

Date _____ - _____ - _____

NAPIS REGISTRATION

(11/28/2016)

Last Name _____ First _____ Middle Initial _____

Address _____ City _____

State _____ County _____ Zip _____

NOTE: If not from our counties, list our county where received service

Phone _____ - _____ - _____ Birth date (required) _____ - _____ - _____

Hispanic: yes [] no []

Race: (mark as many as apply)

African American	[]	Indian / Alaskan	[]
Asian	[]	White	[]
Hawaiian / Pacific Islander	[]	Other Race	[]

Gender: Male [] Female [] Number in household: _____ Low income: yes [] no []

Services senior adult gets: (required)

Family Café Meals []
 Home Delivered Meals []

Services caregiver/non-parent gets: (required)

In-Home Respite arranged for a caregiver/NP []
 All Day Club arranged for a caregiver []
 Gap-Filling arranged for a caregiver/NP []
 III-E Case Management for a caregiver/NP []

If a service on the right above is checked:

If this a care receiver, who is the caregiver _____ County _____

If this a caregiver, who is the care receiver _____ County _____

If a caregiver, is care receiver registered (both must be registered) yes [] no []

If a caregiver, relationship to care receiver is ... wife [] husband [] son / son-in law []
 daughter / daughter-in-law [] other relative [] non-relative []

Is this an older person raising children (0-18) or disabled adults (19-59)? yes [] no []

If yes, relationship is... grandparent [] other elderly relative [] elderly, but not a relative []

If yes, # of children age 0-18 _____ # of disabled adults age 19-59 _____

Complete the Nutritional Health form on the next page if a senior adult and received Family Café Meals, HDM, In-Home Respite, or All Day Club

Complete contact below info unless this is a caregiver or older person raising children/DD.

Emer. Contact _____ Relationship _____

Home phone # _____ Work # _____

Complete difficulties below if received HDM, In-Home Respite, or All Day Club

Do you have any difficulties with these?

Do you have any difficulties with these?

Eating	1-yes []	0-no []	Preparing meals	1-yes []	0-no []
Dressing	1-yes []	0-no []	Being left alone	1-yes []	0-no []
Bathing	1-yes []	0-no []	Medication management	1-yes []	0-no []
Toileting	1-yes []	0-no []	Money management	1-yes []	0-no []
Transferring	1-yes []	0-no []	Using telephone	1-yes []	0-no []
Grooming	1-yes []	0-no []	Heavy housework	1-yes []	0-no []
			Light / routine housework	1-yes []	0-no []
			Getting to places outside the home	1-yes []	0-no []

Interviewer _____ Site _____ Phone _____ - _____

EAAA-117P

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(04/02/2014)

NUTRITIONAL HEALTH

Participant's Name _____ Date _____

Address _____ City _____ County _____

The following is required **ANNUALLY FOR ALL** Family Café Meal and HDM participants and once for all **NEW** In-Home Respite, and All Day Club participants.

Send this completed form to the Egyptian Area Agency on Aging.

Read the statements below. Circle the number under the column for answer that applies. Total the nutritional risk score at the bottom.

Nutritional Health Statement - Circle "Yes," "No," or check "No Answer."	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 take 3 or more different prescribed or over-the-counter drugs a day.	1	0
3. I have tooth or mouth problems that make it hard for me to eat.	2	0
4. Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2	0
5. I am not always physically able to shop, cook, and/or feed myself.	2	0
6. I eat fewer than 2 meals a day.	3	0
7. I don't always have enough money to buy the food I need.	4	0
8. I eat few fruits & vegetables or milk products.	2	0
9. I eat alone most of the time.	1	0
10. I have 3 or more drinks of beer, liquor, or wine almost every day.	2	0
TOTAL (0-21)		

Total Nutritional Score

Meaning of the score

0 - 2

Good! Recheck your nutritional score annually.

3 - 5

Moderate nutritional risk – See what can be done to improve eating habits and lifestyle. We recommend rechecking your nutritional score in 3-6 months.

6+

High nutritional risk – Show a copy of this form the next time you see your doctor, dietician, or other qualified health professional. Talk with them about any health problems you may have. Ask them for help to improve your nutritional health score.

Remember that warning signs suggest risk, but do not represent diagnosis of any condition.

INSTRUCTIONS FOR NAPIS REGISTRATION FORM**General Instructions**

- A. NAPIS, which stands for National Aging Program Information System. Registration is required for all new participants, caregivers, and older adults raising children under age 18 that receive congregate or home delivered meals, In-Home Respite, and / or Adult Day Services.
- B. Get information directly from participants when possible. Let them know that you need this information for reporting purposes only. Make sure they understand that their individual answers will NOT be revealed to anyone else, but are combined with other participants for state reports.
- C. Fill out NAPIS forms completely. Ask the participants to assist you in filling out these forms, if possible. It is important for NAPIS forms to be filled out completely.
- D. Please, write LEGIBLY!
- E. We need information on everyone. Fill out a separate form for a spouse or eligible dependent.
- F. Indicate if someone refuses to answer a question by writing "refused" by it. DON'T leave lines blank (or boxes unchecked) without an explanation.
- G. Send completed forms monthly to the Egyptian Area Agency on Aging, 200 E. Plaza Dr., Carterville, IL 62918.
- H. Call the Egyptian Area Agency if you need clarification at 1-888-895-3306.

NAPIS Registration Form Instructions

Register participants, caregivers of older people, and older people caring for children who use or receive congregate meals, home delivered meals, III-E In-Home Respite, and III-E Adult Day Services, III-E Info & assistance, and/or III-E Outreach. Also, indicate if they receive Transportation, III-B I&A, or III-B Outreach services. If the participant has received only Transportation, Title III-B I&A, or III-B Outreach, DO NOT register them or send us this form.

1. Date, Update, & 1-Time Visitor – Indicate the date the participant started or when you completed this form. If this is an update of previous information sent to the Egyptian AAA, indicate by marking "Yes." Indicate whether the individual is a 1-time visitor.
2. Name, Middle Initial, Address, City, State, County, & Zip – Please fill out this information on the form completely and clearly as it helps us to find duplicate names. Please list the county where the participant received service if they are not from Southern Illinois.
3. Phone & Birth date or Age – List the telephone number of the individual and his/her date of birth (preferred) or age.
4. Hispanic & Race – Indicate whether participant is Hispanic. Indicate one or more races, including "Other Race," if needed. Individuals may self declare their race(s).
5. Gender, Number in Household, & Low income – Indicate the participant's gender, the number in the household, and if they have low income (see poverty guidelines released in March of each year).
6. Services – Check the box or boxes to the right of every service that is provided to this senior adult and/or caregiver.
7. Caregiver – Mark *yes or no* whether this individual (of any age) is the caregiver to an older person. If yes, indicate the care receiver's name and county, whether the care receiver has been registered in NAPIS (required), and the relationship of caregiver to the care receiver.
8. Older person raising a child or children – Mark yes or no whether this older person is raising a child or children, the number of children (age 0 to 18) and disabled adults (age 19-59) in their care, and the relationship to the children or disabled adults.
9. Emergency Contact – Indicate the participant's emergency contact. Please include complete home and work phone numbers. The Egyptian AAA uses this information for disaster planning purposes.

Continue if not a caregiver or older person raising children.

10. Activities of Daily Living (ADL's) & Instrumental Activities of Daily Living (IADL's) – This section must be completed for all clients who receive home delivered meals, III-E in-home respite care, and III-E adult day services. Clients must be asked if they have difficulty with any of the activities listed. Check either the "Yes" or "No" box. Check the "No" box if participant refuses to answer. Definitions for these activities start below.
11. Interviewer, Site, & Phone – Provide your name, site name (or town), and telephone number in case we need to contact you. Please provide this information on all forms as we will file these forms and we may need to refer to them later.

Continue with the Nutritional Health form if received congregate meals or HDM.

General Instructions for ADL and IADL Impairments

Even if the participant can perform most essential components of the activities listed below, with or without an assistive device, if some impairment of function remains such that the participant requires some supervision or physical assistance to accomplish some or all components of the activity, indicate an impairment by checking the 'Yes' box. Check the 'No' box if there is no impairment or you are not sure.

Impairment includes participants who:

- Experience minor, intermittent fatigue in performing the activity; or
- Take longer to accomplish task(s) than an unimpaired person requires; or
- Must perform the activity more frequently than an unimpaired person.

ADL Impairments

1. Eating – Is the participant able to feed himself/herself? Consider the participant's ability to feed him or herself a meal without frequent spills, regardless if adapted table utensils are needed. Consider the ability to chew, swallow, cut food into manageable sized pieces, and to chew and swallow hot and cold foods / beverages.
2. Dressing – Is the participant able to dress and undress as necessary to carry out other activities of daily living? Consider the participant in terms of appropriate dress for weather or street attire as needed. Also, consider the ability to put on prostheses or assistive devices.
3. Bathing – Is the participant able to shower, bathe, or take sponge baths to maintain adequate hygiene?
4. Incontinence – Is the participant able to take care of bladder/bowel functions without difficulty? Consider the participant's ability to take care of bladder/bowel functions by reaching the bathroom or other appropriate facility in a timely manner. Consider need for reminders.
5. Transferring – Is the participant able to get into and out of bed or other usual sleeping place? Consider the participant's ability to reach assistive devices and appliances necessary to ambulate, and the ability to transfer (from/to) between bed and wheelchair, walker, etc. Do not consider putting on prostheses or assistive devices as these considered in dressing.
6. Grooming – Is the participant able to take care of his/her personal appearance? Only consider shaving, nail care, hair care, and dental hygiene.

IADL Impairments

1. Preparing meals – Is the participant able to prepare hot and/or cold meals that are nutritionally balanced or therapeutic, as necessary, which the participant can eat? Consider the participant's ability to prepare foodstuffs, to open containers and to use kitchen appliances. Do not consider the ability to plan therapeutic or prescribed meals or kitchen cleanup (included under housework below).
2. Being left alone – Can the participant be left without supervision? Consider the participant's ability to be left alone and to recognize, avoid, and respond to danger and/or emergencies. Include the participant's ability to evacuate the premises or alert others to the participant's need for assistance.
3. Managing Medications – Is the participant able to follow the directions of doctors, nurses, or therapists, as needed, for routine healthcare? Consider the participant's ability to manipulate equipment in the

performance of routine healthcare. Include simple dressings, special diet planning, monitoring of symptoms and vital signs, taking medications, following medication instructions. Do not consider the absence of routine healthcare as IADL impairment.

4. Managing money / paying bills – Is the participant able to manage money and determine which bills to pay? Consider the participant's ability to plan, budget, write checks or money orders, exchange currency, and handle paperwork and coins. Include ability to read, write and count sufficiently to perform the activity.
5. Using telephone – Is the participant able to use the telephone to communicate essential needs? The participant must be able to use the phone to: answer, dial, articulate, and comprehend. If the participant uses special adaptive telephone equipment, consider the participant based on the ability to perform this activity with that equipment. Do not consider the absence of a telephone in the participant's home as IADL impairment for this item.
6. Heavy housework – Is the participant able to do heavy housework? Consider the participant's ability to do "deep, down" type cleaning, such as washing windows, cleaning basements, etc. Do not include the refusal to do tasks if refusal is unrelated to the impairment..
7. Light / routine housework – Is the participant able to do light, routine housework? Consider the participant's ability to sweep, scrub, and vacuum floors. Consider washing and drying dishes, dusting, cleaning up spills, and cleaning sinks, toilets, bathtubs, and laundry. Minimum hygiene conditions for participant's health and safety are required. Do not include the refusal to do tasks if refusal is unrelated to the impairment.
8. Getting to places outside the home – Can the participant use transportation easily? Consider the participant's ability to drive, or be driven by someone else with no escort assistance from the driver, or to use public transportation, if available. The availability of transportation or ability to pay for transportation should not be considered as IADL impairment for this item.

End of Instructions for NAPIS