Area Agency on Aging of Southwest Arkansas, Inc.

CLIENT REGISTRATION FORM

NAME (First/Last): _____ ☐ MALE ☐ FEMALE

ADDRESS: _____ PHONE NUMBER _____

EMERGENCY CONTACT INFORMATION:

NAME (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (_____) _____ WORK OR CELL PHONE: (_____) _____

ETHNICITY

☐ HISPANIC OR LATINO

☐ NON-HISPANIC OR LATINO

If below 60, reason for service

☐ Spouse ☐ Caregiver ☐ Volunteer

☐ Lives in Elder Housing ☐ Lives w/client

RACE

☐ WHITE, CAUCASIAN

☐ HISPANIC

☐ AMERICAN INDIAN / ALASKAN NATIVE

☐ ASIAN

☐ BLACK / AFRICAN AMERICAN

☐ OTHER _____

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

According to the current Federal Poverty Guidelines, YOUR INCOME IS:

☐ BELOW POVERTY ☐ ABOVE POVERTY

(The Service Provider will supply you with the current Poverty Guidelines.)

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

DO YOU LIVE ALONE? ☐ Yes ☐ No

ARE YOU DISABLED? ☐ Yes ☐ No

FRAIL? ☐ Yes ☐ No

HOMEBOUND? ☐ Yes ☐ No

MARITAL STATUS

☐ Single ☐ Married ☐ Widowed

☐ Divorced ☐ Separated

NUMBER IN HOUSEHOLD_____

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

Activities of Daily Living (ADLs):

☐ Eating ☐ Dressing

☐ Bathing ☐ Toileting

☐ Walking in Home

☐ Transferring In/Out of a Bed/Chair

☐ **None – I can perform these activities**

Instrumental Activities of Daily Living (IADLs):

☐ Preparing Meals ☐ Light Housework

☐ Taking Medication ☐ Heavy Housework

☐ Managing Money ☐ Using the Telephone

☐ Shopping ☐ Using Transportation Services

☐ **None – I can perform these activities**

I understand AAASWA is required to report statistical and demographic information about me to funding agencies for the purposes of program monitoring and quality assurance. My information will not be sold or used for commercial purposes.

Client Signature _____ Date _____
(Initial or Revised Registration)

Client Signature – 2nd year _____ Date _____
(I certify that my information has not changed.)

Client Signature – 3rd year _____ Date _____
(I certify that my information has not changed.)

Client Signature – 4th year _____ Date _____
(I certify that my information has not changed.)

Read the statements below. Check the box to the right of the "Yes" column number for those that apply to you.

NUTRITION HEALTH SCREENING	YES	
I have made changes to my eating habits because of a health condition.	2	☐
I eat fewer than two meals a day.	3	☐
I eat fewer than 5 servings (1/2 cup each) of fruits or vegetables every day	1	☐
I have fewer than 2 servings of dairy products (milk, cheese, yogurt) every day	1	☐
I don't always have enough money to buy the food I need.	4	☐
I have tooth or mouth problems that make it hard for me to eat.	2	☐
I eat alone most of the time.	1	☐
Without wanting to, I have lost or gained ten pounds in the last six month.	2	☐
I am not always physically able to shop, cook and/or feed myself.	2	☐
I have three or more drinks of beer, liquor or wine almost every day.	2	☐
I take three or more different prescribed or over-the-counter drugs a day.	1	☐
TOTAL		

Nutritional Health Score

0 – 2	**Good**
3 – 5	**Moderate Nutritional Risk**
6 or More	**High Nutritional Risk**

HOME DELIVERED MEAL PROGRAM

(Mr. Ms. Mrs.)

NAME:_____ DATE:_____

DOB:_____ GENDER: (M) (F) AGE:_____ TELEPHONE: (___) - ____

ADDRESS:_____, _____, AR _____
(Street or P.O. Box) (City) (Zip)

NEED STATEMENT: The applicant is unable to attend the senior center and is requesting a home delivered meal for the following reason(s) (list incapacitating reason(s) or illness(s):

1._____ 2._____

3._____ 4._____

5._____ 6._____

Comments or other services needed: _____

_____

Referred by: a. Minister b. Doctor c. Family Member d. AAA or Provider Personnel

Recipient signature:_____ Date:_____

Assessed by:_____ Date:_____ Reassessment Date:_____

HOME BOUND EVALUATION

1. MEALS: Morning_____ Noon_____ Evening_____ Week-ends_____ Holidays_____
2. WHO DOES YOUR SHOPPING? _____ HOW OFTEN?_____
3. IS THERE ANY DIFFICULTY GETTING YOUR SHOPPING DONE?_____
4. WHAT ARE YOUR REASONS FOR NOT COMING TO THE CENTER?_____

_____

5. WHAT OTHER SERVICES ARE YOU CURRENTLY RECEIVING? _____

_____

COMMENTS:

_____

_____

_____

INTERVIEWER'S NAME:_____ DATE:_____

ARKANSAS DEPARTMENT OF HUMAN SERVICES
APPLICATION FOR SOCIAL SERVICES BLOCK GRANT SERVICES

Applicant's Name _____ SSN _____ DOB_____

Client's Name (if different from applicant)_____ SSN_____ DOB_____

Mailing Address _____

Telephone (Home)_____ (Work) _____

FAMILY MEMBERS		FAMILY INCOME	
Name	Relationship	Income Source	Monthly Amount

Total Number in Family _____ Total Monthly Family Income _____

Service(s) Requested _____

Review the following and ask for clarification if necessary.

1. You will be notified if you are eligible to receive services within thirty (30) days.
2. You can choose which services you receive (if you qualify) and you may refuse any service.
3. You can request a hearing from DHS if you are unhappy with the handling of your case. Hearing requests must be filed (in writing) with the provider or the Office of Finance and Administration, Chief Fiscal Officer, P.O. Box 1437, Slot W401, Little Rock, Arkansas 72203-1437.
4. You must report the following changes within 5 days:
   - a change of address;
   - a member of your household enters a nursing home or institution;
   - you or a member of your household has changes in income.;
   - any change in the number in the household; (ex., marriage, divorce, birth, death, or moving of a family member)
   - any other changes of information on the application form.
5. The provider will keep a case record about you and your family. It may include the reason(s) for services, the services provided, and general information such as name, address, and employment status. The provider is required to make information in your case record available to DHS and the federal government, if requested. Your signature on this form is your consent to the release of this information. You may refuse to supply any or all of this information to the provider, but your refusal may result in the denial or termination of SSBG services.
6. Your eligibility for services may be reviewed by a representative of DHS or the provider.
7. Both the provider and DHS are required to keep information about you, your family, and your case record confidential, except as stated in item five (5) above, or unless you give your written consent.

Certification:

Federal law requires that a written declaration of U.S. citizenship or lawful alien status be made for each individual applying for Social Services Block Grant funding. I declare that all service recipients named on my application are U.S. citizens, U.S. nationals, or lawfully admitted aliens.

The information I have furnished is correct and I understand my rights and responsibilities as outlined and I am in need of the services requested.

_____

Applicant's Signature (or parent/guardian's signature) Date

FOR PROVIDER OR DEPARTMENT USE ONLY

1. **Categorical Eligibility:** (check one)

☐ TEA/WORK PAYS ☐ SSI (if checked, indicate SSI# here_____) ☐ Income Eligible ☐ Without Regard to Income ☐ Status Eligible

2. **Service Need Established:** ☐ Yes ☐ No

3. **Legal Arkansas Resident** ☐ Yes ☐ No

ELIGIBLE FOR SERVICES REQUESTED? ☐ Yes ☐ No

STATUTORY GOAL (circle one) 1 2 3 4 5

Certification: I have given the applicant a completed copy of this form.

_____ _____

Signature of Provider Date

DHS-0100 (R.01/12/10) Alternate formats (large print, audio, etc.) of this form will be provided upon request.

Area Agency on Aging of Southwest Arkansas, Inc.

Privacy Notice:

Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	· You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. · We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	· You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. · We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	· You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. · We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	· You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care. · If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. • We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	· You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. · We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within
Get a copy of this privacy notice	· You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	We can share health information about you in response to a court or subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective 03/01/2014

Area Agency on Aging of Southwest Arkansas, Inc. P O Box 1863, Magnolia, AR 71753 870-234-7410

Choose someone to act for you	· If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. · We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	· You can complain if you feel we have violated your rights by contacting us using the information on page 1. · You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.com. · We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

☐ **I certify that I have read the Area Agency on Aging of Southwest Arkansas, Inc. Privacy Notice under Federal Law for Protected Health Information.**

Client Signiture/Initials >