

NAPIS REPORTING FORM

All clients eligible to receive services under the Older Americans Act programs must fill out this form.

1. Date of Intake	2. Agency:	3. Interviewer's Name	4. Program Name
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IDENTIFICATION:

5. Client's Name: _____
Last
First
Middle
Nickname

6. Date of Birth: (mm-dd-yyyy): _____ Homeless?: Yes No

8. Address: _____
Number and Street
City
UT
State
Zip Code

County: _____ Phone Number: _____

Rural: Yes No

CONTACTS:

<p>9. Personal Contacts:</p> <p>Primary (non-medical): Emergency - Name _____ Last First Middle</p> <p>Relationship: _____</p> <p>Address: (Number and Street Name) _____ _____</p> <p>City: _____</p> <p>State: _____ UT _____ Zip Code: _____</p> <p>Phone: _____</p>	<p>10. Medical Contacts:</p> <p>Primary Care Physician's Name _____ Last First Middle</p> <p>Address: (Number and Street Name) _____ _____</p> <p>City: _____</p> <p>State: _____ UT _____ Zip Code: _____</p> <p>Phone: _____</p>
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DEMOGRAPHICS:

<p>11. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>12. Ethnic Background: (<i>Check all that applies</i>)</p> <p style="margin-left: 40px;">Non-Minority (White, non-Hispanic) <input type="checkbox"/></p> <p style="margin-left: 80px;">African-American <input type="checkbox"/></p> <p style="margin-left: 80px;">Hispanic Origin <input type="checkbox"/></p> <p style="margin-left: 40px;">American Indian/Native Alaskan <input type="checkbox"/></p> <p style="margin-left: 80px;">Asian <input type="checkbox"/></p> <p style="margin-left: 40px;">Asian/Pacific Islander (includes Native Hawaiian) <input type="checkbox"/></p> <p style="margin-left: 40px;">Native Hawaiian/Other Pacific Islander <input type="checkbox"/></p> <p style="margin-left: 80px;">Other <input type="checkbox"/></p> <p style="margin-left: 80px;">Missing <input type="checkbox"/></p> <p>Primary Language: _____</p> <p>13. Race: Not Hispanic or Latino <input type="checkbox"/></p> <p style="margin-left: 40px;">Hispanic Origin <input type="checkbox"/></p>	<p>14. If under 60, reason for service:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Spouse <input type="checkbox"/> Disabled</p> <p style="margin-left: 20px;"><input type="checkbox"/> Meal Volunteer <input type="checkbox"/> Living with Client</p> <p style="margin-left: 20px;"><input type="checkbox"/> Lives in Elder Housing <input type="checkbox"/> Other</p> <p>15. Select one answer in this box:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Client lives alone</p> <p style="margin-left: 20px;"><input type="checkbox"/> Client lives with spouse</p> <p style="margin-left: 20px;"><input type="checkbox"/> Client lives with family</p> <p style="margin-left: 20px;"><input type="checkbox"/> Client lives with other(s)</p> <p style="margin-left: 20px;"><input type="checkbox"/> Not Disclosed</p> <p>16. Poverty: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to state</p>
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NUTRITIONAL INFORMATION

	Yes	No
1. Has the client made any changes in lifelong eating habits because of health problems?	_____	_____
2. Does the client eat fewer than 2 meals per day?	_____	_____
3. Does the client eat fewer than five (5) servings (1/2 cup each) of fruits or vegetables every day?	_____	_____
4. Does the client eat fewer than two (2) servings of dairy products (such as milk, yogurt, or cheese) every day?	_____	_____
5. Does the client sometimes not have enough money to buy food?	_____	_____
6. Does the client have trouble eating well due to problems with chewing/swallowing?	_____	_____
7. Does the client eat alone most of the time?	_____	_____
8. Without wanting to, has the client lost or gained 10 pounds in the past six months?	_____	_____
9. Is the client not always physically able to shop, cook, and/or feed themselves (or get someone to do it for them)?	_____	_____
10. Does the client have 3 or more drinks of beer, liquor, or wine almost every day?	_____	_____
11. Does the client take 3 or more different prescribed or over-the-counter drugs per day?	_____	_____