NAPIS Client Registration Form

****Confidential Information****

Form Date ☐☐ / ☐☐ / ☐☐☐☐

☐ CARE_RECIPIENT_REGISTRATION ☐ CAREGIVER_REGISTRATION

C | **Vendor ID** ☐☐ - ☐☐☐☐☐☐☐☐ **Site** | **Region ID** ☐☐ | **Social Security Number** *(Optional)* ☐☐☐ - ☐☐ - ☐☐☐☐ | **Date Of Birth** ☐☐ / ☐☐ / ☐☐☐☐

First Name | **Last Name** | **Mid Init**

Address

City | **State** MI | **Zip Code** | **Plus 4** | **County** | **Township**

Mail Address *(Optional)* | **City** *(Optional)* | **State**

Zip Code *(Optional)* **Plus 4** | **Phone** ( ) - | **Gender** ○ Male ○ Female | **Lives Alone** ○ Yes ○ No

Income Status

○ Yes ○ No

Monthly income is below the poverty level?

(See instructions for income details)

Race

○ White ○ Asian ○ Hawaiian / Pacific Islander

○ Black ○ American Indian / Eskimo / Aleut

Is Client Hispanic? ○ Yes ○ No

Multi-Racial Status ○ Yes ○ No

(mark all that apply)

☐ White ☐ Asian ☐ Hawaiian/Pacific Islndr

☐ Black ☐ American Indian / Eskimo / Aleut

Client Intake Date ☐☐ / ☐☐ / ☐☐☐☐ (Date of client's initial NAPIS service registration, e.g., 10/01/1999)

Care Recipient Services Information

Cluster I Services — **Start Date**

- ☐ Care Management ☐☐ / ☐☐ / ☐☐☐☐
- ☐ Care Coord/Support ☐☐ / ☐☐ / ☐☐☐☐
- ☐ Home Health Aide ☐☐ / ☐☐ / ☐☐☐☐
- ☐ Personal Care ☐☐ / ☐☐ / ☐☐☐☐
- ☐ Homemaker ☐☐ / ☐☐ / ☐☐☐☐
- ☐ Chore Services ☐☐ / ☐☐ / ☐☐☐☐
- ☐ Home Deliv'd Meals ☐☐ / ☐☐ / ☐☐☐☐

Cluster II Services

- ☐ Congregate Meals
- ☐ Nutrition Counseling
- ☐ Assisted Transportation

Cluster III Services

- ☐ Counseling
- ☐ Health Promotion
- ☐ Nutrition Education
- ☐ Elder Abuse Prev
- ☐ Friendly Reassurance
- ☐ Health Screening
- ☐ Hearing Services
- ☐ Home Injury Control
- ☐ Home Repair
- ☐ Info & Assistance
- ☐ Legal Services
- ☐ Medication Mgt.
- ☐ Ombudsman
- ☐ Other
- ☐ PERs
- ☐ Outreach
- ☐ Senior Ctr Operations
- ☐ Senior Ctr Staff
- ☐ Transportation
- ☐ Vision Services

Nutritional Status Information

The High Nutritional Risk determination in #1 below is required for Care Recipients receiving any of these services: Home Delivered Meals, Congregate Meals, Care Mgmt/Case Coord, Nutrition Counseling. NOTE - The Nutritional Risk score in #1a is **recommended** but not required.

1) Is Care Recipient at High Nutritional Risk? (Screen score of 6 or more is High Risk) ○ Yes ○ No

1a) Score from High Nutritional Risk Screen (Numeric Score) ☐

This section is required for Care Recipients receiving Cluster I services. Mark all activities that require assistance.

Activities of Daily Living ☐ None ☐ All

- ☐ Eating / Feeding
- ☐ Toileting
- ☐ Dressing
- ☐ Bladder Function
- ☐ Bathing
- ☐ Bowel Function
- ☐ Walking
- ☐ Wheeling
- ☐ Stair Climbing
- ☐ Transferring
- ☐ Bed Mobility
- ☐ Mobility Level

Instrumental Activities of Daily Living ☐ None ☐ All

- ☐ Shopping
- ☐ Handling Finances
- ☐ Heavy Cleaning
- ☐ Light Cleaning
- ☐ Using Public Transportation
- ☐ Using Private Transportation
- ☐ Cooking Meals
- ☐ Reheating Meals
- ☐ Taking Medication
- ☐ Using Phone
- ☐ Doing Laundry
- ☐ Keeping Appointments
- ☐ Heating Home

NAPIS Client Registration Form (Page 2 - Caregiver Services)

Care Recipient's First Name

Care Recipient's Last Name

Care Recipient Social Security Number *(Optional)*

- -

Care Recipient Date Of Birth

/ /

Caregiver Services Information

Registered Caregiver Services

Start Date

Counseling Services
- ☐ Individual Counseling
- ☐ Support Group
- ☐ Caregiver Training
- ☐ Other Counseling

Respite Care Services
- ☐ In Home Respite
- ☐ Chore
- ☐ Homemaker
- ☐ Home Del Meals
- ☐ Home Health Aide
- ☐ Kinship
- ☐ Overnight
- ☐ Personal Care
- ☐ Specialized
- ☐ Volunteer Respite
- ☐ Adult Day Care
- ☐ Direct Payment
- ☐ Other

Defined Supplemental Services
- ☐ Caregiver Supplemental
- ☐ Direct Payment
- ☐ Other (specify"other" below if applicable)
  - ○ Home Modification ○ PERS ○ Medical Equip/Supplies

Non-registered Caregiver Services

- ☐ Case Management ☐ Nutrition Counseling
- ☐ Health Education ☐ Nutrition Educ. ☐ Transportation
- ☐ Information & Assistance ☐ Outreach ☐ Other

Care Recipient Status Information

This is required for Caregivers receiving any of these services:
Respite Care (all forms) & Defined Supplemental Services

1) Does the care recipient need assistance with 2 or more activities of daily living (ADLs)?

AND / OR ○ Yes ○ No

2) Does the care recipient have a cognitive impairement (e.g., Alzheimer's Dementia, etc.)?

○ Yes ○ No

Caregiver History

1) How did caregiver hear about this program (referral source)?

○ Newspaper ○ Television ○ Brochure ○ Friend ○ Agency
○ Web Site ○ Physician ○ Health Care Provider ○ Other

2) Caregiver relationship to Care Recipient (check all that apply):

☐ Spouse ☐ Daughter ☐ Son ☐ Daughter-in-Law ☐ Son-in-Law
☐ Parent ☐ Grandparent ☐ Other Relative ☐ Non-Relative

3) How long has the Caregiver provided care to the Care Recipient?

○ 0-6 months ○ 7-12 months ○ 13-36 months ○ 37+ months

4) How long does it take to get to the Care Recipient's home?

○ Less than 1 hour ○ 1-3 hours ○ More than 3 hours
○ Caregiver Lives w/ Care Recipient

5) Caregiver provides care to Care Recipient:

○ Daily ○ Several times a week ○ Weekly
○ Less Than 1 Day/Week ○ Monthly ○ Occasionally

6) Does the Caregiver provide hands-on care to Care Recipient?:

○ Yes ○ No

If yes, hands-on care is provided:(Check the appropriate number of hours and frequency e.g., 1-3 hours per week)

○ Less than 1 hour ○ 1-3 hours ○ More than 3 hours
○ Per Day ○ Per Week ○ Per Month

7) Caregiver is employed: ○ Full Time ○ Part Time ○ Not Employed

8) Caregiver's health is: ○ Excellent ○ Good ○ Fair ○ Poor

9) Are other friends or family members willing and capable to help care for the Care Recipient: ○ Yes ○ No

10) How many Care Recipients does the Caregiver care for:

10a) How many is the Caregiver the primary caregiver for:

11) How many dependents does the Caregiver have:

Under age 19: **Age 19- 59:** **Over age 59:**

12) Is this a Kinship Care family/situation? ○ Yes ○ No

(Q.12 refers to Kinship supported w/ grant funds. If Yes, complete Kinship Care page 3. If No, don't complete p 3)

I understand that the confidential information I am providing on this form will be used for state and federal reporting requirements, program management, quality assurance, public safety and research. No other use of personal identifying information on this form is intended unless I authorize it or a court orders it.

Signature

OSA NAPIS FY2005

08/12/2004

Draft

NAPIS Client Registration Form (Page 3 - Kinship Care Information)

****Confidential Information****

Kinship Care Information

Vendor ID ☐☐ - ☐☐☐☐☐☐☐ **Site ID** ☐☐ **Region ID** ☐☐

Caregiver Social Security Number *(Optional)* ☐☐☐ - ☐☐ - ☐☐☐☐

Caregiver's First Name

Caregiver's Last Name

Child 1 First Name

Last Name

Child's Date Of Birth ☐☐ / ☐☐ / ☐☐☐☐

Child's Gender ○ Male ○ Female

Child 2 First Name

Last Name

Child's Date Of Birth ☐☐ / ☐☐ / ☐☐☐☐

Child's Gender ○ Male ○ Female

Child 3 First Name

Last Name

Child's Date Of Birth ☐☐ / ☐☐ / ☐☐☐☐

Child's Gender ○ Male ○ Female

Child 4 First Name

Last Name

Child's Date Of Birth ☐☐ / ☐☐ / ☐☐☐☐

Child's Gender ○ Male ○ Female

Child 5 First Name

Last Name

Child's Date Of Birth ☐☐ / ☐☐ / ☐☐☐☐

Child's Gender ○ Male ○ Female

Status of child(ren) in care? (Check all That Apply):

☐ Informal Arrangement ☐ Foster Care ☐ Adoption
☐ Guardianship ☐ Legal Custody ☐ Other

Are any of the Child(ren)'s Parents also living with Caregiver? ○ Yes ○ No

Reason for Kinship Care (Check all That Apply):

☐ Abandonment ☐ Mental / Emotional Illness ☐ Divorce
☐ Teen Pregnancy ☐ Incarceration ☐ Illness ☐ Other
☐ Substance Abuse ☐ Unemployment ☐ Death

Child(ren)'s Special Needs (Check all That Apply):

☐ Developmental Disability
☐ Emotional Impairment
☐ Learning Disability
☐ Physical Disability

I understand that the confidential information I am providing on this form will be used for state and federal reporting requirements, program management, quality assurance, public safety and research. No other use of personal identifying information on this form is intended unless I authorize it or a court orders it.

Signature