



State of New York County of Broome Government Offices

Office for Aging

Jason T. Garnar, County Executive · Mary E. Turbush, Director

Dear Broome County Resident:

Thank you for your interest in the Office for Aging ID Card. Enclosed is the form for an Office for Aging ID Card. To fill out the form, please do the following:

- **Complete all questions:** It is important to complete all sections, including the National Nutrition Screen, as funding sources require the Office for Aging to collect this information. All information you provide is confidential and will never be reported individually.
- **List a local emergency contact** with working telephone numbers in the appropriate section on the application.
- **Provide a copy of an ID with your date of birth:** It is acceptable to send in your old Office for Aging ID card as proof of age.
- **Complete and sign the enclosed Consent Form:** This form gives the Office for Aging permission to place this information in our statewide database. Please note that if you do not return the signed consent form, we cannot send you a card.

Once we received your completed OFA ID Card application and consent form, your new OFA ID card will be created, laminated, and mailed to you or your senior center for pick up per your request.

Depending on your age, you will receive one of these three OFA ID cards:

- **The yellow ID card** is for people age 65+ and it can be used for the OFA Mini-Bus, discounted fares on the BC Transit fixed route and BC Country buses. It can also be used to demonstrate eligibility to participate in senior centers' programs and activities.
- **The blue ID card** is for people ages 60 to 64 and can be used for the OFA Mini-Bus and to receive discounted rates on the BC Country buses. It can also be used to demonstrate eligibility to participate in senior centers' programs and activities.
- **The tan ID card** is for people under 60 who are married to someone age 60 and older. This card demonstrates eligibility to participate in senior centers' programs and activities.

If you have any questions, please call 607-778-2411.

Thank you,
The staff of the Office for Aging

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Please complete all sections on both sides and sign your consent form. All information is confidential.

Today's Date: _____

First Name: _____

Middle Initial: _____

Last Name: _____

Nickname: _____

Gender: ☐ Male ☐ Female ☐ Other

Date of Birth: ____/____/19____

Residential Address with ZIP code:

Mailing Address: (if different)

Home Phone #: ____-____-____

Cell Phone #: ____-____-____

Work Phone #: ____-____-____

Email: _____

County of Residence:

1. You are currently....

- ☐ Divorced
☐ A Domestic Partner/Significant Other
☐ Married
☐ Separated
☐ Single
☐ Widowed

2. Are you Frail? Are you Disabled?

☐ No ☐ Yes ☐ No ☐ Yes

3. Are you a Veteran? ☐ No ☐ Yes

4. Who do you live with?

- ☐ Alone
☐ Child (ren)
☐ Domestic Partner Only
☐ Non-Relative Community Based
☐ Non-Relative Facility/Institution
☐ Others not Listed
☐ Parent/Guardian
☐ Domestic Partner & Others
☐ Non-Relative(s)
☐ Relative(s) without Spouse
☐ Spouse
☐ Spouse & Others

5. Please check all that may apply to you:

- ☐ Can't read English
☐ Can't speak English
☐ Can't Understand English

6. What is your Primary Language?

7. Please select your Race.

(check all that apply)

- ☐ American Indian/Alaskan Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian/Pacific Islander
☐ White Hispanic
☐ White Not Hispanic

8. Are you Hispanic or Latino?

☐ No ☐ Yes

2025		
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 \$1,304	\$0 to \$1,763	\$0 to \$2,221
\$1,305 to \$1,630	\$1,764 to \$2,203	\$2,222 to \$2,776
\$1,631 to \$1,956	\$2,204 to \$2,644	\$2,777 to \$3,331
\$1,957 to \$2,413	\$2,645 to \$3,261	\$3,332 to \$4,109
\$2,414+	\$3,262+	\$4,110+

Emergency Contact Information

Please provide a local emergency contact.

Last Name _____

First Name _____ MI _____

Relationship to you _____

Residential Address

Home phone ____-____-____

Cell Phone ____-____-____

Work Phone ____-____-____

Must complete other side.

Please sign and initial enclosed consent form.

What kind of health insurance do you have? Please check all that apply.

☐ Medicaid ☐ Medicare

☐ Other _____

Transportation – OFA Mini-Bus

☐ Check here if you would like a copy of this form sent to BC Transit so that you can make reservations for the Office for Aging Mini-Bus.

Are you registered to vote?

☐ Yes ☐ No

If **No**, would you like to register?

☐ Yes ☐ No

If you selected **yes**, we will mail you a voter registration form.

Senior Center Staff Use Only

Proof of Age Checked _____

Staff Signature _____

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

N	Y	I have illness or condition that has made me change the kind or amount of food I eat.
N	Y	I eat fewer than 2 meals per day.
N	Y	I eat few fruits, vegetables, or milk products per day.
N	Y	I have 3 or more drinks of beer, liquor, or wine almost every day.
N	Y	I have tooth or mouth problems that make it hard for me to eat.
N	Y	I don't always have enough money to buy the food I need.
N	Y	I eat alone most of the time.
N	Y	I take 3 or more different prescribed or over the counter drugs per day.
N	Y	Without wanting to, I have lost or gained 10 pounds in the past 6 months.
N	Y	I am not always physically able to shop, cook, and/or feed myself.

Please return your completed form with the signed and initialed consent form to the following office:

Broome County Office for Aging
Edwin L. Crawford County Building
PO Box 1766
Binghamton, NY 13902-1766

Broome County Office for Aging

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Please remember to call the Office for Aging at 778-2411 if your phone number, address, or emergency contact information change.



I.D. CARD
Broome County Office Building
Binghamton, NY 13902
(607) 778-2411

www.gobroomecounty.com/senior

Free ID Card Form

Easy access to a variety of programs and services

607-778-2411

gobroomecounty.com/senior



Find us on Facebook.



Please initial each section that applies and sign at the end. Worker must complete attestation.

Informed Consent to Collect and Record Personal Information

I consent to the Broome County Office for Aging saving personal information provided by me or my authorized representative in the Client Data System maintained by the New York State Office for the Aging (NYSOFA). Saving my information like this allows other agencies that use the Client Data System to see my information if a referral is made, but this will only happen with my permission.

I understand that this information is being collected to help in providing services under the State Office for the Aging and local Offices for the Aging. It also helps to identify other services that I may need. I understand that this information is needed in order for some services to be provided. The authority to provide these services and to collect my information for these purposes is found in the Older Americans Act and the New York State Elder Law.

I understand that, per New York State's Personal Privacy Protection Law, my personal information will be kept confidential. It will not be shared without my permission.

I understand what information will be recorded, the need for the information, and that there are laws and regulations protecting my information.

I understand that signing this authorization is voluntary, but that refusal to do so may limit options available to me.

Initial _____

Informed Consent to Refer and Share Personal Information

I request and consent to the release by Broome County Office for Aging of all requested records, including but not limited to, personal information, health information, and any other information concerning me that I have provided to Broome County Office for Aging to the following entities so they can make referrals for services that I may need, or for the purposes identified as follows:

☐ **Broome County Transit for reservations and rides on the OFA Mini-Bus**

I understand what information will be released, the need for the information, and that there are laws and regulations protecting the confidentiality of this information.

I understand that signing this authorization is voluntary, but that refusal to do so may limit options available to me.

I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and in such an event may no longer be protected by federal or state law.

Initial _____

Informed Consent to Share Certain Information in the event of a Disaster or Emergency

In the event of a disaster or emergency, I consent to the release of information about services I receive, my housing situation and who I live with, medical equipment or services needed daily, prescription medications taken daily, special dietary needs, special communication needs, blindness or other visual impairments, and information about my general condition and mobility.

I understand that this information will only be given to those who will use it to respond to an emergency, such as government agencies, law enforcement, or those acting on their behalf if there is a disaster or emergency situation.

I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and in such an event may no longer be protected by federal or state law.

Initial _____

I consent to actions above where I have initialed. The authorizations provided shall not expire unless revoked.

Signature of individual or legal representative

Date

Individual's name (Print)

Individual's Address

If legal representative, provide name and relationship to individual

~~~~~FOR OFFICE USE ONLY~~~~~

**ATTESTATION**

*To be completed by worker*

I attest that informed consent, as indicated, was obtained from the above individual, who provided his/her signature above. All appropriate processes were followed, and consent was provided voluntarily.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Print*