Maple Knoll Outreach Services for Seniors Information Sheet

Please check all services that apply to you

☐ Transportation ☐ Home Delivered Meals ☐ Home Health

Today's Date: _____

Full Name _____ Birth Date _____

Home Phone # _____ Cell Phone # _____

Address _____ Community (Ex: Blue Ash) _____

City/State _____ Zip Code _____ County _____

SSN _____ Email _____@_____

Any "Also Known As" name(s) _____

In Case Of Emergency Please Notify:

Name _____ **Name** _____

Address _____ Address _____

City/State/Zip _____ City/State/Zip _____

Home Phone _____ Home Phone _____

Work/Cell _____ Work/Cell _____

Relationship _____ Relationship _____

Primary Care Physician _____ Hospital Preference _____

Demographic Information:

Gender

☐ Female
☐ Male

Marital Status

☐ Divorced
☐ Married
☐ Separated
☐ Never
☐ Married/Single
☐ Widowed

Race

☐ Asian
☐ Black/African American
☐ Hispanic
☐ White
☐ Other

Currently Resides In

☐ House/mobile home
☐ Private apartment
☐ Nursing home
☐ Private apt in senior housing
☐ Residential care home
☐ Unavailable
☐ Other

How long in this residence?

☐ Less than 12 mos.
☐ 1-3 years
☐ 3 years or more

Living Arrangement

☐ Live Alone
☐ With Spouse/partner
☐ Other

Are You Employed?

☐ Yes
☐ No

Monthly Income

☐ _____
☐ Refused

Medical Information: (Please list any important medical information, such as allergies or diabetes that we need to be aware of in case of an emergency.)

_____

_____

_____

-Continued on reverse page-

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How did you hear about us? ☐ Friends/Neighbors ☐ Newspaper ☐ Website

☐ State Agency ☐ Cable TV ☐ Other: _____

Disclosure Statement

The Client Registration Form was developed to assist the Council on Aging to monitor the effectiveness of senior programs offered to the citizens of Ohio. Any client information obtained from this form will be kept confidential and no personal identifying information about a client (i.e. name, address, telephone number, etc…) will be released to the public without the client's prior written consent, or unless otherwise required under federal law.

The data collected (i.e. age, sex, race, etc.) will be forwarded to the Council on Aging and summarized and reported to the Ohio Department of Aging (ODA) and the Administration on Aging (AOA) in order to keep both state and federal legislators informed on the effectiveness of senior programs (as required by the Older Americans Act reauthorization). While all clients receiving services under the Older Americans Act are asked to complete the attached form in full, no client may be denied services for refusing to provide any of the information requested, including Social Security number.

If you have any questions, ask a staff member to explain why this is necessary.

Privacy Notice

The above health information will only be used or disclosed to provide you with treatment and services in the case of illness or injury that occurs while on a trip.

Authorization/Release

I agree to release from liability, MKOSS staff and volunteers for any injury or illness accidentally incurred by me. First aid may be administered by a competent person. In the event of an emergency, I hereby give permission to the person in charge to send me to a physician or hospital, as required.

Consent for Release of Information

I authorize the MKOSS to share information obtained in the assessment process and updates with other professional agencies for the purpose of planning services to meet my needs, including both personal and medical files. I also understand that I can revoke this consent at any time by calling Social Services at 984-1234. My signature further indicates that I have read or had read and explained to me this consent and the information to be released.

X _____

Applicant Signature **Date**

_____

Witness Signature (if necessary) Relationship Date

Applicant is unable to sign because:

_____

I have discussed/read/explained the Disclosure Statement with the client

_____ (Provider Signature) Date_____