

Please complete all sections on both sides.
All information is confidential.

Today's Date _____

First name: _____

Middle Initial: _____

Last Name: _____

Nickname _____

Gender: Male Female

Date of Birth: ____/____/19____

E-mail Address:

Home Phone #: _____ - _____ - _____

Cell Phone #: _____ - _____ - _____

Residential Address including zip code:

Mailing Address: (if different)

Do you live in the Town of Union?

Yes No

County of Residence:

Last 4 digits of Social Security Number

____ - ____ - ____ - ____

Are you Frail? Are you Disabled?

Yes No Yes No

Please mark your primary race with P and
check all others that apply.

- ___ American Indian/Alaskan Native
- ___ Asian
- ___ Black/African American
- ___ Native Hawaiian/Pacific Islander
- ___ White
- ___ Other

Are you Hispanic or Latino?

Yes No

Are you a Veteran? Yes No

Spouse of a Veteran? Yes No

Are you currently

- ___ Divorced
- ___ Married
- ___ Never Married
- ___ Separated
- ___ Widowed
- ___ A Domestic Partner



Highest Grade or Education completed:

Who do you live with?

- ___ Alone
- ___ Spouse Only
- ___ Relatives
- ___ Non Relatives
- ___ Significant Other

Do you speak, read and write English?

Yes No

2014		
Please circle the one income range that best describes your estimated household monthly income.		
I live alone	I live with one other person	I live with two other people
\$0 to 973	\$0 to 1,311	\$0 to 1,649
\$974 to 1,458	\$1,312 to 1,965	\$1,650 to 2,473
\$1,459+	\$1,966+	\$2474+

Transportation

Check here if you would like staff to copy this form and send it to BC Transit to allow you to make reservations for the Office for Aging Mini-bus.

*** Please remember to call the Office for Aging if your phone number, address, or emergency contact information change.**



Over

This is the National Nutrition Screen.
Please check "Y" for yes and "N" for no.

- Y__ N__ You have an illness or condition that has made you change the kind or amount of food you eat.
- Y__ N__ You eat fewer than 2 meals per day.
- Y__ N__ You eat few fruits, vegetables, or milk products per day.
- Y__ N__ You have tooth or mouth problems that make it hard for you to eat.
- Y__ N__ You sometimes do not have enough money to buy the food you need.
- Y__ N__ You eat alone most of the time.
- Y__ N__ You take 3 or more different prescribed or over the counter drugs per day.
- Y__ N__ Without wanting to have you lost or gained 10 pounds in the past 6 months.
- Y__ N__ You are not always physically able to shop, cook and/or feed yourself.
- Y__ N__ You have 3 or more drinks of beer, liquor, or wine almost every day.

Please check any activities that you have needed help with in the past 7 days.

- Bathing
- Walking
- Transferring in and out of bed
- Dressing
- Personal Hygiene
- Toileting
- Eating
- Shopping
- Transportation
- Light housekeeping (laundry)
- Heavy housework
- Meal Preparation
- Managing money and bills
- Using the telephone
- Managing medications

Emergency Contact Information

Please provide a local emergency contact.

Name _____

Home phone _____ - _____ - _____

Cell Phone _____ - _____ - _____

Address _____

In case of a medical emergency at a senior center which hospital would you prefer?

Hospital _____

Physician _____

Phone _____

Please return this to the
Broome County Office for Aging
Edwin L. Crawford County Building
PO Box 1766
Binghamton, NY 13902-1766

Broome County Office for Aging

Free ID Card Application



Staff Use Only

Proof of Age Checked _____

Staff Signature _____

Entered _____ Emergency to sr. center _____

Card Issued _____ Initial _____

