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

MEMBERSHIP APPLICATION

CONTACT INFORMATION

_____ _____ _____ _____ _____ / _____ / 19____
Last Name *First Name* *Middle Ini al* *Su x (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* *Relati nship*

_____ (_____) _____ - _____ _____
#2 Emergency Contact Name *Phone* *Relati nship*

X _____ _____
Signature *Date*

YORK COUNTY AREA ON AGING—REGISTRATION QUESTIONNAIRE

PSA ID #: 25

1) What is your current gender identity? *De ned 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 addi onal 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