

Program Registration – Older Adult

Referring Agency:

Referring Staff's Name:

Phone:

Email:

Referring Staff's Title:

Contact Date

/ /

Release of Information
signed on:

ID Number / Initial

Basic Demographics – Older Adult

Last Name:

First Name:

Middle Initial:

Lives in Rural Area

Yes No

Gender: Female Male

Unspecified

Date of Birth:

Address:

Address #2:

City:

State:

Zip Code:

County:

Work Phone:

Mobile Phone:

Home Phone:

Emergency Contact:

Name:

Relationship:

Mobile Phone:

Home Phone:

Work Phone:

Email Address:

Race (Check one): African African American
 American Indian Asian/Pacific Islander White
 Other (specify _____) Missing/not specified
 Hispanic/Latino

Preferred language: English Hmong
 Somali Oromo Spanish
 Other, (specify: _____)
 Missing/not specified

What is the approximate monthly income? \$ _____

Living Alone: yes, no

Dementia Diagnosis yes, no

Disability yes, no

Use of Information

I understand that the information I am providing on this form is for registration purposes. The information will be used by the U.S. Health and Human Services Administration for Community Living (ACL), the Minnesota Board on Aging (MBA) and the local Area Agency on Aging to create statistical reports. ACL, MBA or its assignees may use this information to conduct a study and/or survey of this service. In addition, information provided here, may be used by other service providers to help identify other services from which I may benefit. This information will not be released to anyone other than the above mentioned parties in a way that will identify me as an individual unless I sign a separate consent for that purpose.

Signature: _____ Today's Date: _____