CONFIDENTIAL

The Life Enrichment Center at Oyster Bay
Member Registration Form

Reverse Must Be Completed to Maintain Gov't Funding

Registration Date________________________________Member ID#_______________________________________

Last Name____First Name_________________________________

Street____Town____________________Zip_________

Phone____Email____

Marital Status: Married_________Widowed_________Divorced_________Single_________

Is your spouse a Center Member: Yes_____No_____ Spouse's Name____

Please list your nearest relative and a personal contact we should call if necessary:

1. Name____Relationship______________________ ______

Street____Town____________________Zip_________________

Phone______________________Email_______________________Alternate Phone (Cell, etc.)___________________

2. Name____Relationship____________________________

Street____Town____________________Zip_________________

Phone______________________Email_______________________Alternate Phone (Cell, etc.)___________________

Medical Information:

Physician's Name____Phone_________________________________

Street____Town____________________Zip__________________

Current Medications____

____

Specific Information:

Special Interests____

Special Talents____

Registration Completed by____

The Life Enrichment Center, Inc. (the Center) assumes **no responsibility** for any injury incurred by Members while in the Center. Members hereby release and hold the Center harmless from any liabilities of whatever nature related to such injuries if incurred and shall indemnify the Center from any and all claims.

Signature:____

Code of Conduct Reviewed ______________________ Member Packet Reviewed ____________________
Please Initial Please Initial

National Aging Program Information System (NAPIS) Registration Form
New York State Office for the Aging

Funds for our lunch and transportation programs are provided by federal, state and local government agencies. Therefore, we are asked to collect information so these agencies can determine that we are adequately meeting the needs of our community. We follow strict confidentiality guidelines to protect your personal information. A code is assigned to your information and your name is removed before being entered on the state database. **Please note it is mandatory that this form be updated annually.**

Provider ID: 2O

SERVICES INFORMATION: Intake Date:____________________________

DOB:___________________________ Income Status (Annual Income less than $11,490) ☐Yes ☐ No

Lives alone: ☐Yes ☐No If No, how many people live in household _________________________

Frail/Disabled: ☐Yes ☐ No Veteran: ☐Yes ☐ No

Race ☐White ☐ Black ☐ Hispanic ☐American Indian/Alaskan Native ☐Asian/Pacific Islander

Please answer the following questions:

I have an illness/condition that made me change the kind/amount of food I eat.	☐ Yes (2)	☐No (0)
I eat fewer than 2 meals a day.	☐ Yes (3)	☐No (0)
I eat few fruits or vegetables, or milk products.	☐ Yes (2)	☐No (0)
I have 3 or more drinks of beer, liquor or wine almost every day	☐ Yes (2)	☐No (0)
I have tooth or mouth problems that make if hard for me to eat.	☐ Yes (2)	☐No (0)
I don't have enough money to buy the food I need.	☐ Yes (4)	☐No (0)
I eat alone most of the time.	☐ Yes (1)	☐No (0)
I take 3 or more different prescribed or over-the-counter drugs a day.	☐ Yes (1)	☐No (0)
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	☐ Yes (2)	☐No (0)
I am not always physically able to shop, cook, and/or feed myself.20	☐ Yes (2)	☐No (0)
Total		

A score of 0-2 means - Good, recheck at six months.
A score of 3-5 means - You are at moderate risk and should improve eating habits and make life-style changes.
A score of 6 or more means - You are at high nutritional risk. Take the checklist to a doctor, dietitian or qualified health or social service professional and ask for definite ways to improve your nutritional health.

If you have any concerns or would like to meet with a Nassau County Nutritionist, speak with the Program Department (516) 922-1770 about setting up an appointment.

Revised 1/6/09 – According to SAMS website – scoring system changed.

Informed Consent to Capture and Record Personal Information (Aging Services)

I consent to the ____ saving personal information
(name of entity capturing)
provided by me or my authorized representative in the Statewide Client Data System maintained by the New York State Office for the Aging. This personal information may include, but is not limited to, medical records, employment records, government records, and any other information collected from me by ____
[name of entity].

I understand that this information is being collected to help in providing services and to identify other services which I may benefit from. I understand that the authority to provide these services and to collect my information for these purposes is found in the Older Americans Act and the New York State Elder Law.

I understand that, consistent with New York State's Personal Privacy Protection Law, my personal information will be treated as confidential and will not be disclosed without my further informed consent for disclosure.

I acknowledge that informed consent has been explained to me and that I understand the information to be recorded, the need for the information, and that there are laws and regulations protecting the confidentiality of authorized information.

I understand that signing this authorization is voluntary and that refusal to do so will have no effect on my eligibility for services, but may make it more difficult to provide these services and to make referrals on my behalf. I have the right to revoke this authorization at any time, except to the extent that action has already been taken based upon this authorization, by writing to ____
[name of entity].

________________________________ ________________________
Signature Date

____
Print

(Please also complete other side)

Worker Attestation of Informed Consent

For each activity for which the informed consent of the client has been obtained, please check below and fill in all fields.

Check all that apply:

Consent to Capture has been Obtained:

☐ "I attest that, on ________________ (date), I read the required Consent Script entitled ______________________ (title of script) to ______________________ (name of client), who provided informed consent for his/her personal information and health information collected to be recorded and maintained in the ______________________ (name of datebase) data system(s). I believe the above individual to have understood the scope and implications of what he or she was consenting to."

Consent to Share has been Obtained:

☐ "I attest that, on ________________ (date), I read the required Consent Script entitled ______________________ (title of script) to ______________________ (name of client), who provided informed consent for his/her personal information and health information collected and maintained in the ______________________ (name of datebase) data system(s) to be shared through such system in the manner described. I believe the above individual to have understood the scope and implications of what he or she was consenting to."

Consent to Refer/Disclose Information has been Obtained:

☐ "I attest that on ________________ (date), ______________________ (name of client), has consented to the disclosure of his or her information for the following entities for referral purposes, and I believe this individual to have understood the scope and implications of what he or she was consenting to:"

____

____

____

____

____
Signature

____
Date

____
Print Name

(Please also complete other side)

Consent to Capture (Aging Services) Script

Client Name (first name, last name):
Address:
Phone number:
Date:

Read or if in person, have the client read the following:

There is currently no record in our database that matches the information you have provided. May I enter your name and contact information to continue?

I would like to ask you some questions so I can understand the situation and then we will talk about what options may be helpful. You do not need to answer any questions you do not want to.

As we talk, I will be entering the information into the Statewide Client Data System maintained by the New York State Office for the Aging. All personal health information and personal identifying information must be kept confidential by law. Only those agencies and individuals assisting you in some way will be granted secure access to see this information, with your permission.

At no time will your personal information be disclosed to third parties without proper authorization.

We will talk more about this when we discuss possible programs or services that may be able to help you. Again, you do not need to answer any questions you do not want to. If you do not want some information entered into the database, you can tell me not to enter it.

Do I have your permission to ask questions and enter your responses into the database as I have explained to you?

- ☐ ***Yes (if in person, written consent is required)***
- ☐ ***No (If no): I can provide you with information for you to follow up on your own, but I will not be able to capture your personal or health information or share or make any referrals on your behalf.***

User (Worker) Signature:
User (Worker) Title :
Date:
This form must be uploaded into the new Statewide Client Data System for this individual.