

Encore Experiences at Harleysville

Please Fill Out Both Front and Back

First Name and Middle Initial :

Last Name :

Birth Date :

****Required****

Telephone :

Street Address :

City / State / Zip :

County :

Municipality :

Email :

Social Security # : Last Four Digits ONLY XXX-XX-__ __ __ __

****Required****

_____ **(INITIAL)** I understand that while participating in programs offered at Encore Experiences at Harleysville, individual or group photographs may be taken. I agree that photographs taken of me during such activities may be used for promotional purposes.

Ethnicity : Please Circle One	American Indian Native Alaskan Black - African American Native Hawaiian	Other Pacific Islander White Hispanic Other _____
Household : Please Circle One	Lives Alone Lives With Spouse Lives With Child	Lives With Other Family Member Other
Marital Status : Please Circle One	Married Widowed Legally Separated	Divorced Single

Gender : Male / Female

Veteran : Yes / No

Head of Household : Yes / No

Primary Language :

Please turn over and complete the back side of this application. Thank You!

Please fill out this section. It is very important for us to be able to contact someone in case of an emergency.

Disabilities :

Emergency Contact :

Emergency Contact Relation :

Emergency Telephone Numbers :
Work: _____
Home: _____
Cell: _____
Other: _____

Doctors Name :

Doctors Telephone :

How Did You Hear About Us:

Courier Insert
Newspaper
Community Calendar
Telephone Book
Website
Friend / Relative
Other

Signature :

Date :

Congregate Meal Participant Section

Have you had changes in the kind or amount of food eaten?	Yes	No
Do you eat fewer than 2 meals per day?	Yes	No
Do you eat less than 5 servings of fruit and vegetables per day?	Yes	No
Do you eat less than 2 servings of dairy products per day?	Yes	No
Do you have more than 3 alcoholic beverages per day?	Yes	No
Do tooth or mouth problems make it hard to eat?	Yes	No
Do you sometimes not have enough money to buy food?	Yes	No
Do you eat alone most of the time?	Yes	No
Do you take more than 3 prescribed or over the counter medications per day?	Yes	No
Have you lost or gained 10 pounds in the last 6 months?	Yes	No
Are you not always physically able to shop, cook, or feed yourself?	Yes	No
Would there be someone to help you shop, cook, or eat if you needed help?	Yes	No