CLIENT REGISTRATION FORM • DAAS 101 (Short Form)
NC Department of Health and Human Services, Division of Aging and Adult Services

Section I: Required for all clients

This Short Form of the DAAS-101Client Registration Form may only be used to register congregate meal and transport

- HCCBG congregate nutrition **(180)**, NSIP-only congregate meals **(181)**, congregate liquid nutritional supplement **(18**
- HCCBG general **(250)** or medical **(033)** transportation – complete Sections I and VII only.

Service Code(s):

1. **Client Status**: *Check the appropriate box(es). Enter the date of client status change.*

☐ New Registration/Activate (Date:)

☐ Waiting for Service (complete Section I only): (Date:)

Enter waiting for service codes:

☐ Change of information (Date:)

(Complete Section 1 – Items 2, 4, 5, plus the information that needs to be changed)

☐ Inactive (Date client made inactive and not expected to return:)

Enter reason for making client inactive. Make a client inactive only if the person is thought to be permanently leaving the service system. Indic

If the client is a caregiver receiving FCSP or Project C.A.R.E. services and the reason for making the client inactive relates more to the care re

Reason for making client inactive applies to: *Client/Caregiver* ☐ OR *Care Recipient* ☐

☐ Moved to adult care home/assisted living
☐ Alternative living arrangement
☐ Death
☐ Hospitalization (not expected to return)
☐ Nursing home placement

2. Legal Name, Last: First: MI: Suffix:

Not for data entry -- name person likes to be called, if different from legal name on SS card:

3. Street Address:

Mailing Address: ☐ Same as street address

City: **State:** **Zip:** **County:**

7. Sex *(check one)*	**8. At or Below Poverty Level?** *(check one)*	**9. Marital Status** *(check one)*
☐ Female	☐ Yes	☐ Single (never married)
☐ Male	☐ No	☐ Married
		☐ Single (divorced/widowed)
		☐ Refused to answer

11. Race

	Check the one race with which client most identifies:	*Check all that apply:*
Black or African-American	☐	☐

Asian	☐	☐
American Indian or Alaska Native	☐	☐
White	☐	☐
Native Hawaiian or other Pacific Islander	☐	☐
Unknown/refused	☐	

Name of Emergency Contact: ☐*Refused to provide emergency contact information*

Day phone no.: Evening phone no.:

14. <u>Client's Overall Functional Status</u>: ☐ Well ☐ At risk ☐ High risk

Enter the client's self-reported overall functional status here. If the client receives other services in addition to congregate nutrition and transp

Section II: Required only for congregate meals, congregate liquid nutritional supplement, or NSIP-only congregate meals.

15. Nutrition Health Score		Refused to Answer
a. Do you have an illness or condition that made you change the kind and/or amount of food you eat?	☐ Yes ☐ No	☐
b. How many meals do you eat per day?	#	☐
c. How many servings of fruit per day?	#	☐
d. How many servings of vegetables per day?	#	☐
e. How many servings of milk/dairy products per day?	#	☐
f. How many drinks of beer, liquor, or wine do you have every day or almost every day?	#	☐
g. Do you have tooth/mouth problems that make it hard for you to eat?	☐ Yes ☐ No	☐
h. Do you always have enough money or food stamps to buy the food you need?	☐ Yes ☐ No	☐
i. How many meals do you eat alone daily?	#	☐
j. How many prescribed drugs do you take per day?	#	☐
k. How many over-the-counter drugs do you take per day?	#	☐
l. Have you lost 10 or more pounds in the past 6 months without trying?	☐ Yes ☐ No	☐
m. Have you gained 10 or pounds in the past 6 months without trying?	☐ Yes ☐ No	☐
n. Are you physically able to shop for yourself?	☐ Yes ☐ No	☐
o. Are you physically able to cook for yourself?	☐ Yes ☐ No	☐
p. Are you physically able to feed yourself?	☐ Yes ☐ No	☐

Section VII: REQUIRED FOR ALL CLIENTS

I, the client, understand that the information contained on this form will be kept confidential unless disclosure is required by court order or for authorized federal, state or local program reporting and monitoring. I understand that any entitlement I may have to Social Security benefits or other federal or state sponsored benefits shall not be affected by the provision of the aforementioned information. My signature authorizes the providing agency to begin the service(s) requested.

DATE: **CLIENT SIGNATURE:**_____

DATE: **AGENCY EMPLOYEE SIGNATURE:**_____

Provider Use Only – inital below if no changes:

Registration Update ____/____/____ Staff Initials _____
Registration Update ____/____/____ Staff Initials _____
Registration Update ____/____/____ Staff Initials _____

Provider Use Only – inital below if no changes:

Registration Update ____/____/____ Staff Initials _____
Registration Update ____/____/____ Staff Initials _____
Registration Update ____/____/____ Staff Initials _____