

Participant Registration Form
Department for the Aging

* Required

CLIENT INFORMATION:		* Date of Birth: / /	
* Last Name:		* First Name:	MI
Address:			
City:	ST:	Zip+4: -	Borough:
* Phone: () -		* Gender: <input type="radio"/> Male <input type="radio"/> Female	
Live Alone: <input type="radio"/> Yes <input type="radio"/> No		U.S. Veteran: <input type="radio"/> Yes <input type="radio"/> No	
*Household Income: <input type="checkbox"/> Under \$9300 <input type="checkbox"/> \$9300- \$12499 <input type="checkbox"/> \$12500- \$15999 <input type="checkbox"/> \$16000- \$18849			
<input type="checkbox"/> \$18850- \$21999 <input type="checkbox"/> \$22000- \$25199 <input type="checkbox"/> \$25200- \$28399 <input type="checkbox"/> \$28400 + <input type="checkbox"/> REFUSED			
Frail/Disabled: <input type="radio"/> Yes <input type="radio"/> No			
Number in Household: (Include yourself)		Ethnicity: <input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic	
Race: <input type="checkbox"/> White- Non-Hispanic <input type="checkbox"/> White-Hispanic <input type="checkbox"/> American Indian/Alaskan Native			
<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Persons Reporting other Race			
Marital Status: <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Divorced <input type="radio"/> Never Married			
Intake Date:		Is Client Active: <input type="checkbox"/>	
SERVICES INFORMATION: <input type="checkbox"/> Congregate Meals <input type="checkbox"/> Nutrition Counseling <input type="checkbox"/> Case Assistance <input type="checkbox"/> Home-Delivered Meals <input type="checkbox"/> Info & Referral <input type="checkbox"/> Chore <input type="checkbox"/> Legal Services <input type="checkbox"/> Transportation <input type="checkbox"/> Friendly Visiting <input type="checkbox"/> Nutrition Education <input type="checkbox"/> Outreach <input type="checkbox"/> Escort <input type="checkbox"/> LTC ombudsman <input type="checkbox"/> Shop Assistance <input type="checkbox"/> Heavy Cleaning <input type="checkbox"/> Telephone Reassurance <input type="checkbox"/> Educ/Rec <input type="checkbox"/> Other Service <input type="checkbox"/> Health Promotion <input type="checkbox"/> Intergeneration <input type="checkbox"/> Counseling <input type="checkbox"/> Soc. Adult Day Srvc.			

Emergency Contact Information

Contact No. 1

First Name:		Last Name:		Relation To Client:	
Phone No. 1: () -		Phone No. 2: () -			
Address Line 1: <input style="width:100%;" type="text"/>					
City: <input style="width:25%;" type="text"/>		State: <input style="width:10%;" type="text"/>	Zip-code: <input style="width:15%;" type="text"/> - <input style="width:10%;" type="text"/>		

Contact No. 2

First Name:		Last Name:		Relation To Client:	
Phone No. 1: () -		Phone No. 2: () -			
Address Line 1: <input style="width:100%;" type="text"/>					
City: <input style="width:25%;" type="text"/>		State: <input style="width:10%;" type="text"/>	Zip-code: <input style="width:15%;" type="text"/> - <input style="width:10%;" type="text"/>		

Contact No. 3

First Name:		Last Name:		Relation To Client:	
Phone No. 1: () -		Phone No. 2: () -			
Address Line 1: <input style="width:100%;" type="text"/>					
City: <input style="width:25%;" type="text"/>		State: <input style="width:10%;" type="text"/>	Zip-code: <input style="width:15%;" type="text"/> - <input style="width:10%;" type="text"/>		

Medication Information

Medication	Dose/Freq	Reason Taken/Comment
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>

Determine Your Nutritional Health

Read the statements below. Check Yes or No.

Client Name: _____

1	I have an illness/condition that made me change the kind and/or amount of food I eat.	<input type="radio"/> YES <input type="radio"/> NO
2	I eat fewer than 2 meals per day.	<input type="radio"/> YES <input type="radio"/> NO
3	I eat few fruits or vegetables, or milk products.	<input type="radio"/> YES <input type="radio"/> NO
4	I have 3 or more drinks of beer, liquor or wine almost every day.	<input type="radio"/> YES <input type="radio"/> NO
5	I have tooth or mouth problems that make it hard for me to eat.	<input type="radio"/> YES <input type="radio"/> NO
6	I don't always have enough money to buy the food I need.	<input type="radio"/> YES <input type="radio"/> NO
7	I eat alone most of the time.	<input type="radio"/> YES <input type="radio"/> NO
8	I take 3 or more different prescribed or over-the-counter drugs a day.	<input type="radio"/> YES <input type="radio"/> NO
9	Without wanting to, I have lost or gained 10 pounds in the last 6 months.	<input type="radio"/> YES <input type="radio"/> NO
10	I am not always physically able to shop, cook and/or feed myself.	<input type="radio"/> YES <input type="radio"/> NO



990 Pelham Parkway South
Bronx, NY 10461
718-792-1800

PHOTO RELEASE

I grant Bronx House the right to take photographs of me in connection with the program I am participating in. I authorize Bronx House, its assignees and transferees to copyright, use and publish the same in print and/or electronically.

I agree that Bronx House may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

CLASS REFUND POLICY

If a participant drops out of a class prior to its start, a refund will be issued. No tuition refunds will be granted after the first class except for medical reasons. If there is a medical reason, the participant must provide a doctor's note within two weeks and will receive a prorated tuition refund or credit. All credits must be used within our fiscal year.

All refunds are subject to a \$35 administrative charge. Insurance fees are non-refundable (except for program cancellations).

I have reviewed and understand the policies stated above:

Participant Name: _____

Signature: _____

Date: _____

Signature of Parent/Guardian (if under 18) _____

BRONX HOUSE

Weinberg Neighborhood Senior Center
990 Pelham Parkway South • Bronx, NY 10461
Tel: 718-792-1800 • Fax: 718-792-6802
www.bronxhouse.org

Weinberg Neighborhood Senior Center Participant Rules and Guidelines

The Weinberg Neighborhood Senior Center is open to adults age 60 years and older to participate in recreation, socialization, and intellectual activities, as well as find a variety of helpful, relevant services. The Center is committed to providing a safe and welcoming environment for all participants, visitors, and staff members. To help ensure a supportive setting for all who attend the Senior Center, the following Participant Guidelines and Rules were established:

General Guidelines

1. Please treat other members and staff members with courtesy and respect.
2. Group activities and educational sessions open to all members will receive first priority when reserving Rooms A3 and A5.
3. Participants who wish to engage in independent games or activities with others are asked to play in the area reserved for such activities in the lunch room.
4. All participants are asked to refrain from unnecessary shouting or loud music that may disrupt others' enjoyment of the Center and to respect requests to lower their voices.

Rules

1. Individuals must be able to care for themselves independently while participating in Center activities. Senior Center staff cannot provide personal care and will determine if participants are required to be accompanied by a care attendant while at the Senior Centers. Individuals needing assistance (memory impairment, incontinence, wheelchair user unable to use restroom independently, etc.) may participate in Senior Center activities with the aid of a care attendant.