

Greater Harleysville and North Penn Senior Services (GHPSS)

Please Fill Out Both Front and Back

First Name and Middle Initial: _____

Last Name : _____

Birth Date : _____

Required

Telephone : _____

Street Address : _____

City / State / Zip : _____

County : _____

Municipality : _____

Email : _____

Social Security # : Last Four Digits ONLY XXX-XX-__ __ __ __

Required

I understand that while participating in programs offered at GHPSS, individual or group photographs may be taken and used for promotional purposes. I do not want photographs taken of me.

_____ (Initial to opt out)

| | | |
|--|--|---|
| Ethnicity : Please Circle One | American Indian Native Alaskan Black - African American Native Hawaiian Other Pacific Islander White Hispanic Other _____ | <u>HOUSEHOLD INCOME</u> Please Circle One <u>1 Person Household</u> Less than \$11,000 \$11,000-\$22,299 \$22,300-\$33,499 \$33,500 and greater <u>2 Person Household</u> Less than \$15,000 \$15,000-\$30,299 \$30,300-\$45,399 \$45,400 and greater |
| Household : Please Circle One | Lives Alone Lives With Spouse Lives With Child Lives with other Family Other | |
| Marital Status : Please Circle One | Married Widowed Legally Separated Divorced Single | |

| | | |
|---|---|------------------------|
| Gender : Male / Female / Transgender | <u>Do you have Prescription Coverage?</u> info will not be shared/statistical purposes only | |
| Veteran : Yes / No | Medicaid Access Card | Medicare Drug Coverage |
| Head of Household : Yes / No | PACE Card | Employer Plan |
| Primary Language : | PACENET Card | None |

Do you currently receive PA Property Tax / Rent Rebate? Yes / No

Please turn over and complete the back side of this application. Thank You!

Please fill out this section. It is very important for us to be able to contact someone in case of an emergency.

Disabilities: _____

Emergency Contact : _____

Emergency Contact Relation: _____

Emergency Telephone Numbers : Work: _____
 Home: _____
 Cell: _____
 Other: _____

Doctors Name & Telephone: _____

Determine Your Nutritional Health

The warning signs of poor nutritional health are often overlooked. Use this checklist to find out if you are at nutritional risk. Please read the statements below. Circle the number in the yes column for those that apply to you. For each yes answer, score the number in the box. Total your nutritional score.

| | YES |
|---|--------------|
| I have an illness or condition that made me change the kind and/or amount of food I eat | 2 |
| I eat fewer than 2 meals per day. | 3 |
| I eat few fruits or vegetables, or milk products. | 2 |
| I have three or more drinks of beer, liquor or wine almost every day. | 2 |
| I have tooth or mouth problems that make it hard for me to eat. | 2 |
| I don't always have enough money to buy the food I need. | 4 |
| I eat alone most of the time. | 1 |
| I take three or more different prescribed over-the-counter drugs a day. | 1 |
| Without wanting to, I have lost or gained 10 pounds in the last six months. | 2 |
| I am not always physically able to shop, cook and/or feed myself. | 2 |
| Total your nutritional score. If it's – | TOTAL |

0-2 Good! Recheck your nutritional score in 6 months.

3-5 You are at moderate nutritional risk. See what can be done to improve your eating habits and lifestyle. Your Office on aging, senior nutrition program, senior citizens center or health department can help. Recheck your nutritional score in 3 months.

6 or more You are at high nutritional risk. Bring this checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional help.

Remember that warning signs suggest risk, but do not represent diagnosis of any condition. Turn the page to learn more about the warning signs of poor nutritional health.