

# CLIENT REGISTRATION FORM

NAME (First/Last): \_\_\_\_\_  MALE  FEMALE

DATE OF BIRTH: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ PHONE NUMBER: ( \_\_\_\_\_ ) \_\_\_\_\_

PHYSICAL ADDRESS: \_\_\_\_\_ MAILING ADDRESS: \_\_\_\_\_  
 \_\_\_\_\_ (If Different) \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

NAME 1 (First/Last): \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

HOME PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_ WORK OR CELL PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_

NAME 2 (First/Last): \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

HOME PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_ WORK OR CELL PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_

**ETHNICITY**  
 HISPANIC OR LATINO  
 NON-HISPANIC OR LATINO

**RACE**  
 WHITE, CAUCASIAN  
 WHITE, HISPANIC  
 AMERICAN INDIAN / ALASKAN NATIVE  
 ASIAN  
 BLACK / AFRICAN AMERICAN  
 NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER  
 OTHER \_\_\_\_\_

If you do not speak English, what is your primary language? \_\_\_\_\_

**MONTHLY INCOME \$ \_\_\_\_\_**  
 Please mark the number of people in your household. Then, indicate if your income is above or below the amount specified for that number of people.

| # of People                | Monthly Income | My Income is:            |                          |
|----------------------------|----------------|--------------------------|--------------------------|
|                            |                | Below                    | Above                    |
| <input type="checkbox"/> 1 | \$867          | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 2 | \$1,167        | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 3 | \$1,467        | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 4 | \$1,767        | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 5 | \$2,067        | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 6 | \$2,367        | <input type="checkbox"/> | <input type="checkbox"/> |

**ARE YOU DISABLED?**  YES  NO      **FRAIL?**  YES  NO

**HOMEBOUND?**  YES  NO      **A CAREGIVER?**  YES  NO

Client Signature \_\_\_\_\_ Date \_\_\_\_\_ Client Signature – 2<sup>nd</sup> year \_\_\_\_\_ Date \_\_\_\_\_  
*(Initial or Revised Registration)* *(if info has not changed)*

Client Signature – 3<sup>rd</sup> year \_\_\_\_\_ Date \_\_\_\_\_ Client Signature – 4<sup>th</sup> year \_\_\_\_\_ Date \_\_\_\_\_  
*(if info has not changed)* *(if info has not changed)*

**FOR OFFICE USE ONLY**

**Services Registered For:** \_\_\_\_\_ **New to This Service?**  Y  N  
 \_\_\_\_\_  Y  N  
 \_\_\_\_\_  Y  N

**Nutrition Risk Assessment Score:** \_\_\_\_\_  
**Client ID:** \_\_\_\_\_  
**Site:** \_\_\_\_\_  
**Notes:** \_\_\_\_\_