Pantry

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#_____

Revised 01/25

Additional Household Information- Continued

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 ___

Senior Necessities Client Survey

This is a supplemental food program. Our program is not meant to be your primary or only source of food.

Initial Survey

1) How would you rate your health?

__Excellent __Very Good __Good __Fair __Poor

2) Is your current diet well balanced?

__Yes __ No

If you answered "No" what is missing from you diet?

__Fresh Vegetables __Fresh Fruit __Grains __Dairy __Protein __Other_____

3) In the last three months have you had to go without a meal due to a lack of food?

__Yes __ No

If you answered "Yes" How often did you have to go without a meal?

__Daily __More than once a week __Once a week __Once a month

Which of the following would you say is the reason? (Check all that apply.)

__I can't afford to purchase enough food

__ I don't have Transportation to get groceries

__I have difficulty preparing meals due to a disability

__I don't want to go to the trouble just for myself

__Have health problems that interfere with eating (such as poor dental health or digestive problems)

__Other _____

4) How often do you worry that your current food resources do not meet your needs?

__Daily __More than once a week __Once a week __Once a month __ Not Applicable

Helping

Senior Necessities Release of Liability

When receiving food and paper goods from our organization we ask that you do the following:

- Please check the food and remove items that you foresee as a health concern.
- Check to be sure the food items are in good condition. We have volunteers who check the items regularly but ask that you check them as an added precaution.

You are required to complete a food survey at initial assessment and then again, every six months.

If you agree to participate and receive food, please complete the bottom of this form.

I, _____ choose to participate in the Senior Necessities program and to receive supplemental bags/boxes of food. Furthermore,

- ☐ I will be responsible for monitoring food and paper products for any possible allergens, and/or medication/food interactions, and sensitivity to dyes, etc.
- ☐ I understand that I will be interviewed every six months as part of a program evaluation.
- ☐ I understand my survey responses will be added to the aggregate data pool for inclusion in comprehensive program evaluation reports which are shared with partner organizations and donors.
- ☐ I will notify the Senior Necessities program if I wish to discontinue service.
- ☐ I will notify the Senior Necessities program if my contact information changes.
- ☐ I will not sell items given to me.
- ☐ I agree that neither the organizations that donate the items, the Senior Necessities Program, or the Amargosa Public Library shall be held liable for any problems resulting from the usage of donated products.

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_____

_____

Signature

Revised 02/2023

Hands of Vegas Valley

Helping

Serving Senior Citizens In Our Community

I have received and read a copy of "Helping Hands Senior Necessities Program Helpful Reminders". I agree to take my responsibilities seriously and understand that this program is a privilege and not a right, and any violation of these responsibilities can result in my removal from this program.

Client's Name Printed _____ Date:_____

Client's Signature _____ Date:_____

Nevada Community Management Information System (CMIS)
Client Consent for Data Collection and Release of Information

What is the CMIS?
The CMIS is a data system that stores information about homelessness services. Bitfocus, Inc. manages the CMIS for the CoCs within the state of Nevada. The purpose of the CMIS is to improve services that support people who are homeless or at risk of homelessness to get housing, and to have better access to those services, while meeting requirements of funders such as the U.S. Department of Housing and Urban Development (HUD).

What is the purpose of this form?
With this form, you can give permission to have information about you collected and shared with Partner Agencies that help Nevada provide housing and services. A current list of Partner Agencies is available at http://nvcmis.bitfocus.com/.

BY SIGNING THIS FORM, I AUTHORIZE the state of Nevada and Bitfocus to share CMIS information with Partner Agencies. The CMIS information shared will be used to help me get housing and services. It will also be used to help evaluate the quality of housing and service programs. I understand that the Partner Agencies may change over time.

The information to be collected and shared includes:
- Name, date of birth, gender, race, ethnicity, social security number, phone number, address
- Basic medical, mental health, substance use, and daily living information
- Housing information
- Use of crisis services, veteran services, hospitals and jail
- Employment, income, insurance and benefits information
- Services provided by Partner Agencies
- Results from assessments
- My photograph or other likeness (if included)

BY SIGNING THIS FORM, I UNDERSTAND THAT:
- Bitfocus and Partner Agencies will keep my CMIS information private using strict privacy policies. I have the right to review their privacy policies.
- I can receive a copy of this Consent and the Client Information Sheet
- I may refuse to sign this Consent. If I refuse, I will not lose any benefits or services.
- This Consent will expire 5 years from my last CMIS recorded activity.

I may revoke this Consent earlier at any time by returning a completed Revocation of Consent form, available at http://nvcmis.bitfocus.com/, to nevada@bitfocus.com.

- The revocation will take effect upon receipt, except to the extent others have already acted under this Consent.
- My CMIS information may be viewed by auditors or funders who review work of the Partner Agencies, including HUD, The Department of Veteran Affairs, and The Department of Health and Human Services. I understand that the list of auditors and funders may change over time.
- My CMIS information may be shared to coordinate referral and placement for housing and services.
- My CMIS information may be further shared by the Partner Agencies to other agencies for care coordination, counseling, food, utility assistance, and other services.
- My CMIS information will be used to help evaluate the quality of social services.
- My CMIS information may be used for research;however, my identity will remain private.

SIGNATURE:

_____ _____
Signature of Patient/Client or Representative Date

_____
PRINTED NAME

Refusing Consent and De-Identification of Information

If you refuse consent to have your information shared with Partner Agencies, the following information will be entered into the system for your profile and will be deemed as anonymous or "de-identified".

1. Your Social Security Number will be entered as all 0s and the Social Security Number Data Quality field will be set to Client Refused;
2. Your Date of Birth will be entered as 01/01/[year of birth] and the Date of Birth Data Quality field will be set to Approximate or Partial DOB Reported;
3. Your First Name will be entered as Anonymous;
4. Your Last Name will be entered as the Unique Identifier automatically assigned by Clarity Human Services; and
5. The Name Data Quality field will be set to Client Refused.

FOR AGENCY USE ONLY:

Client Opted Out (Refused Consent) _____ *(Staff/Agency Initials)*

_____ _____

Witness Staff & Agency Date