WOOD COUNTY COMMITTEE ON Aging

SERVICES REGISTRATION FORM 2021

Grand Rapids • Northeast • North Baltimore • Pemberville
Perrysburg • Rossford • Wayne • Wood County

For Office Use Only		
____Site	___SAMs	___Filed by Data Technician
____MSC	___Social Services	

Last Name:	First Name:	MI:	Birthdate:	Gender:
Address:		City:		ZIP:
Phone #:	Last 4 digits of SSN:	Email:		

If there is an epidemic or pandemic that requires it, I am willing to have the necessary medication delivered to me.	**X**
I do hereby authorize the Wood County Committee on Aging to use my photograph for publicity or other purposes as they see fit.	**X**

Emergency Contact:

Contact Name:		City & State:
Relationship:	Phone #1:	Phone #2:

Primary Doctor:	Telephone:

Race: ( ) *Refused* ( ) African-American ( ) White ( ) Hispanic ( ) Asian/Pacific Islander ( ) Native American	Is your income under $1040/month? ( ) Yes ( ) No	# in Household	Do you have any disabling conditions? ( ) Yes ( ) No

Determine Your Own Nutritional Health Checklist - Form ODA0010	**YES**	**NO**
1. I have an illness or condition that made me change the kind and/or amount of food I eat.	2	0
2. I eat fewer than two meals per day.	3	0
3. I eat few fruits or vegetables, or milk products.	2	0
4. I have three or more drinks of beer, liquor or wine almost every day.	2	0
5. I have tooth or mouth problems that make it hard for me to eat.	2	0
6. I don't always have enough money to buy the food I need.	4	0
7. I eat alone most of the time.	1	0
8. I take three or more different prescribed or over-the-counter drugs a day.	1	0
9. Without wanting to, I have lost or gained 10 pounds in the last six months.	2	0
10. I am not always physically able to shop, cook and/or feed myself.	2	0
Total Score Today: (Add ALL circled answers. If your score is 6 or above, a staff person from Social Services will contact you to discuss resources.)		

For Staff Use Only

FOLLOW UP SECTION FOR HIGH NUTRITIONAL RISK
(a score of 6 or higher on the Determine Your Own Nutritional Health Checklist):

Date Nutritional Checklist received by Social Service Staff: ______________________________

Date of client contact: ______________________

Client was referred to the following agencies for follow-up regarding nutritional concerns:

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Social Services Staff Signature: __________________________________ Date: _______________