City of Bridgeport
Department of Health & Social Services
Department of Aging
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CITY OF BRIDGEPORT SENIOR CENTER REGISTRATION FORM

Enrollment Date: _____

Senior Sites: Please check the site at which you want to participate:

◯ Black Rock ◯ Eisenhower ◯ East Side ◯ North End Bethany

MEMBERSHIP IS OPEN TO SENIORS WHO ARE 55 YEARS OF AGE OR OLDER!

PLEASE PRINT:

First Name:_____Last Name:_____

Date of Birth:_____◯ Female ◯ Male Telephone: _____

Address:_____Apt #: _____

City/State/Zip:_____

First Time Member: ◯ Yes ◯ No

If no, at which location and in what year did your membership expire?

_____

Please indicate what Activities you are interested in:

_____

_____

EMERGENCY CONTACT:
Please provide 2 Emergency contacts if possible

Name:_____Relationship:_____

Number:_____

Name:_____Relationship:_____

Number:_____

Transportation: I will need transportation to and from the Center

◯ Yes ◯ No

(Please fill out Transportation form)

Allergies: ◯ Yes ◯ No

If yes, and if you would like to share this information, please describe below:

_____

_____

FEDERAL GRANT INFORMATION

Every year we apply for Federal Grant money to offset the expense of different activities provided at the Centers. The below requested information is used for the Federal Grant applications. Please note, providing this information is entirely **VOLUNTARY AND OPTIONAL**:

Ethnicity: ◯ Hispanic/Latino ◯ Not Hispanic/Latino

Race:

◯ White ◯ Hispanic ◯ Latino or Spanish Origin ◯ Black or African American ◯ Asian ◯ American Indian or Alaska Native ◯ Middle Eastern or Northern African ◯ Native Hawaiian or Other Pacific Islander ◯ Other

Other:_____

Name of head of household:_____

Head of Household Age:_____ ◯ Under 62 Years ◯ Over 62 years

Number of persons in Household, including head of household: _____

Age of Youngest person in Household:_____years of age

Gender of Head of Household: ◯ Female ◯ Male

IS HEAD OF HOUSEHOLD DISABELD: ◯ Yes ◯ No

PHOTO RELEASE & DISCLAIMER

From time to time, the Senior Center captures photos and video for the City's Department on Aging for printed or electronic publications including by not limited tonews releases, publications, bulletin boards and the website related to Senior Centerfunctions and activities. Any photos, prints and digital reproductions shall be the property of the Center. If you do not wish to consent to the use of your likeness as described above, you may opt out by signing below.

I do **NOT** consent to use of my photograph and/or name in accordance with the above:

Signature:_____Date: _____

WAIVER AND RELEASE LIABILITY

In consideration of my use of the facilities, the exercise equipment and any other items utilized in connection with Senior Center programs, I hereby waive and release, on behalf of myself, my heirs, executors, administrators, successors and assigns, any and allclaims against the Senior Center, the City of Bridgeport and its Department on Aging, the City's elected officials, employees, officers, directors, and associates, for personal injuries (including death) or other damages sustained by me, or to any guest of mine, in,on, or about the premises, or as a result of the use of the equipment or facilities, regardless of whether such injuries result, in whole or in part, from the negligence of theSenior Center, the City of Bridgeport and/or its Department on Aging.

By executing this agreement, I hereby fully and forever release and discharge the SeniorCenter, the City of Bridgeport and its Department on Aging, the City of Bridgeport, its elected officials, employees, officers, directors, and associates, from any and all claims, demands, damages, rights of action, or causes of action, present or future, whether the same be known or unknown, resulting from or arising out the use of said equipment andfacilities and agree to defend, indemnify and hold harmless the

Senior Center, the City of Bridgeport and its Department on Aging, the City of Bridgeport, its elected officials, employees, officers, directors, and associates for any injuries, damages or losses described herein.

I have read the foregoing Waiver and Release of Liability, understand it, and agree to its terms.

ZERO TOLERANCE POLICY

The City of Bridgeport Department on Aging Senior Centers maintain a "zero tolerance" policy with respect to harassment of any kind or nature, the use of obscene language, the making of real or perceived threats, the making of disparaging comments, and the causing or threat of causing physical injury to other members, staff, or visitors. Membersunderstand, acknowledge, and agree that they will at all times act in a manner consistent with this policy and that anyone determined to have engaged in any of the foregoing conduct may be immediately suspended and/or their membership terminated, in the sole and complete discretion of the Senior Center, and in accordance with the Senior Center's Rules, Regulations and Standards of Conduct regarding same. All members agree to conduct themselves in accordance with the Rules, Regulations andStandards of Conduct of the Department on Aging's Senior Center.

I have read the foregoing application in its entirety and agree to all of its terms andconditions.

Signature_____Date_____

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: ❑Female ❑Male ❑Non-Binary ❑Other	d.) Birth Date: / /	e.) SSN (Social Secuirty): 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: *(office use only)*	Level of Care:	Service/Care Program:

II. Details - Basic Information

a.) Marital Status: ❑Currently Married ❑Divorced ❑ Separated ❑Single (Never Married) ❑Widowed

II. Details - NAPIS

a.) NSIP Eligible: ❑Yes ❑No

b.) NSIP Eligiblilty Type: ❑Age 60 and Older ❑Disabled in Elderly Housing ❑Disabled Living with an Elderly Person ❑Spouse of Person Age 60+ ❑Volunteer

II. Details - Other Characteristics

a.) Cognitive Impairment: Has Alzheimer's disease or a related dementia: ❑No - None ❑Yes - Early Onset Dementia ❑Yes - Mild ❑Yes - Moderate ❑Yes - Severe

b.) Disabled: ONLY FOR NFCSP CARE RECIPIENTS
Care recipient is between the ages of 18 and 59 and has a disability.
❑Yes ❑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:	❑ Is Caregiver	Name of Care Recipient:
	❑ Is Care Recipient	Name of Caregiver:

b.) Relationship:

Relationship ALWAYS Means Caregiver's Relationship to the Care Recipient

❑ Brother ❑ Daughter ❑ Daughter-in-Law ❑ Domestic Partner
❑ Father* ❑ Granddaughter ❑ Grandfather* ❑ Grandmother*
❑ Grandson ❑ Husband ❑ Mother* ❑ Non-Relative
❑ Other Relative ❑ Sister ❑ Son ❑ Son-in-Law
❑ Wife

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.

IV. Assessment Form - Demographics

a.) Primary Language:

Primary language spoken at home:

❍ American Sign Language ❍ Arabic ❍ Cambodian (Khmer) ❍ Chinese
❍ English ❍ French ❍ German ❍ Greek
❍ Gujarati ❍ Haitian Creole ❍ Italian ❍ Korean
❍ Polish ❍ Portuguese ❍ Russian ❍ Spanish
❍ Tactical Sign Lanuage ❍ Turkish ❍ Urdu ❍ Vietnamese
❍ Other _____ *Please Specify*

b.) Speaks English: ❍ Very Well ❍ Well ❍ Not Well ❍ Not At All

c.) Ethnicity: ❍ Hispanic/Latino ❍ Not Hispanic/Latino

d.) Race: (check all that apply)

❑ American Indian/Alaskan Native ❑ Asian/Asian American ❑ Black/African American
❑ Native Hawaiian/Pacific Islander ❑ White

e.) Housing:

❍ Private Home ❍ Private Apartment ❍ Senior Housing ❍ Congregate Housing
❍ Public Housing ❍ Residential Care Home ❍ Nursing Home ❍ Assisted Living
❍ Other _____
Please Specify

f.) Income: (2/2021)

I live alone or with someone other than a spouse and MY monthy income is about:

❍ At or Below $1,073 *(100%)* ❍ $1,074 - $1,342 *(125%)* ❍ $1,343 - $1,610 *(150%)*
❍ $1,611 - $1,878 *(175%)* ❍ $1,879 - $2,147 *(200%)* ❍ $2,148 or over *(over 200%)*

I live with my spouse and OUR monthly income is about:

❍ At or Below $1,452 *(100%)* ❍ $1,453 - $1,815 *(125%)* ❍ $1,816 - $2,178 *(150%)*
❍ $2,179 - $2,540 *(175%)* ❍ $2,541 - $2,903 *(200%)* ❍ $2,904 or over *(over 200%)*

g.) In Poverty: ❍ Yes ❍ No

h.) Living Arrangements:

❍ Alone ❍ With Spouse ❍ With Unmarried Partner ❍ With Spouse/Partner and Child/ren
❍ With Child/ren Only, No Spouse/Partner ❍ With Grandchild/ren ❍ With Other Relatives
❍ With Others

V. Assessment Form - Functional Status

a.) ADL/IADL:

I need help with the following ADL activities:

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

VIII. Service Delivery

a.) Site Name (if applicable): _____

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

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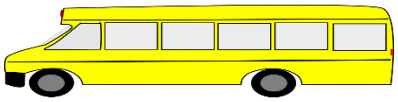
TRANSPORTATION FORM FOR THE DEPARTMENT ON AGING



PLEASE CHECK FOR WHICH CENTER:

___ EISENHOWER __ BLACK ROCK ___EAST SIDE ___NORTH BETHANY

PICK UP STARTING DAY:_____ PICK-UP TIME:_____

LAST NAME: _____FIRST NAME:_____

ADDRESS:_____TELEPHONE #:_____

DATE OF BIRTH: _____ MALE _____ FEMALE: _____

REQUESTED PICK-UP DAYS: _____

INTERESTED ACTIVITIES: _____

ADDITIONAL COMMENTS: _____

PLEASE BE AWARE THAT THE BUS WILL PICK UP AS CLOSE TO YOUR TIME AS POSSIBLE. THERE ARE CIRCUMSNTANCES DUE TO WEATHER OR TRAFFIC THAT THE BUS WILL BE LATE. PLEASE DO NOT CALL THE DRIVER UNLESS 20 MINUTES HAS PASSED BEFORE YOUR SCHEDULED PICK UP TIME. IF YOU ARE NOT COMING TO THE CENTER ON YOUR DESIGNATED DAY, PLEASE CALL THE BUS DRIVER EITHER EARLY THE MORNING OF OR THE NIGHT BEFORE. THANK YOU.

BUS NUMBER: (203) 650-1075