

# NAPIS Client Registration Form

**\*\*Confidential Information\*\***

Form Date

 CARE\_RECIPIENT\_REGISTRATION

 CAREGIVER\_REGISTRATION

 /  / 

<b>Vendor ID</b>	<b>Site</b>	<b>Region ID</b>	<b>Social Security Number</b> (Optional)	<b>Date Of Birth</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

<b>First Name</b>	<b>Last Name</b>	<b>Mid Init</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Address**

<b>City</b>	<b>State</b>	<b>Zip Code</b>	<b>Plus 4</b>	<b>County</b>	<b>Township</b>
<input type="text"/>	<b>MI</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

<b>Mail Address</b> (Optional)	<b>City</b> (Optional)	<b>State</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>

<b>Zip Code</b> (Optional) <b>Plus 4</b>	<b>Phone</b>	<b>Gender</b>	<b>Lives Alone</b>
<input type="text"/>	( <input type="text"/> ) <input type="text"/> - <input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No

<b>Income Status</b>	<b>Race</b>	<b>Multi-Racial Status</b>
<input type="radio"/> Yes <input type="radio"/> No Monthly income is below the poverty level? (See instructions for income details)	<input type="radio"/> White <input type="radio"/> Asian <input type="radio"/> Hawaiian / Pacific Islander <input type="radio"/> Black <input type="radio"/> American Indian / Eskimo / Aleut	<input type="radio"/> Yes <input type="radio"/> No (mark all that apply) <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> American Indian / Eskimo / Aleut

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

## Care Recipient Services Information

<b>Cluster I Services</b> <input type="checkbox"/> Care Management <input type="checkbox"/> Care Coord/Support <input type="checkbox"/> Home Health Aide <input type="checkbox"/> Personal Care <input type="checkbox"/> Homemaker <input type="checkbox"/> Chore Services <input type="checkbox"/> Home Deliv'd Meals	<b>Cluster II Services</b> <input type="checkbox"/> Congregate Meals <input type="checkbox"/> Nutrition Counseling <input type="checkbox"/> Assisted Transportation	<b>Cluster III Services</b> <input type="checkbox"/> Info & Assistance <input type="checkbox"/> Counseling <input type="checkbox"/> Health Promotion <input type="checkbox"/> Nutrition Education <input type="checkbox"/> Elder Abuse Prev <input type="checkbox"/> Friendly Reassurance <input type="checkbox"/> Health Screening <input type="checkbox"/> Hearing Services <input type="checkbox"/> Home Injury Control <input type="checkbox"/> Home Repair
<b>Start Date</b> <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Legal Services <input type="checkbox"/> Medication Mgt. <input type="checkbox"/> Ombudsman <input type="checkbox"/> Other <input type="checkbox"/> PERs <input type="checkbox"/> Outreach <input type="checkbox"/> Senior Ctr Operations <input type="checkbox"/> Senior Ctr Staff <input type="checkbox"/> Transportation <input type="checkbox"/> Vision Services	

## Nutritional Status Information

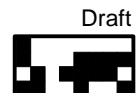
**The High Nutritional Risk determination in #1 below is required for Care Recipients receiving any of these services:** Home Delivered Meals, Congregate Meals, Care Mgmt/Case Coord, Nutrition Counseling. NOTE - The Nutritional Risk score in #1a is **recommended** but not required.

**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.

<b>Activities of Daily Living</b> <input type="checkbox"/> None <input type="checkbox"/> All <input type="checkbox"/> Eating / Feeding <input type="checkbox"/> Toileting <input type="checkbox"/> Dressing <input type="checkbox"/> Bladder Function <input type="checkbox"/> Bathing <input type="checkbox"/> Bowel Function <input type="checkbox"/> Walking <input type="checkbox"/> Wheeling <input type="checkbox"/> Stair Climbing <input type="checkbox"/> Transferring <input type="checkbox"/> Bed Mobility <input type="checkbox"/> Mobility Level	<b>Instrumental Activities of Daily Living</b> <input type="checkbox"/> None <input type="checkbox"/> All <input type="checkbox"/> Shopping <input type="checkbox"/> Cooking Meals <input type="checkbox"/> Doing Laundry <input type="checkbox"/> Handling Finances <input type="checkbox"/> Reheating Meals <input type="checkbox"/> Keeping Appointments <input type="checkbox"/> Heavy Cleaning <input type="checkbox"/> Taking Medication <input type="checkbox"/> Heating Home <input type="checkbox"/> Light Cleaning <input type="checkbox"/> Using Phone <input type="checkbox"/> Using Public Transportation <input type="checkbox"/> Using Private Transportation
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# NAPIS Client Registration Form (Page 2 - Caregiver Services)

Care Recipient's First Name

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Care Recipient Social Security Number (Optional)

--	--	--	--	--	--	--	--	--	--	--	--

Care Recipient's Last Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Care Recipient Date Of Birth

--	--	--	--	--	--	--	--

## Caregiver Services Information

### Registered Caregiver Services

Start Date

#### Counseling Services

<input type="checkbox"/>	Individual Counseling						
<input type="checkbox"/>	Support Group						
<input type="checkbox"/>	Caregiver Training						
<input type="checkbox"/>	Other Counseling						

#### Respite Care Services

<input type="checkbox"/>	In Home Respite						
<input type="checkbox"/>	Chore						
<input type="checkbox"/>	Homemaker						
<input type="checkbox"/>	Home Del Meals						
<input type="checkbox"/>	Home Health Aide						
<input type="checkbox"/>	Kinship						
<input type="checkbox"/>	Overnight						
<input type="checkbox"/>	Personal Care						
<input type="checkbox"/>	Specialized						
<input type="checkbox"/>	Volunteer Respite						
<input type="checkbox"/>	Adult Day Care						
<input type="checkbox"/>	Direct Payment						
<input type="checkbox"/>	Other						

#### Defined Supplemental Services

<input type="checkbox"/>	Caregiver Supplemental						
<input type="checkbox"/>	Direct Payment						
<input type="checkbox"/>	Other (specify "other" below if applicable)						
<input type="checkbox"/>	Home Modification	<input type="checkbox"/>	PERS	<input type="checkbox"/>	Medical Equip/Supplies		

### Non-registered Caregiver Services

<input type="checkbox"/>	Case Management	<input type="checkbox"/>	Nutrition Counseling		
<input type="checkbox"/>	Health Education	<input type="checkbox"/>	Nutrition Educ.	<input type="checkbox"/>	Transportation
<input type="checkbox"/>	Information & Assistance	<input type="checkbox"/>	Outreach	<input type="checkbox"/>	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 impairment (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.

OSA NAPIS FY2005

**08/12/2004**  
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**Signature**

\_\_\_\_\_



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

**\*\*Confidential Information\*\***

## Kinship Care Information

<b>Vendor ID</b> <input style="width: 100%;" type="text"/> - <input style="width: 100%;" type="text"/>	<b>Site ID</b> <input style="width: 100%;" type="text"/>	<b>Region ID</b> <input style="width: 100%;" type="text"/>	<b>Caregiver Social Security Number (Optional)</b> <input style="width: 100%;" type="text"/> - <input style="width: 100%;" type="text"/> - <input style="width: 100%;" type="text"/>
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**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):**

- |   |  |                                   |
|---|--|-----------------------------------|
| <input type="checkbox"/> Informal Arrangement | <input type="checkbox"/> Foster Care   | <input type="checkbox"/> Adoption |
| <input type="checkbox"/> Guardianship         | <input type="checkbox"/> Legal Custody | <input type="checkbox"/> Other    |

**Are any of the Child(ren)'s Parents also living with Caregiver?**

Yes  No

**Reason for Kinship Care (Check all That Apply):**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Abandonment     | <input type="checkbox"/> Mental / Emotional Illness | <input type="checkbox"/> Divorce                                |
| <input type="checkbox"/> Teen Pregnancy  | <input type="checkbox"/> Incarceration              | <input type="checkbox"/> Illness <input type="checkbox"/> Other |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Unemployment               | <input type="checkbox"/> 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**

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