Michigan National Aging Program Information System (NAPIS)
Client Registration / Enrollment Form

(CONFIDENTIAL INFORMATION)

SECTION 1: Client Contact and Demographic Information

Intake Date	Client Registration Type ☐ Care Recipient ☐ Caregiver/Kinship Caregiver	Date of Birth

First Name	Middle Initial	Last Name

Street Address

City	State	Zip code

Mailing Address (if different)

County of Residence	Township of Residence
Telephone ( ) —	**Email**

Gender:
- ☐ Male
- ☐ Female
- ☐ Other
- ☐ Prefer not to say
- ☐ No response/Unknown

Do you consider yourself to be transgender or gender non-conforming?
- ☐ Yes
- ☐ No
- ☐ No response/Unknown

Sexual Orientation:
- ☐ Straight/Heterosexual
- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Other
- ☐ Prefer not to say
- ☐ No response/Unknown

Do you live alone?
- ☐ Yes
- ☐ No
- ☐ No response/Unknown

Household size:
- ☐ Two people in household
- ☐ Three people in household
- ☐ Four or more people in household
- ☐ No response/Unknown

Income at or below poverty:
- ☐ Yes
- ☐ No
- ☐ No response/Unknown

Race, check all that apply:
- ☐ Black/African American ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ White ☐ No response/Unknown

Multi-Racial?
- ☐ Yes
- ☐ No
- ☐ No response/Unknown

Ethnicity:
- ☐ Hispanic
- ☐ Not Hispanic
- ☐ No response/Unknown

Do you speak a language other than English at home? ☐ Yes ☐ No ☐ No response/Unknown

If you speak a language other than English at home:

What is the language?

How well do you speak English? ☐ Very well ☐ Well ☐ Not well ☐ Not at all ☐ No response/Unknown

Have you ever served in any branch of the U.S. Armed Forces, including the Reserves or National Guard?
- ☐ Yes
- ☐ No
- ☐ No response/Unknown

How did you hear about this program?
- ☐ Newspaper ☐ Television ☐ Brochure
- ☐ Website ☐ Friend ☐ Agency
- ☐ Physician ☐ Health Care Provider
- ☐ Other ☐ No response/Unknown

SECTION 2: Nutrition Risk Screen

DETERMINE Your Nutritional Health

(2) ☐ I have an illness or condition that made me change the kind and/or amount of food I eat.
(3) ☐ I eat fewer than 2 meals per day.
(2) ☐ I eat few fruits or vegetables, or milk products.
(2) ☐ I have 3 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.
(4) ☐ I don't always have enough money to buy the food I need.
(1) ☐ I eat along most of the time.
(1) ☐ I take 3 or more different prescribed or over-the-counter drugs a day.
(2) ☐ Without wanting to, I have lost or gained 10 pounds in the last 6 months.
(2) ☐ I am not always physically able to shop, cook and/or feed myself.

Nutritional Risk Score: Total score for all items checked.	**High Nutritional Risk (score of 6 or more)?** ☐ Yes ☐ No ☐ No response/Unknown

SECTION 3: Limitations of Activities of Daily Living and Instrumental Activities of Daily Living

Client requires assistance with the following activities:

Activities of Daily Living (ADLs)

☐ No assistance with ADLs required

☐ **Eating/Feeding**
☐ **Dressing**
☐ **Bathing**
☐ Walking
☐ Stair Climbing
☐ Bed Mobility
☐ **Toileting**
☐ **Continence**
  ☐ Bladder Function
  ☐ Bowel Function
☐ Wheeling
☐ **Transferring**
☐ Mobility Level

☐ No response/Unknown

Instrumental Activities of Daily Living (IADLs)

☐ No assistance with IADLs required

☐ **Shopping**
☐ **Handling Finances**
☐ **Housekeeping**
  ☐ Heavy Cleaning
  ☐ Light Cleaning
☐ **Mode of Transportation**
  ☐ Using Public Transportation
  ☐ Using Private Transportation
☐ **Food Preparation**
  ☐ Cooking Meals
  ☐ Reheating Meals
☐ **Taking Medication**
☐ **Using Telephone**
☐ **Doing Laundry**
☐ Keeping Appointments
☐ Heating Home

☐ No response/Unknown

A limitation is defined as unable to perform the activity without substantial assistance (including verbal reminding, physical cuing, or supervision).

SECTION 4: Caregivers of Older Adults

1. Caregiver relationship to care recipient:

☐ Husband ☐ Wife ☐ Domestic partner/civil union ☐ Brother ☐ Sister ☐ Son
☐ Daughter ☐ Son-in-Law ☐ Daughter-in-Law ☐ Other Relative ☐ Non-Relative
☐ No response/Unknown

2. Care recipient date of birth:

Does the care recipient need assistance with completing two or more activities of daily living?

☐ Yes
☐ No
☐ No response/Unknown

3. Does the care recipient have a cognitive impairment?

☐ Yes
☐ No
☐ No response/Unknown

4. How long has the caregiver been providing care to this care recipient?

☐ 0-6 months ☐ 7-12 months ☐ 13-36 months ☐ 37+ months
☐ No response/Unknown

5. How long does it take to get to the care recipient's home?

☐ 0 hours (lives with care recipient) ☐ Less than 1 hour ☐ 1-2 hours ☐ More than 3 hours
☐ No response/Unknown

6. Caregiver provides care to the care recipient:

☐ Daily ☐ Several times a week ☐ Weekly ☐ Less than one day per week ☐ Monthly
☐ Occasionally ☐ No response/Unknown

7. Does the caregiver provide hands on care to the care recipient?

☐ Yes
☐ No
☐ No response/Unknown

8. If hands on care is provided, how much:

☐ Less than 1 hour ☐ 1-3 hours ☐ More than 3 hours ☐ No response/Unknown

9. If hands on care is provided, how frequently:

☐ Per day ☐ Per week ☐ Per month ☐ No response/Unknown

10. Caregiver is employed:

☐ Full time ☐ Part time ☐ Not employed ☐ No response/Unknown

11. Caregiver's health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ No response/Unknown

12. The caregiver provides care to (how many) care recipients?

SECTION 5: Older Relative (Kinship) Caregivers

1. Caregiver relationship to care recipient:

☐ Grandparent ☐ Parent ☐ Other Relative ☐ Non-Relative ☐ No response/Unknown

2. Total children (under 18 years) receiving care:

3. Total adults with disabilities (18-59 years) receiving care:

SECTION 6: Care Transition Coordination & Support

Discharge Date:

Reducing Readmission for The Same Diagnosis

1. Was the participant readmitted to a medical care institution within 30 days?

☐ Yes ☐ No

2. Was the participant readmitted to a medical care institution for the same diagnosis within 30 days?

☐ Yes ☐ No

3. If yes, what factors contributed to the readmission?

☐ Discharged too early
☐ Non compliant with medications
☐ Misunderstanding of medication changes
☐ Unwilling to change lifestyle
☐ New diagnosis
☐ Did not see primary care physician in a timely manner
☐ Other (please describe): _____

4. If the participant was readmitted for the same diagnosis, how did the Area Agency on Aging follow up?

Provide readmittance diagnosis

☐ Hyperglycemia
☐ Congestive Heart Failure
☐ Pneumonia
☐ Atrial fibrillation
☐ Shortness of breath
☐ Chronic Obstructive Lung Disease
☐ Other (please describe): _____

5. Type of medical institution

☐ Hospital ☐ Nursing facility ☐ Clinic ☐ Other (please describe): _____

Medication Management

6. Was a medication review of current and new medications completed with health professional?

☐ Yes
☐ No

Primary Care Follow Up

7. Did the participant follow up with their primary care physician within 7 days?

☐ Yes
☐ No

8. If no, what were the barriers that contributed to the inability to follow up within 7 days?

☐ No appointments available
☐ Transportation
☐ Unwilling to see primary care physician before specialist
☐ Unwilling to move previously scheduled appointment
☐ Other (please describe): _____

SECTION 6: Care Transition Coordination & Support

Service Arrangement: What long term supports and services (LTSS) were:

Service	9. Recommended to Participant	10. Accepted by Participant	11. Received by Participant
Adult Day Services	☐	☐	☐
Assistance to Hearing Impaired & Deaf Community	☐	☐	☐
Assistive Devices & Technologies	☐	☐	☐
Care Management	☐	☐	☐
Caregiver Education	☐	☐	☐
Caregiver Support Groups	☐	☐	☐
Caregiver Training	☐	☐	☐
Case Coordination & Support	☐	☐	☐
Chore Services	☐	☐	☐
Congregate Meals	☐	☐	☐
Counseling	☐	☐	☐
Health Promotion Services	☐	☐	☐
Friendly Reassurance	☐	☐	☐
Home-Delivered Meals	☐	☐	☐
Home Injury Control	☐	☐	☐
Home Repair	☐	☐	☐
Homemaker	☐	☐	☐
Respite Care	☐	☐	☐
Information & Assistance	☐	☐	☐
Kinship Support Services	☐	☐	☐
Legal Assistance	☐	☐	☐
Medication Management	☐	☐	☐
Nutrition Counseling	☐	☐	☐
Nutrition Education	☐	☐	☐
Options Counseling	☐	☐	☐
Personal Care	☐	☐	☐
Transportation	☐	☐	☐
Vision Services	☐	☐	☐
Other (please describe):_____	☐	☐	☐

Transportation

12. Was medical transportation needed?	13. Was medical transportation provided?
☐ Yes ☐ No	☐ Yes ☐ No

Accessible Housing

14. Did the participant request durable medical equipment?	15. Were there barriers to receiving durable medical equipment?
☐ Yes ☐ No	☐ Yes ☐ No

Comments:

SECTION 7: Instructions for Form Completion
(Internal Use Only)

Instructions:
NAPIS client enrollment/registration information should be collected and reported for any client (care recipient or caregiver) receiving registered services funded in whole or in part with Older Americans Act (OAA) and/or Older Michiganians Act (OMA) funding. Check the registered services in the table below for which the client is being enrolled and complete the required sections of the form.

- All registered services require completion of 'SECTION 1: Client Contact and Demographic Information'
- The following supplemental information, sections 2-6, are completed for the services as indicated in the table below.
  - SECTION 2: Nutrition Risk Screen
  - SECTION 3: Limitations of Activities of Daily Living and Instrumental Activities of Daily Living
  - SECTION 4: Caregivers of Older Adults
  - SECTION 5: Older Relative (Kinship) Caregivers
  - SECTION 6: Care Transition Coordination & Support

Older Adult Services
Client Type = 'Care Recipient'

Complete sections 1, 2, 3
- ☐ Care Management
- ☐ Case Coordination & Support
- ☐ Carry-Out Meals
  (Registered in NAPIS under 'Home-Delivered Meals')
- ☐ Home-Delivered Meals
- ☐ Supplemental Nutrition Services—Food
- ☐ Supplemental Nutrition Services—Oral Nutrition Supplements (ONS)

Complete sections 1, 3
- ☐ Chore Services
- ☐ Home Health Aide
- ☐ Homemaker
- ☐ Personal Care

Complete sections 1, 3, 6
- ☐ Care Transition Coordination & Support

Complete sections 1, 2
- ☐ Congregate Meals
- ☐ Nutrition Counseling

Caregivers of Older Adults Services
Client Type = 'Caregiver'

Complete sections 1, 4
- ☐ Caregiver Case Management
- ☐ Caregiver Counseling
- ☐ Caregiver Supplemental—Assistive Devices & Technologies
- ☐ Caregiver Supplemental—Other
- ☐ Caregiver Supplemental—Transportation
- ☐ Caregiver Supplemental—Nutrition (Non-NSIP)
- ☐ Caregiver Training
- ☐ Home-Delivered Meals—Respite Care
- ☐ Adult Day Services
- ☐ Respite Care—In-Home Respite
- ☐ Respite Care—Out-of-Home (Day)
- ☐ Respite Care—Out-of-Home (Overnight)

Older Relative (Kinship) Caregiver Services
Client Type = 'Caregiver'

Complete sections 1, 5
- ☐ Kinship Caregiver Case Management
- ☐ Kinship Caregiver Counseling
- ☐ Kinship Caregiver Respite Care
- ☐ Kinship Caregiver Supplemental—Other
- ☐ Kinship Caregiver Training

Area Agency on Aging	**Vendor Name / Vendor ID / NAPIS Site ID**