



# KIC ELDER MEALS AND WHEELS PARTICIPANT REGISTRATION FORM

**CONFIDENTIAL**

ADA# \_\_\_\_\_

IDN# \_\_\_\_\_

907-247-RIDE (7433)  
Fax 800-865-6310

HD meals must include reasons on page 2  
LOCATION: KIC – 615 Stedman St., Ketchikan, AK 99901 907-228-9437

NAME (Last, First, Middle Initial): \_\_\_\_\_

PHYSICAL ADDRESS: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY, STATE: ZIP: \_\_\_\_\_

HOME PHONE NUMBER: \_\_\_\_\_ CELL PHONE NUMBER: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ GENDER: MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

**\*\*This information below is important for Federal Funding\*\***

ETHNIC RACE (Check 1 box)  Black/African American  Hispanic origin  Alaska Native/American Indian  
 Native Hawaiian/Other Pacific Islander  Asian  Caucasian/Non-Minority  Other

DO YOU LIVE ALONE?  YES  NO DO YOU HAVE DIABETES?  YES  NO

IS YOUR INCOME ABOVE (\$1,133-1 PERSON) OR (\$1,532-Couple) PER MONTH (Not including Senior Benefits Program and Permanent Fund Dividend?)  YES  NO

DO YOU HAVE DISABILITY?  YES  NO ARE YOU 80 YRS OF AGE OR OLDER?  YES  NO

EMERGENCY CONTACT: \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

|   |                          |  |
|---|--------------------------|--|
| <b>QUALIFIED MEAL GUESTS UNDER 55 PLEASE CHECK <input checked="" type="checkbox"/></b>                                  |                          | <b>SERVICES REQUESTED PLEASE CHECK <input checked="" type="checkbox"/></b> |
| ARE YOU A MEALTIME VOLUNTEER? <input type="checkbox"/> YES <input type="checkbox"/> NO                                  | <input type="checkbox"/> | Congregate   |
| IS YOUR SPOUSE OVER 55? <input type="checkbox"/> YES <input type="checkbox"/> NO  | <input type="checkbox"/> | Transportation   |
| DO YOU HAVE A DISABILITY AND LIVE IN LOW INCOME SENIOR HOUSING <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> | Home-Delivered Meals   |
| <b>For Program Office Use Only:</b><br>Class: C S V DE MV Status: O N I R M D V MV NR<br>_____ ADL _____ LADL _____     | <input type="checkbox"/> | Shopping Assistance  |
|   | <input type="checkbox"/> | Homemaker/Chore  |
|   | <input type="checkbox"/> | Care Coordination  |
|   | <input type="checkbox"/> | Adult Day Program  |
|   | <input type="checkbox"/> | Other  |
|   |                          | <b>(Please complete the survey on the back)</b>                            |

**KIC CONGREGATE AND HOME DELIVERED MEAL CLIENTS COMPLETE QUESTIONS BELOW**

**Nutritional Risk Questions**

**(Circle the number if YES)**

|  |   |
|--|---|
| I have an illness or condition that made me change the kind and/amount of food I eat.  | 2 |
| I eat fewer than two (2) meals per day.  | 3 |
| I eat fewer than five (5) servings of fruits & vegetables and 2 milk servings per day. | 2 |
| I have three (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 three (3) or more different prescribed or over-the-counter drugs a day.         | 1 |
| Without wanting to, I have lost or gained ten (10) pounds in the last six (6) months.  | 2 |
| I am not always physically able to shop, cook, and/or feed myself.                     | 2 |
| <b>TOTAL NUTRITIONAL SCORE</b>   |   |

**Score Guide**

**0-2** Good! Recheck your nutritional score again in six (6) months.

**3-5** you are at **Moderate Nutritional Risk**. See what can be done to improve your eating habits and lifestyle. Your senior nutrition program can help. Recheck your nutritional score again in three (3) months.

**6+** You are at **High Nutritional Risk**. Bring this checklist the next time you see your doctor, dietician or other qualified health or social service professional. Talk with them about any problems you have. Ask for help to improve your nutritional health.

**Remember that Warning Signs suggest risk, but do not represent a diagnosis of any condition.**

**PARTICIPANTS REQUESTING HOME DELIVERED MEALS, ASSISTED RIDES & HOMEMAKER/CHORE SERVICES COMPLETE BELOW**

Do you need assistance with any of the following activities? Please check  the activity:

|   |
|---|
| <input type="checkbox"/> Eating                           |
| <input type="checkbox"/> Dressing                         |
| <input type="checkbox"/> Bathing                          |
| <input type="checkbox"/> Bathroom                         |
| <input type="checkbox"/> Transferring in/out of bed/chair |
| <input type="checkbox"/> Walking                          |
| <b>Total IADL's</b>                                       |

|   |
|---|
| <input type="checkbox"/> Preparing meals                |
| <input type="checkbox"/> Shopping for personal items    |
| <input type="checkbox"/> Medication management          |
| <input type="checkbox"/> Managing money                 |
| <input type="checkbox"/> Using telephone                |
| <input type="checkbox"/> Doing heavy housework          |
| <input type="checkbox"/> Doing light housework          |
| <input type="checkbox"/> Using available transportation |
| <b>Total IADL's</b>                                     |

Is the participant bedridden?  YES  NO

Indicate if the participant uses a: Walker  YES  NO Cane  YES  NO Wheelchair  YES  NO

\*\*\*REASONS FOR MEALS AT HOME: \_\_\_\_\_

\_\_\_\_\_

ADDITIONAL CONCERNS? \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

**RETURN THIS COMPLETED FORM TO KIC ELDER SERVICES 615 STEDMAN OR FAX TO 800-865-6310**