

## Form 5 - Consumer Registration Form

Information provided on this form is important for the State of Connecticut to receive federal funds and to continue to provide services to older adults. Please take the time to answer all the questions on this form.

Your personal privacy is very important to us. The law prohibits sharing any information you give without a court order or without permission from you or your personal representative EXCEPT for the following: state, federal and local monitoring relative to program reporting requirements; program management, public safety and research. Be assured that your information will only be used as necessary under those provisions.

Consumer Signature: \_\_\_\_\_

Registration:  New  Update  NFCSP/Statewide Respite  Caregiver  Includes Service Data  
(Caregivers complete sections I, III, IVc,d, IVf [grandparents]) (Complete section VIII)

### I. Add Consumer

a.) Consumer Name:			
First:	MI:	Last:	
b.) Today's Date: / /	c.) Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-Binary <input type="checkbox"/> Other	d.) Birth Date: / /	e.) SSN (Social Security): 000 - 00 - _____
f.) Home Telephone: ( )		g.) Cell Telephone: ( )	
h.) Email Address:			
i.) Provider Name:			
j.) Home Street Address 1:			
k.) Home Street Address 2:			l.) County:
m.) Town:		n.) State (if not CT)	o.) Zip Code:
p.) Care Enrollment <small>(office use only)</small>	Level of Care:	Service/Care Program:	

### II. Details - Basic Information

a.) Marital Status:	<input type="checkbox"/> Currently Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Single (Never Married)	<input type="checkbox"/> Widowed
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### II. Details - NAPIS

a.) NSIP Eligible:	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.) NSIP Eligibility Type:	<input type="checkbox"/> Age 60 and Older <input type="checkbox"/> Disabled in Elderly Housing <input type="checkbox"/> Disabled Living with an Elderly Person <input type="checkbox"/> Spouse of Person Age 60+ <input type="checkbox"/> Volunteer

### II. Details - Other Characteristics

a.) Cognitive Impairment:	Has Alzheimer's disease or a related dementia: <input type="checkbox"/> No - None <input type="checkbox"/> Yes - Early Onset Dementia <input type="checkbox"/> Yes - Mild <input type="checkbox"/> Yes - Moderate <input type="checkbox"/> Yes - Severe
b.) Disabled:	ONLY FOR NFCSP CARE RECIPIENTS Care recipient is between the ages of 18 and 59 and has a disability. <input type="checkbox"/> Yes <input type="checkbox"/> No

### III. Caregiver Programs ONLY (NFCSP and CSRCP)

#### Details - Care Recipient/Caregiver - Add New (only for NFCSP and CT Statewide Respite Care)

a.) Care Status:	<input type="checkbox"/> Is Caregiver	Name of Care Recipient:
	<input type="checkbox"/> Is Care Recipient	Name of Caregiver:
b.) Relationship:	Relationship ALWAYS Means Caregiver's Relationship to the Care Recipient <input type="checkbox"/> Brother <input type="checkbox"/> Daughter <input type="checkbox"/> Daughter-in-Law <input type="checkbox"/> Domestic Partner <input type="checkbox"/> <u>Father*</u> <input type="checkbox"/> Granddaughter <input type="checkbox"/> <u>Grandfather*</u> <input type="checkbox"/> <u>Grandmother*</u> <input type="checkbox"/> Grandson <input type="checkbox"/> Husband <input type="checkbox"/> <u>Mother*</u> <input type="checkbox"/> Non-Relative <input type="checkbox"/> Other Relative <input type="checkbox"/> Sister <input type="checkbox"/> Son <input type="checkbox"/> Son-in-Law <input type="checkbox"/> Wife	
	<small>* Must only be checked if the caregiver is age 55 or older and is the primary caregiver for a child under age 18 or an adult child between age 18 - 59 with a disability. Non-relative and Other relative may be checked for these caregivers as well as caregivers of older adults.</small>	

### IV. Assessment Form - Demographics

a.) Primary Language:	Primary language spoken at home: <input type="radio"/> American Sign Language <input type="radio"/> Arabic <input type="radio"/> Cambodian (Khmer) <input type="radio"/> Chinese <input type="radio"/> English <input type="radio"/> French <input type="radio"/> German <input type="radio"/> Greek <input type="radio"/> Gujarati <input type="radio"/> Haitian Creole <input type="radio"/> Italian <input type="radio"/> Korean <input type="radio"/> Polish <input type="radio"/> Portuguese <input type="radio"/> Russian <input type="radio"/> Spanish <input type="radio"/> Tactical Sign Language <input type="radio"/> Turkish <input type="radio"/> Urdu <input type="radio"/> Vietnamese <input type="radio"/> Other _____ <i>Please Specify</i>
b.) Speaks English:	<input type="radio"/> Very Well <input type="radio"/> Well <input type="radio"/> Not Well <input type="radio"/> Not At All
c.) Ethnicity:	<input type="radio"/> Hispanic/Latino <input type="radio"/> Not Hispanic/Latino
d.) Race: (check all that apply)	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Asian American <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White
e.) Housing:	<input type="radio"/> Private Home <input type="radio"/> Private Apartment <input type="radio"/> Senior Housing <input type="radio"/> Congregate Housing <input type="radio"/> Public Housing <input type="radio"/> Residential Care Home <input type="radio"/> Nursing Home <input type="radio"/> Assisted Living <input type="radio"/> Other _____ <i>Please Specify</i>
f.) Income: (2/2021)	<p><b>I live alone or with someone other than a spouse and <u>MY</u> monthly income is about:</b></p> <input type="radio"/> At or Below \$1,073 (100%) <input type="radio"/> \$1,074 - \$1,342 (125%) <input type="radio"/> \$1,343 - \$1,610 (150%) <input type="radio"/> \$1,611 - \$1,878 (175%) <input type="radio"/> \$1,879 - \$2,147 (200%) <input type="radio"/> \$2,148 or over (over 200%)
	<p><b>I live with my spouse and <u>OUR</u> monthly income is about:</b></p> <input type="radio"/> At or Below \$1,452 (100%) <input type="radio"/> \$1,453 - \$1,815 (125%) <input type="radio"/> \$1,816 - \$2,178 (150%) <input type="radio"/> \$2,179 - \$2,540 (175%) <input type="radio"/> \$2,541 - \$2,903 (200%) <input type="radio"/> \$2,904 or over (over 200%)
g.) In Poverty:	<input type="radio"/> Yes <input type="radio"/> No
h.) Living Arrangements:	<input type="radio"/> Alone <input type="radio"/> With Spouse <input type="radio"/> With Unmarried Partner <input type="radio"/> With Spouse/Partner and Child/ren <input type="radio"/> With Child/ren Only, No Spouse/Partner <input type="radio"/> With Grandchild/ren <input type="radio"/> With Other Relatives <input type="radio"/> With Others

### V. Assessment Form - Functional Status

a.) ADL/IADL:

**I need help with the following ADL activities:**

- |                       |                       |                       |                          |                       |                       |
|-----------------------|-----------------------|-----------------------|--------------------------|-----------------------|-----------------------|
| Yes                   | No                    | Yes                   | No                       | Yes                   | No                    |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>    | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>    | <input type="radio"/> | <input type="radio"/> |
|                       | Eating                |                       | Dressing                 |                       | Bathing/Washing       |
|                       | Using the Toilet      |                       | Getting Out of Bed/Chair |                       | Continence            |

**I need help with the following IADL activities:**

- |                       |                          |                       |                       |                       |                       |
|-----------------------|--------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Yes                   | No                       | Yes                   | No                    | Yes                   | No                    |
| <input type="radio"/> | <input type="radio"/>    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/>    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/>    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|                       | Planning/Preparing Meals |                       | Shopping              |                       | Managing Money        |
|                       | Using the Telephone      |                       | Housekeeping          |                       | Doing Laundry         |
|                       | Taking Medicine          |                       | Using Transportation  |                       |                       |

### VI. Assessment Form - Nutrition

a.) Nutritional Risk:

- |                       |                       |                       |                                                                                          |
|-----------------------|-----------------------|-----------------------|------------------------------------------------------------------------------------------|
| Yes                   | No                    | Unknown               |                                                                                          |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | I have an illness or condition that made me change the kind or amount of food I eat. (2) |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | I eat fewer than 2 meals per day. (3)                                                    |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | I eat few fruits and vegetables or milk products. (2)                                    |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | I have problems chewing/swallowing that make it hard for me to eat. (2)                  |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | I do not always have enough money or food stamps to buy the food I need. (4)             |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | I take 3 or more different prescription or over-the-counter drugs each day. (1)          |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | I eat alone most of the time. (1)                                                        |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | I have 3 or more drinks of beer, liquor or wine almost every day. (2)                    |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Without wanting to, I have lost or gained 10 pounds in the last 6 months. (2)            |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | I am not always physically able to shop, cook or feed myself. (2)                        |

### VII. Assessment Form - Service Indicators

In the last 12 months:

1.) If I had groceries available, I was able to use them to prepare a meal:

- Yes (skip to question 2)  No (Please answer 1b below)

1b.) You had someone who could cook for you or helped you cook

- Yes  No

If you answered NO, did you experience this in the last:

- 1-3 months  4-6 months  7 months or more

2.) In the last 12 months have you experienced the following situations because you did not have enough money

a.) Did you or other adults in your household ever skip meals?

- Yes  No

b.) Did you eat less food than you felt you needed?

- Yes  No

c.) Were you ever hungry?

- Yes  No

If you answered YES to ANY of these questions, did you experience this in the last:

- 1-3 months  4-6 months  7 months or more

3.) Have you recently lost weight without trying?

- Yes  No

If YES, how much weight have you lost?

- 1-13 lbs.  14-23 lbs.  24-33 lbs.  34 or more lbs.  Unsure

4.) Have you been eating poorly because of a decreased appetite?

Yes       No

5.) Have you been hospitalized in the last 12 months?

Yes       No

If YES, when were you last in the hospital?

In the last 3 months       In the last 4-6 month       In the last 7-12 months

### VII. Service Delivery

a.) Site Name (if applicable): \_\_\_\_\_

b.) Service Category (if applicable)	c.) Service (sub-service)	d.) Fund Identifier	e.) Number of Units
_____ /	_____ /	_____ /	_____
_____ /	_____ /	_____ /	_____
_____ /	_____ /	_____ /	_____
_____ /	_____ /	_____ /	_____