FREDERICK COUNTY Department of Aging

Participant Information Form

AIM ID#: | | | | - | | | - | | | | | |

(Staff only) Entered by:_____ Date:_____

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail Address: _____ Check to receive FCDOA e-news.___

Birth Date: _____ Gender : Male Female Other

Marital Status: _____ Occupation: _____

Emergency Contact Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: _____ Secondary Phone: _____ Email: _____

Relationship: _____

I need more information about:

- ❑ Caregiver Issues and Support
- ❑ Educational Opportunities
- ❑ Employment Resources
- ❑ Food Resources
- ❑ Financial Assistance / Tax Credits
- ❑ Health Education
- ❑ Health Resources
- ❑ Housing Resources
- ❑ Legal Resources
- ❑ Long Term Care
- ❑ Medicare/Medicaid
- ❑ Insurance
- ❑ Physical Fitness Opportunities
- ❑ Recreation Opportunities
- ❑ Transportation Resources
- ❑ Veterans Benefits
- ❑ Volunteer Opportunities
- ❑ Other _____

Other Information (Please check all that apply)

Please indicate race:
- ❑ African American
- ❑ American Indian/Alaskan
- ❑ Asian
- ❑ Hawaiian/Pacific Islander
- ❑ White
- ❑ Other
- ❑ 2 or more races
- ❑ Decline to answer

Please indicate ethnicity:
- ❑ Hispanic
- ❑ Non-Hispanic
- ❑ Decline to answer

I live alone:
- ❑ Yes
- ❑ No

I am a registered voter:
- ❑ Yes
- ❑ No
- ❑ Need Forms

I served in the Military:
- ❑ Yes
- ❑ No

Monthly Household Income:
- ❑ Single, under $980/mo
- ❑ Single, over $980/mo
- ❑ Married, under $1327/mo
- ❑ Married, over $1327/mo

Number in Household _____

Personal Health:
- ☐ I have no disability
- ☐ I have one or more disabilities
  - ☐ chronic disease
  - ☐ physical
  - ☐ mental health
  - ☐ developmental/intellectual
  - ☐ traumatic brain injury

I have read and agree to the Privacy Policy and Participant Agreement stated on the back. Signature: _____ Date: _____

Privacy Policy

The information you include on this registration form will be used to help improve programs for seniors and/or determine if you qualify for a program.
It may be shared with the Maryland Department of Aging (MDOA).

The Frederick County Department of Aging and the MDOA will not voluntarily share any information that identifies you except with people working for them who need the information to perform their jobs. This includes your name, address and telephone number.

You may refuse to give some or all of the information requested. However, if a program is only for people who meet its qualifications (such as age, income or health condition) and you choose not to share the facts that show you qualify, you may not be able to take advantage of that program. The Frederick County Department of Aging staff can tell you exactly what information is needed to determine if you qualify for a program.
You may look at a record that identifies you to ensure the information is correct. To view your record, you must make your request in writing to:

Carolyn B. True, Director
Frederick County Department of Aging 1440 Taney Avenue
Frederick, MD 21702
ctrue@FrederickCountyMD.gov

or

Maryland Department of Aging 301 West Preston Street
Suite 1007
Baltimore, MD 21201

Revised: October 2015

Participant Agreement

I agree to allow the Frederick County Department of Aging staff to make referrals to other agencies as appropriate on my behalf and disclose pertinent information as necessary. I agree to allow representatives of agencies, programs, or services for which I have applied or am currently enrolled to provide pertinent information to representatives of the Department of Aging.

I acknowledge that there are inherent risks and dangers associated with senior center program/s and therefore, I agree to waive and release any and all claims against Frederick County, MD, its officers, employees, and agents for any damages, loss, direct or indirect, or bodily injuries sustained by me as a result of my participationin any Frederick County Department of Aging Senior Center activity.

I agree to allow Frederick County Department of Aging to take and utilize photos, slides, and video images for the purpose of promotion and publicizing of the Department's programs, facilities, and/or events.

I acknowledge that information provided to the Frederick County Department of Aging will be maintained according to confidentiality guidelines established by the Department of Aging, HIPAA and the Maryland Board of Nursing.

I acknowledge I am aware of and agree to observe the senior center guidelines, policies and procedures as posted in the center and on the Department website. I may receive a print copy upon request.

I understand that I may revoke my consent to release information, but not retroactive to release of information already made in good faith.

Good nutrition has been identified as a key component to maintain health and independence as we age. The Nutrition Health Survey is an initiative to identify individuals who may be at nutritional risk and could benefit from resources offered by the Frederick County Department of Aging and other community agencies.

How Is Your Nutritional Health?

Do you have a dietary influenced illness?
☐ **Yes** ☐ **No**

Do you eat less than 2 meals per day?
☐ **Yes** ☐ **No**

Do you have 3 or more alcoholic drinks daily?
☐ **Yes** ☐ **No**

Do you eat less than 5 servings of fruits, vegetables and dairy products each day?
☐ **Yes** ☐ **No**

Do you have tooth/mouth problems?
☐ **Yes** ☐ **No**

Do you lack money for food?
☐ **Yes** ☐ **No**

Do you usually eat alone?
☐ **Yes** ☐ **No**

Do you use 3 or more prescription and/or over-the-counter medications daily?
☐ **Yes** ☐ **No**

Have you had unintentional weight fluctuations of 10 lbs or more in the last six months?
☐ **Yes** ☐ **No**

Are you unable to shop for/cook/eat food?
☐ **Yes** ☐ **No**

Count your YES answers. _____
0 – 2 Good Job!
3 – 5 Doing okay, but consider making some changes.
6 – 9 Needs improvement. Check with your health care provider.