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

The DAAS-101 Client Registration Short Form may only be used to register Congregate Nutrition and Transportation clients. Complete all applicable information relative to Congregate Nutrition and/or Transportation.

- COMPLETE SECTIONS I, II and VII ONLY for codes **(180)**-Congregate Nutrition, **(181)**-Congregate Nutrition-NSIP, and **(182)**-Congregate Nutrition Supplemental Meals.
- COMPLETE SECTIONS I and VII ONLY for codes **(250)**-Transportation, **(033)**-Transportation (Medical) and **(252)**-Transportation-Pilot Bus Pass Program.

Service Codes: 180	**Region Code:** O	**Provider Code:** 041

CLIENT STATUS: ***Check the Appropriate box(es) and enter the date.***

☐ **New Registration**	DATE:
☐ **Activation**	DATE:
☐ **Waiting for Service** *[Complete Section I ONLY]*	DATE: *(enter 3 service codes):*
☐ **Change of Information**	DATE: *(complete Section I when a change is needed for any client information)*

☐ **Inactive** – DATE: _____ *(check box below) (make inactive only if permanently leaving ARMS)*

If client is a caregiver receiving FCSP/Project C.A.R.E. services and the client inactive reason relates more to CR status, check Care Recipient box.

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

☐ Moved to adult care home/assisted living
☐ Alternative living arrangement
☐ Death
☐ Hospitalization (not expected to return)
☐ Nursing home placement
☐ Moved out of service area
☐ Improved function/Need eliminated
☐ Service not needed/wanted
☐ Illness (not expected to return)
☐ Other (specify):

SECTION I: CLIENT/CAREGIVER INFORMATION (Required for *ALL* Clients/For FCSP the Caregiver is the Client)

Legal Name: Last	First	M.I.
Suffix	**Last 4 Digits SSN:**	**Phone:** ☐ No phone
Address **County:**	**Email**	**DOB:** ☐ *Check if special eligibility*
City:	**State:**	**Zip:**

Sex *(check one)*
☐ Female
☐ Male

At/Below Poverty Level? *(check one)*
☐ Yes
☐ No

Marital Status *(check one)*
☐ Single ☐ Divorced
☐ Married ☐ Widowed
☐ Separated ☐ Partnered
☐ Client Refused ☐ Unknown

Household Status *(check one)*
☐ Lives alone ☐ Lives with Other
☐ Unknown ☐ Client Refused
☐ Lives in Long Term Care (LTC) facility [Legal Assistance is the only service to collect "Lives in Long Term Care (LTC) facility"]

Race (Check all that apply)
☐ Black or African American
☐ White
☐ Asian or Asian American
☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaska Native
☐ Refused/Unknown/Not Reported

Ethnicity (Are you of Hispanic or Latino Origin?)
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unreported/Missing/Client Refused

Primary Language Spoken: ☐English ☐Spanish
☐Other _____ *[see languages in Client Registration Form (CRF) manual]*

Name of Emergency Contact: _____ ☐ Refused to provide
Cell#: _____ Home#: _____ Day#: _____

Caregiver's Overall Functional Status: ☐ Well ☐ At risk ☐ High risk

(When the CAREGIVER IS REGISTERED AS THE CLIENT, use this field for the CAREGIVER'S SELF-REPORTED functional status and complete Section IV for Care Recipient.) If SECTION IV is required, SKIP THIS QUESTION. ARMS will automatically calculate the Caregiver's Overall Functional Status when SECTION IV is entered.

SECTION II: Required ONLY for clients of HCCBG Congregate Nutrition, Congregate Nutrition Supplemental Meals, NSIP (only Congregate Nutrition meals).

Nutrition Health Score

Assessment Date:	Response	Refuse
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 do you eat per day?	#	☐
d. How many servings of vegetables do you eat per day?	#	☐
e. How many servings of milk/dairy products do you consume 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 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/CAREGIVER SIGNATURE:** _____

DATE: _____ **AGENCY EMPLOYEE SIGNATURE:** _____

Provider Use Only – initial below after re-assessment:

Registration Update: _____ Staff Initials: _____
Registration Update: _____ Staff Initials: _____
Registration Update: _____ Staff Initials: _____

NOTES/COMMENTS: