Provider Name: **SAMPLE 2, CLUSTER 1**	*Unique Participant ID: _____
Region/Site Name:	Registration/Assessment Date: _____
	*Termination Date: *Reason:

Service Categories(Titles IIIB, IIIC and IIID):

☐ **Personal Care** (A,I) ☐ **Homemaker** (A,I) ☐ **Chore** (A,I)

☐ **Home-Delivered Meals** (A,I,N) ☐ **Adult Day Care/Health** (A,I) ☐ **Case Management** (A,I)

Notes: *Reference the Data Dictionary for allowable "Other" service categories; Requires: **A**-ADLs, **I**-IADLs, **N**-Nutritional Assessments on Page 2*

SECTION 1 (Client)

(*) Required for All Registered Programs

Personal Data (Please Print):	
First Name:	
Middle Initial:	
Last Name:	
*** What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
*** What was your sex at birth? (Check only one)**	☐ Male ☐ Female ☐ Declined/not stated
*** How do you describe your sexual orientation or sexual identity (Check only one)**	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***Birth Date**:	
Last 4 Digits Social Security # *Optional*	☐☐☐☐
Home Phone #:	( )

Residential Address:	
Street:	
City:	
*Zip Code:	

Mailing Address: Same As Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
* Zip Code:	
Emergency Contact:	Name: Relationship: Phone #: ( )
***Ethnicity**:	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State
***Federal Poverty Level (FPL)**	☐ At or below FPL ☐ Above FPL ☐ Declined to State
***Lives Alone?**	☐ Yes ☐ No ☐ Declined to State
***Rural?**	☐ Yes ☐ No ☐ Declined to State

***Race:** (Please Check ONE)

☐ White ☐ Black ☐ American Indian/Alaska Native
☐ Other Race ☐ Multiple Race

Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Vietnamese ☐ Other Asian

Hawaiian/Other Pacific Islander:
☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander
☐ Declined to State

Title III B Eligibility:
Are you age 60 or over? ☐ Yes ☐ No

SECTION 2 – Client ADL and IADL
(Activities of Daily Living and Instrumental Activities of Daily Living Annual Assessment)
** **Required for (III-C)**: Home-Delivered Meals; **(III-B)**: Personal Care, Homemaker, Chore, Adult Day Care, Case Management*

ADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 –Lots of Human Help	5 – Dependent	Declined to State
*Eating						
*Bathing						
*Toileting						
*Transferring In/Out of Bed/Chair						
*Walking						
*Dressing						
Notes:						

IADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
*Meal Preparation						
*Shopping						
*Medication Management						
*Money Management						
*Using Telephone						
*Heavy Housework						
*Light Housework						
*Transportation						
Notes:						

SECTION 3 – Nutritional Assessment (Annual)
***Required for (IIIC)**: Home-Delivered Meals*

*Nutritional Assessment:	Circle if 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 3 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 3 or more different prescribed or over–the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the past 6 months?	2
I am not always physically able to shop, cook, and/or feed myself.	2
Total Score: (If equal to or greater than 6, the client is at high nutritional risk)	
	☐ **Declined to State**