Frozen

Helping Hands of Vegas Valley
CLIENT REGISTRATION FORM
Please Print Information

Date: ____________
☐ Initial Assessment
☐ Annual Reassessment
☐ RTC ☐ CDBG-E ☐ CDBG-Q
Assessed by: ____________

LEGAL NAME
(First/Last):

DATE OF BIRTH: / / **SSN Last 4:** **NICKNAME:**

ADDRESS: ____________
BLDG/APT: ____________ **ZIP CODE:** ____________
CITY: ________ **COMPLEX NAME:** ____________
GC: ________ MAILING ADDRESS SAME: ☐ Yes ☐ No

SEX AT BIRTH ☐ **MALE** ☐ **FEMALE** ☐ **OTHER**
GENDER IDENTITY ____________
PHONE 1: ____________ **Text? Y/N**
PHONE 2: ____________ **Text? Y/N**
EMAIL: ____________

EMERGENCY CONTACT:
NAME (First/Last): ____________
RELATIONSHIP: ____________ PHONE: ____________

NV DL/ID: ____________ **EXP. DATE:** ________
ARE YOU A VETERAN? ☐ Yes ☐ No

ETHNICITY
☐ HISPANIC/LATINO ☐ NON-HISPANIC OR LATINO

RACE-Check all that apply:
☐ WHITE (NON-MINORITY)
☐ WHITE (HISPANIC)
☐ BLACK/AFRICAN AMERICAN ☐ ASIAN
☐ AMERICAN INDIAN/ALASKAN NATIVE
☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER
☐ MIDDLE EASTERN/NORTH AFRICAN
☐ OTHER ____________

If you do not speak English, what is your primary language? ____________

Are you the Head of Household? ☐ Yes ☐ No
How many people live in your household in each age group?
Age 0-17 ____ Age 18-59 ____ Age 60 and older ____

What is your Monthly Household Income?
☒ $0 to $1,304 ☐ $1,305 to $1,762
☐ $1,763 to $1,956 ☐ $1,957 to $2,221
☐ $2,222 to $2,644 ☐ $2,645 to $3,130
☐ $3,131 to $3,331 ☐ $3,332 to $3,596
☐ $3,597 to $4,019 ☐ $4,020 to $4,695

ARE YOU DISABLED? ☐ Yes ☐ No
Do you use a: ☐ wheelchair ☐ pwr chair ☐ oxygen ☐ walker ☐ cane
DO YOU RECEIVE STATE MEDICAID? ☐ Yes ☐ No
ARE YOU A PRIMARY CAREGIVER? ☐ Yes ☐ No
IF YES, for whom do you provide care?
☐ Spouse ☐ Child, Age 0-17 ☐ Adult Child
☐ Parent ☐ Family Member
ACCESS TO THE INTERNET? ☐ Yes ☐ No
Do you receive SNAP? ☐ Yes ☐ No
If not, would you like to apply? ☐ Yes ☐ No

WHICH OF THE FOLLOWING ARE YOU *UNABLE* TO PERFORM WITHOUT ASSISTANCE?

Activities of Daily Living (ADLs):
☐ Eating ☐ Dressing ☐ Maintain Continence
☐ Bathing ☐ Use the Bathroom
☐ Transferring In/Out of a Bed/Chair
☐ **None – I can perform these activities**

Instrumental Activities of Daily Living (IADLs):
☐ Preparing Meals ☐ Laundry
☐ Taking Medication ☐ Housework
☐ Managing Money ☐ Using the Telephone
☐ Shopping ☐ Using Transportation Services
☐ **None – I can perform these activities**

☐ I was provided with the *Notice of Privacy Practices*

Client Signature: **Date:**

FOR OFFICE USE ONLY
Database: ________ Sams: ________ GG: ________ HMIS: ________ Trip Master: ________
Program: ☐ SNP-D ☐ SNP-W ☐ Congregate ☐ Rural-M ☐ Rural-G ☐ Transportation ☐ HR

Bar Code#________ SAMS ID#________ HMIS ID#________ Trip Master ID#________

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Additional Household Information

Client Name: ____ Date: __________

Number of People in Household other than yourself: ____________

Please complete the following for each additional member of your household

Family Member Name: ________________________________ Date of Birth: ______________

Male: ___________Female: ___________Other: ___________Gender Identity: ___________

Hispanic: ___________ Non-Hispanic: ___________Race: ________________________

Individuals Monthly Income: $______________________

Relationship to senior: ______________________ Is senior legal guardian: ___________

If under the age of 18 do the parents live in the home? Yes ___ No ___

Family Member Name: ________________________________ Date of Birth: ______________

Male: ___________Female: ___________Other: ___________Gender Identity: ___________

Hispanic: ___________ Non-Hispanic: ___________Race: ________________________

Individuals Monthly Income: ______________

Relationship to senior: ______________________ Is senior legal guardian: ___________

If under the age of 18 do the parents live in the home? Yes ___ No ___

Family Member Name: ________________________________ Date of Birth: ______________

Male: ___________Female: ___________Other: ___________Gender Identity: ___________

Hispanic: ___________ Non-Hispanic: ___________Race: ________________________

Individuals Monthly Income: ______________

Relationship to senior: ______________________ Is senior legal guardian: ___________

If under the age of 18 do the parents live in the home? Yes ___ No ___

HHOVV's Nutrition Program Release

of Liability

When receiving meals from our organization we ask that you do the following:

- Please check the meals for quality and do not consume foods that you foresee as a health concern. Quality control procedures are regularly conducted by Three Square staff; however, we ask that you check them as an added precaution.

You are required to complete an initial assessment and annual reassessments to continue the program. A health and satisfaction survey is required after 6 months.

If you agree to participate and receive meals, please sign and date the bottom of this form.

I, ____ choose to participate in Helping Hands of Vegas Valley's Nutrition Program and receive meals. Furthermore,

- ☐ I acknowledge this program is a privilege and not a right. Any discourteous or rude behavior towards staff, volunteers, or vendors is not tolerated and grounds for immediate termination.
- ☐ I will be responsible for monitoring food and for any possible allergens, and/or medication/food interactions, and sensitivity to dyes, etc.
- ☐ I agree that the organization, Three Square, community partners, volunteers nor the HHOVV Nutrition Program shall be held liable for any problems resulting from consuming meals.
- ☐ I understand my assessment/survey responses will be added to a data pool which is shared with partner organizations and donors for reporting purposes.
- ☐ I will notify the Nutrition Program if I wish to discontinue services.
- ☐ I will notify the Nutrition Program if my contact information changes.
- ☐ I will not sell any meals that are provided to me.

By signing this agreement, I acknowledge that I have read or that it has been read to me, and I agree to the terms.

Dated ____________________, 20___________

X____
Signature

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Rural Frozen Meals Program – Client Responsibilities

Acknowledgement and Agreement to Follow Check-in Policy and Procedures

I have received and read a copy of the "Rural Frozen Meal Program" Policies and Procedures to abide by and follow. I agree to take my responsibilities seriously and acknowledge:

- **This program is a privilege and not a right.** Any discourteous or rude behavior towards any staff, volunteers, or community partners is not tolerated and is grounds for immediate termination.
- I must pick up the food myself. If I cannot pick it up, I will go over other possible options with the HHOVV Community Partner staff.
- I will notify the Program Manager, Intake Coordinator should I wish to SKIP A MONTH of service or CANCEL services.
- I will inform staff of any changes in your status such as phone number change, address change, or hospitalization, as soon as possible.
- I will be responsible for monitoring food for any possible allergens, and/or medication/food interactions, and sensitivity to dyes, etc.
- I will notify the Program Manager, Driver or Intake Coordinator if there are any concerns regarding delivery or damaged meal trays/boxes.

Any violation of these responsibilities can result in my termination from this program.

Client's name – Print: ______________________________

Client Signature: ______________________________ Date: ________

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Rural Frozen Meals Program
Initial Survey

Client Name: ______________________ Date: ____________

1. **Are you currently experiencing the following situations? Choose Yes (Y) or No (N) below.**
   I must travel a far distance from home to get to a grocery store/pantry/congregate meal. **Y / N**
   I don't have enough money to purchase enough food. **Y / N**
   I have difficulty preparing/cooking meals for myself. **Y / N**

2. **How would you rate your overall health?**
   Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐

3. **Please describe your current health and/or diet. Choose Yes (Y) or No (N) below.**
   I am not eating enough nutritious and well-balanced meals. **Y / N**
   I have been eating poorly because of decreased appetite. **Y / N**
   I have dental health or digestive problems that interfere with my eating. **Y / N**
   I have difficulty chewing and/or swallowing. **Y / N**
   I have diagnosed medical condition(s) that affect my diet. **Y / N**

4. **Do you have any dietary needs or goals you would like to accomplish? Check all that apply.** **Y / N**
   Lose healthy weight ☐ Consume more fruits and vegetables ☐ Portion control ☐
   Cutting down sugar/sodium ☐ Eating more throughout the day ☐
   Other (Please explain)
   ____

5. **What, if any, health condition(s) have you been diagnosed with?**
   High Blood Pressure (Hypertension) ☐ Pre-Diabetes ☐ Diabetes ☐ High Cholesterol ☐
   Heart Disease ☐ Auto Immune Disease ☐ Renal Disease ☐ Cancer ☐
   Other ______________________

6. **Are you currently receiving any additional food assistance?** **Y / N**
   If yes, what kind of assistance (i.e. food stamps, neighbor/friend helps w/ food, food pantry, Meals on Wheels, etc.)
   ____

Survey Conducted By – Print Name: ______________________

Date Entered In Database: