-by assistance, supervision, or cues to perform the following activities please check the corresponding box. Check all that apply.

Instrumental Activities of Daily Living (IADLs)

- ☐ Preparing meals
- ☐ Shopping for personal items
- ☐ Medication management
- ☐ Managing Money
- ☐ Using telephone
- ☐ Doing laundry
- ☐ Doing light housework
- ☐ Using available transportation

Activities of Daily Living (ADLs)

- ☐ Feeding
- ☐ Dressing
- ☐ Continence
- ☐ Transferring in/out of bed/chair
- ☐ Bathing
- ☐ Toileting

Has Alzheimer's or Related Dementia/Disorder (ADRD):

Yes No Don't Know

Has Traumatic or Acquired Brain Injury (TABI):

Yes No Don't Know

Total score from Determine Your Nutritional Health (required for home delivered meals)

Fairbanks Senior Center

Employee Initials _____

Date: _____

For Adult Day Services (ADS) Consumers Only

Indicate Payment Source:

Adult Day Services (ADS) Grant

Medicaid Waiver

Private Pay

For Caregivers Only

Indicate relationship to care recipient

Parent

Grandparent

Other Relative

Non-Relative

Partner/Spouse