THE MODERN MATURITY CENTER, INC.
1121 FORREST AVE. DOVER, DELAWARE 19904 734-1200 FAX 674-1265

PARTICIPANT INFORMATION

PLEASE PRINT. All information is strictly confidential and is used by MMC staff only.

Last Name _____ First Name _____

Address _____

City _____ State _____ Zip _____

Home phone number _____ Race _____ Birthdate _____

Social Security Number _____-_____-_____ ❑ Male ❑ Female

Verification of Age ❑ Driver's License ❑ Birth Certificate ❑ Other _____

Preferred Doctor _____ Phone _____

Emergency Contact Person:

Name _____

Address _____

Home Phone _____ Work Phone _____

Back-Up Emergency Contact Person:

Name _____

Address _____

Home Phone _____ Work Phone _____

For Staff ONLY:

CODE: _____ Membership Number _____

Minus 60 Spouse: ❑ Yes ❑ No Minus 60 Eligible Handicapped ❑ Yes ❑ No

Site _____

Staff Member Completing Form _____ Date _____

Computer Operator _____ Date _____

Delaware Health and Social Services

Division of Services for Aging and Adults with Physical Disabilities

☐ New Client ☐ Update Client

NAPIS Intake

Assessment Date: ____/____/____

Membership #: _____ Re-Assessment Date: ____/____/____

Provider: _____

Last Name:	**First Name & Middle Initial:**	**Weight**	Height
Address 1:		**Birth Date:** ____/____/____	
Address 2:		**Sex:** ☐ Male ☐ Female	
City:	**State:** **Zip Code:**	**Marital Status:** ☐ Married ☐ Single/Widowed	
Home Phone: ( ) -	**Cell Phone:** ( ) -	**Cell Phone:** ( ) -	
Age 60 or Over (verified by): ☐ License/ID ☐ Medicare Card ☐ Other		**Rural:** ☐ Yes ☐ No	
Individual Income Status (annual): ☐ At or below $11,770 ☐ Above $11,770	☐ Refused to Answer ☐ Missing (not provided)	**Living Arrangements:** ☐ Alone ☐ With Someone	
If Under Age 60 (nutrition only):	☐ Eligible through Spouse ☐ Social Security Disability ☐ Volunteer	**Physical Condition:** Frail / Disabled ☐ Yes ☐ No	

Ethnic Group (Check only one):

☐ African American ☐ Asian/Pacific Islander (inc. Native Hawaiian)

☐ Hispanic Origin ☐ Non-Minority (White, not of Hispanic Origin)

☐ American Indian/Native Alaskan

Understands English: ☐ Yes ☐ No

Emergency Contact:

Name: _____ Phone #: _____ Relationship: _____

The information provided above is true and correct to the best of my knowledge.

Signature of person completing form _____ **Date: ____/____/____**

The above information is pertinent to help provide us with funding sources for you needs.

Revised 7/7/2014

********** **Please turn over & fill in other side.** **********

DETERMINE YOUR NUTRITIONAL HEALTH

<u>The top section is required!</u> **All applications for over 60 clients <u>must</u> have the top section filled out.**
*Homebound meals & new case manangement will be filled out by an outreach worker.

Read the statements below. Circle the number under the column for answer which applies.
Total the nutritional risk score at the bottom.

Nutritional Health Statement - Circle in the appropriate column or check "No Answer".	Yes	No	No Answer
1. Have you made changes in the way you eat because of an illness or medical condition?	2	0	
2. Do you eat only 1 meal per day?	3	0	
3. Do you eat few fruits, or vegetables, or milk products?	2	0	
4. Do you have 3 or more drinks of beer, liquor or wine almost every day?	2	0	
5. Do you have tooth or mouth problems that make it hard for you to eat?	2	0	
6. Do you not always have enough money to buy the food you need?	4	0	
7. Do you eat alone most of the time?	1	0	
8. Do you take 3 or more different prescribed or over-the-counter drugs a day?	1	0	
9. Have you lost or gained 10 pounds in the last 6 months without wanting to?	2	0	
10. Do you need assistance to shop, cook, or feed yourself?	2	0	
Total (0 - 21)			

Total the Nutritional Score. If it's -

0 - 2 **Good!** Recheck nutritional risk score in 12 months.

3 - 5 **At moderate nutritional risk.** See what can be done to improve your eating habits and lifestyle.

6 or more **At high nutritional risk.** The next time you see your doctor, dietitian, or other qualified health or social professional, talk with them about any problems you may have. Ask for help to improve your nutritional health.

Remember Warning signs suggest risk, but do not represent a diagnosis of any condition.

Client Signature: ______________________________ Date: __________________

* *

Answer these only if client received home delivered meals or adult day care.

Independent = I **Assistance = A** **Dependent = D**

Activities of Daily Living (ADL)
Do you have any difficulties with:

1. Bathing I ☐ A ☐ D ☐
2. Walking I ☐ A ☐ D ☐
3. Dressing I ☐ A ☐ D ☐
4. Toileting I ☐ A ☐ D ☐
5. Transferring I ☐ A ☐ D ☐
6. Eating I ☐ A ☐ D ☐

Instrumental Activities of Daily Living (IADL)
Do you have any difficulties with:

1. Using the telephone I ☐ A ☐ D ☐
2. Shopping I ☐ A ☐ D ☐
3. Preparing meals I ☐ A ☐ D ☐
4. Light housekeeping I ☐ A ☐ D ☐
5. Heavy housekeeping I ☐ A ☐ D ☐
6. Getting to places outside the home I ☐ A ☐ D ☐
7. Following medicine directions I ☐ A ☐ D ☐
8. Finance and money I ☐ A ☐ D ☐

Interviewer: ________________ Site: ______________________ Phone: ______________