

The information requested on this Registration Packet is required by the U.S. Administration on Aging and/or the Maryland Department of Aging. Without this information the USA Area Agency on Aging will not receive funding critical to the operation of our programs.

All fields are required. Registration Packets are to be done yearly. Please print clearly.

New Registration Renewal	Today's Date:					
Name:						
LAST	FIRST MI					
Date of Birth:/ / Age:	Gender: Female Male Other					
Street Address:						
Street	City State Zip					
Mailing Address (if different):						
Phone Number: Email Ad	ldress:					
Race (Check All that Apply): American Indian or Alaska Native Asian or Asian American Black or African American Native Hawaiian or Pacific Islander White Other						
Ethnicity (Check One): Hispanic/Latino	Not Hispanic/Latino Refuse to Answer					
Check One: Single Married Separated Divorced Widowed						
Check One: Live Alone Live with Spouse/Friend Live with Family/Adult Child Live with Hired Caregiver Live with Disabled Adult/Child Head of Household?						
How many people are living in your household? Veteran?						
Income Per Month (Check One): Single, less than \$1,304 Single, more than \$1,304 Married, less than \$1,762 Married, more than \$1,762 Refuse to Answer						
Do you use any assistive devices (Check All that A	pply): Cane Walker Wheelchair Other					
Emergency Contact:	Emergency Contact Phone Number:					
Emergency Contact Relationship						
How did you hear about our services?						
STAFF USE: Location: All forms and Administrative staff verify all information is completed that the staff initials:	are fully complete. Staff Initials:ete and entered in AIM and Nutrition Screening.					

NOTICE INFORMED CONSENT

The information collected on this form may be shared with the Maryland Department of Aging (MDoA). Upper Shore Aging, Inc. and MDoA will not share any personal information which identifies you (such as your name, social security number, address or telephone number) with any other person or agency. Upper Shore Aging, Inc. and MDoA will use the information collected to prepare local, state, and federal reports and to help improve programs and services for seniors in Maryland but will keep your identity confidential.

You may refuse to provide any or all the information requested on the attached form. If you refuse to provide the information requested, you will still be eligible to receive any service which does not require proof of limited income information and proof of identity to receive any service which requires proof of a limited income.

You may inspect your personal information at:

Upper Shore Aging, Inc. 100 Schauber Rd. Chestertown, MD 21620

You may also call us at (410) 778-6000 or 1-800-721-6651

You may provide a written request to Upper Shore Aging, Inc. will allow you to inspect your personal information as soon as reasonably possible, but no later than 30 days from the date of your request. You must provide proof of your identity at the time of your inspection.

I have read and understand the above informed Consent Notice.

(Please check the one that applies)

I consent to share information with the MDoA

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Senior Center Packet



Determine Your Nutritional Health Screening Initiative Form

Nutrition Question	Check if Yes Only	Score If Yes
I have an dietary illness or condition that made me change the kind and/or amount of food I eat.		2
I eat fewer than two meals per day.		3
I eat few fruits or vegetables, or milk products.		2
I have three or more drinks of beer, liquor, or wine almost every day.		2
I have tooth or mouth problems that make it hard for me to eat.		2
I don't always have enough money to buy the food I need.		4
I eat alone most of the time.		1
I use 3 or more prescribed or over the counter drugs/medicine a day?		1
I have unintentional weight fluctuation.		2
I am unable to shop/cook/or feed myself on my own.		2
Total the Nutrition Score 0-2: Low nutritional risk 3-6: Moderate nutritional risk 6 or more: High nutritional risk.		



Photography Release Form

Participant's Name:
I hereby authorize Upper Shore Aging, Inc. to publish photographs taken of me, and my name, for use in USA's printed publications and website.
I acknowledge that since my participation in publications and websites produced by USA is voluntary, I will receive no financial compensation.
I release USA, its board members and its employees from liability for any claims by me or any third party in connection with my participation.
I understand that USA is a non-profit organization and that use of photographs will be limited to educational, non-commercial purposes.
I represent that I am over the age of eighteen and that I have read the foregoing and completely understand the contents thereof. I have read and understand the above:
and a state of the
Signature
Printed Name
Date Senior Center Packet



Waiver of Liability Form

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All activities involve some level of risk, and group exercise classes are no exception. Before beginning any exercise program, you should consult your physician. Always inform the Instructor prior to class if there is any change in your medical condition that would impair your ability to participate safely in class. Listen to your own body and go at your own pace. Anything worth doing is worth doing safely. Please read the waiver below carefully and sign it only if you understand and agree with it.

For participation in SAIL (Staying Active and Independent for Life) group exercise classes at the (Name of Facility) the Participant, by signing below, hereby voluntarily indemnifies.
releases from liability, and holds harmless the Instructor. (Instructor Name) and/or
(Facility Name) for any accident, injury, illness, death, loss, damage to person or property, or other
consequences suffered by Participant or any other person arising or resulting directly or indirectly from
Participant's participation in group fitness classes.
In the event that Participant is injured, Participant agrees to assume any financial obligation, either through
Participant's personal health insurance, or through some other means, for any medical costs which Participant
incurs. The Instructor and/or Facility assumes no responsibility for any medical expenses, injury, or damage
suffered by Participant in connection with the use of any facilities or services in connection with the Activity.
It is the intention of participant by signing below to expressly assume all risk of personal injury, death,
or property damage upon him/herself, to the exclusion of the instructor and/or Facility and to exempt
and relieve the instructor and/or Facility from liability for personal injury, property damage or wronglu
death.
Partidpant further agrees that Partidipant, his/her spouse, assignees, heirs, guardians, and legal
representatives will not make any claim against, sue or attach the Instructor and/or Facility for any loss or
damage resulting from Participant's participation in the Activity.
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Participant is aware of the potential dangers incidental to engaging in the fitness activities. Participant agrees
that this is a release of liability, a waiver of the participant's legal right to collect damages in the event of injury,
death or property damage and a contract between participant and the Instructor and/or Facility and participant
signs it of his/her own free will.
Man of the state o
Print Participant Name:
Signature of Participant:
Date:
a

AD8 Dementia Screening Interview

Patient ID#:	
CS ID#:	
Date:	

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	YES, A change	NO, No change	N/A, Don't know
1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)	P		
2. Less interest in hobbies/activities		,	
 Repeats the same things over and over (questions, stories, or statements) 			
4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)	it.		
5. Forgets correct month or year			
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)			M
7. Trouble remembering appointments		-	
8. Daily problems with thinking and/or memory			
TOTAL AD8 SCORE			

Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005:65:559-564
Copyright 2005. The AD8 is a copyrighted instrument of the Alzheimer's Disease Research Center, Washington University, St. Louis, Missouri. All Rights Reserved.

Senior Center Handbook Acknowledgement

I acknowledge that I, have received the senior center handbook and have read its contents thoroughly. I understand that if I ever have any questions or concerns, I can report them to the Senior Center Manager and/or the Director of Senior Centers &
Nutrition. Participant Signature:
County:
Senior Center Manager Signature:
Date: