Membership Application

OFFICE USE ONLY!
____ /____ /20____
Today's Date

Contact Information

_____ _____ _____ _____ _____ / _____ / 19____
Last Name *First Name* *Middle Initial* *Suffix (Dr., Jr., Sr.)* *Date of Birth*

_____
Preferred First Name / Nick Name

Last 4 of Social Security
- ## - __ __ __ __

Residential/Mailing Address

Is your postal/mailing address exactly the same as the residential address? ❑ No ❑ Yes

_____ _____ **PA** _____
Street Address *City* *State* *Zip*

_____ _____
PO Box If Applicable *Municipality/Borough/Township*

Do you live in a rural area?
❑ No ❑ Yes

(_____) _____-_____ ❑ Home ❑ Cell (_____) _____-_____ ❑ Home ❑ Cell
Primary Phone # *Secondary Phone #*

_____
Email Address

Emergency Contact Information

_____ (_____) _____ - _____ _____
#1 Emergency Contact Name *Phone* *Relationship*

_____ (_____) _____ - _____ _____
#2 Emergency Contact Name *Phone* *Relationship*

X _____ _____
Signature *Date*

York County Area on Aging—Registration Questionnaire

PSA ID #: 25

1) What is your current gender identity? *Defined as one's inner sense of one's own gender. Please Select ONLY ONE!*

❑Female ❑Male	❑Non-Binary ❑Transgender Male (female to male) ❑Transgender Female (male to female)	❑Choose not to disclose ❑Something else that was not named. *Please specify* _____

2) What is Your Ethnicity? *Please Select ONLY ONE!*

❑Hispanic or Latino	❑Not Hispanic or Latino	❑Unknown

3) What Is Your Race? *Please Select ONLY ONE!*

❑American Indian/Native Alaskan ❑Asian ❑Black/African American	❑Native Hawaiian/Other Pacific Islander ❑Non-Minority (White, non-Hispanic) ❑White-Hispanic	❑Unknown/Unavailable ❑Other _____

4) Is Your annual income LESS than 100% of the current Federal Poverty Income Guidelines (FPIG)? *Current Annual Total FPIG: $13,590 for One (1) person, $18,310 for Two (2) persons (Add $4,720 for each additional person in the household)*

❑ No ❑ Yes ❑ Pending

5) Do You have a Medicaid Number?

❑ No ❑ Yes ❑ Pending
If Yes, # _____

6) Do You have a Medicare Number?

❑ No ❑ Yes
If Yes, # _____

7) Do You have any other insurance?

❑ No ❑ Yes ❑ Don't Know
*If Yes, Name:*_____

YORK COUNTY AREA ON AGING—REGISTRATION QUESTIONNAIRE, CONTINUED...

8) Are You Currently Homeless?

❑ No ❑ Yes

9) Type of PERMANENT Residence in which you reside:

❑ AL-Assisted Living	❑ Nursing Home	❑ Specialized Rehab/Rehab Facility
❑ Apartment	❑ Own Home	❑ State Institution
❑ Domiciliary Care	❑ PCG - *Personal Care Home*	❑ Other
❑ Group Home	❑ Relative's Home	_____

10) What is your PERMANENT living arrangement?

❑ Lives Alone *(Check if individual lives in an AL, DC , PCH, or pay rent and have NO ROOMMATE)*	❑ Lives with other Family Member(s)
❑ Lives with Spouse Only	❑ Unknown
❑ Lives with Child(ren) but *NOT* Spouse	❑ Other _____

11) What is Your Marital Status

❑ *Single*	❑ *Legally Separated*
❑ *Married*	❑ *Widowed*
❑ *Divorced*	❑ *Other*_____

12) Are You a Veteran?

❑ *No*
❑ *Yes*
❑ *Unable to Determine*

13) Are You a Spouse, Widow or Dependent Child of a Veteran?

❑ No ❑ Yes

14) Are You Receiving Veteran Benefits?

❑ No ❑ Yes

15) Do you require communication assistance?

❑ No ❑ Yes

16) Is sign language your PRIMARY language?

❑ No ❑ Yes

17) What is your PRIMARY language?

❑ *English*
❑ *Russian*
❑ *Spanish*
❑ *Other*_____

18) Do you need a voter registration form?

❑ No ❑ Yes

YORK COUNTY AREA ON AGING—DIETARY ASSESSMENT

19) Do you generally have a good appetite? ❑ No ❑ Yes If No, explain: _____

20) Do you use a dietary supplement? ❑ No ❑ Yes If No, explain: _____

21) Do you have any food allergies? ❑ No ❑ Yes If No, explain: _____

22) Do you have a special diet for:

Medical reasons? ❑ No ❑ Yes If No, explain: _____

Religious/cultural reasons? ❑ No ❑ Yes If No, explain: _____

YORK COUNTY AREA ON AGING—NUTRITIONAL RISK ASSESSMENT

Has there been a change in lifelong eating habits because of health problems?	❑ No ❑ Yes
Do you eat fewer than 2 meals per day?	❑ No ❑ Yes
Do you eat fewer than 2 servings of dairy products *(ex: milk, yogurt, or cheese)* every day?	❑ No ❑ Yes
Do you eat fewer than 5 servings (1/2 cup each) of fruits or vegetables every day?	❑ No ❑ Yes
Do you have 3 or more drinks of beer, liquor or wine almost every day?	❑ No ❑ Yes
Do you have trouble eating due to problems with chewing/swallowing?	❑ No ❑ Yes
Do you not have enough money to buy the food you need?	❑ No ❑ Yes
Do you eat alone most of the time?	❑ No ❑ Yes
Do you take 3 or more prescribed or over-the-counter drugs (OTC) per day?	❑ No ❑ Yes
Have you lost or gained at least 10 pounds or more in the LAST 6 MONTHS? ❑No ❑Yes, Gained ❑Yes, Lost ❑Don't Know	
Are you not always physically able to shop, cook and/or feed yourself *(or to get someone to do it for you)*?	❑ No ❑ Yes