Thank you for your interest in RSS—Center for Ageless Living, formally known as Riverdale Senior Services, Inc.

Here is our new member application packet. It is important for RSS to have the name, address, phone number, date of birth and signature for everyone participating in our programs or receiving services from our center. Some of the other information on the application is required for statistical purposes. If you do not want to provide the information on your doctor, medications or emergency contact, please make a note of that by writing refused in the applicable place.

Kindly read, initial where applicable and sign the Consent to Collect Data form.

Please note in order to be a member of RSS, you must be 60 years of age or older and live in the five boroughs of NYC.

Information regarding our programs and events can be found on our website rssny.org.

Thank you in advance for completing the application and I welcome you to RSS!

If you have any questions regarding the application, please do not hesitate in contacting RSS at 718-884-5900.

RSS
CENTER FOR AGELESS LIVING
2600 Netherland Avenue, Bronx, NY 10463
(718) 884-5900 | rssny.org

New York City Department for the Aging

Last Name: _____ First Name: _____

Address: _____ Apt. Number: _____

City: _____ State: _____

Zip: Home Phone: _____

RSC CENTER FOR AGELESS LIVING Program ID #C61

Cell Phone: _____

Consent to Collect Data

Date Consent Provided to Collect Data: _____

I consent to having personal information provided by me or my legal representative entered into the Client Data System maintained by the New York City Department for the Aging. I understand what information will be recorded, why this information is needed, and that there are laws and regulations protecting my personal health and identifying information.

I understand that this information is being collected to help in providing services, including services funded through the New York City Department for the Aging. It also helps identify other services that I may qualify for. I understand that this information is needed in order for some services to be provided.

I understand that signing this authorization is voluntary and can be revoked at any time. If I refuse to sign this authorization, the above named service provider will not be able to help by making referrals for me. Information can be given to me to follow-up on my own.

Client Initial: _____

Consent to Share Emergency Preparedness Information

Date of Emergency Preparedness Consent: _____

In the event of an emergency, I consent to the release of my information contained in the Emergency Preparedness Form and have received a copy of this form. I understand that my basic demographics and social history are a part of my Emergency Preparedness information.

I understand that my information will be shared only with persons authorized to respond in an emergency, such as government agencies, law enforcement, or those acting on their behalf.

Client Initial: _____

I consent to the collection and sharing of my information as initialed above. This authorization shall not expire unless revoked by me or my legal representative.

Signature of Individual or Legal Representative

Date

Individual's Name (Print)

Legal Representative's Name (Print)

☐ Power of Attorney (POA)
☐ Guardianship

Please describe the relationship between the legal representative and the client:

FOR OFFICE USE ONLY

ATTESTATION (*To be completed by the 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

Worker's Name (Print)

Worker's Title (Print)

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PARTICIPANT REGISTRATION **DATE**_____

NAME:_____ DATE OF BIRTH_____

ADDRESS_____ CITY_____STATE_____ZIPCODE:_____

PHONE#_____ CELLNUMBER_____EMAIL ADDRESS:_____

GENDER ___MALE ___FEMALE U.S. VETERAN ___YES ___NO___ LIVES ALONE; YES_____NO____

HOUSEHOLD INCOME: ____ UNDER $11,670 ___$ 11,670-15,730 ___$15,731-17,504 ___$17,505-19,790 ___$19,791-23,596

____$23,596-23,850 ___$23,851-27,910 __$27,911-29,685 ___$29,686-31970___$31,971+ _____REFUSE

FRAIL/HANDICAPPED____YES ____NO **PRIMARYLANGUAGE:** _____

NUMBER IN HOUSEHOLD (INCLUDE YOURSELF) _____ **ETHNICITY:** _____HISPANIC _____NON-HISPANIC

RACE:____WHITE-NON-HISPANIC ___WHITE-HISPANIC ____AMERICAN INDIAN/ALASKAN NATIVE ___ASIAN

____BLACK OR AFRICAN AMERICAN ____ NATIVE HAWAIIAN OR PACIFIC ISLANDER

MARITAL STATUS ____MARRIED _____WIDOWED _____DIVORCED _____SINGLE_____NEVER MARRIED

YOUR PRIMARY PHYSICIAN INFORMATION

NAME:_____HOSPITAL AFFILATION:_____

PHONE (1)_____ PHONE (2)_____

ADDRESS _____

EMERGENCY CONTACT INFORMATION:FAMILY MEMBER/FRIED/AIDE-PLEASE INDICATE UNDER RELATION

NAME_____RELATION:_____

PHONE#_____CELLNUMBER_____EMAIL ADDRESS:_____

ADDRESS _____

MEDICATIONS: NAME, DOSE/FREQUENCY AND REASON

NAME	*DOSE/FREQ*	*REASON*

DECLARATION OF AGE

I declare that I am at least 60 years of age. I understand that this declaration is required by the New York City Department for the Aging in lieu of proof of age.

It ensures that I meet the eligibility requirements for programs and services provided by the senior center under contract with the Department for the Aging.

SIGNATURE:_____**DATE:**_____

IF SIGNED ON-LINE, IT WILL BE CONSIDERED YOUR SIGNATURE.

DETERMINE YOUR NUTRITIONAL NEEDS

YOUR NAME _____

READ THE STATEMENTS. PLEASE CHECK *YES* OR *NO*

1	*I have an illness/ condition that made me change the kind and/or amount of food I eat.*	O YES	O NO
2	*I eat fewer than two meals per day.*	O YES	O NO
3	*I eat few fruits or vegetables, or milk products.*	O YES	O NO
4	*I have 3 or more drinks of beer, liquor or wine almost every day*	O YES	O NO
5	*I have tooth or mouth problems that make it hard for me to eat.*	O YES	O NO
6	*I don't always have enough money to buy the food I need.*	O YES	O NO
7	*I eat alone most of the time.*	O YES	O NO
8	*I take three or more different prescribed or over- the-counter drugs a day.*	O YES	O NO
9	*Without wanting to, I lost or gained 10 pounds in the last six months.*	O YES	O NO
10	*I am not always physically able to shop, cook and/or to feed myself.*	O YES	O NO

Are you a registered voter: *Yes* _____ *No*_____

We would like to send you notifications on upcoming programs and services.

*Can you provide your Email? EMAIL ADDRESS IS:*_____

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To the best of my knowledge I do not have a medical condition that would prohibit me from participation in the Exercise/Dance Classes at RSS. I will seek the advice of my physician should I have concerns.

I acknowledge that any type of exercise has a risk of injury and the level at which I participate will be at my own pace. I will take responsibility for my own self and will alert the instructor or staff at RSS should I experience any untoward health symptom during class. I take full responsibility for my participation and will not hold *RSS (Riverdale Senior Services)* responsible.

_____

PRINT NAME

_____

SIGNATURE DATE

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DECLARATION OF AGE

I declare that I am at least 60 years of age.

I understand that this declaration is required by the New York City Department for the Aging in lieu of proof of age.

It ensures that I meet the eligibility requirements for programs, meals, and services provided by the older adult center under contract with the Department for the Aging.

Client's Signature _____ Date_____

Staff's Signature _____ Date_____

Witness (if appropriate) _____ Date _____

RELEASE OF PHOTO AUTHORIZATION

I authorize RSS to take my pictures for promotional purposes. RSS can use them within the agency or provide them to the media.

Client's Signature _____ Date_____

Staff Member's Signature _____ Date_____

Witness (if appropriate) _____ Date _____

Name:
Date:

Emergency Preparedness	
Risk Factors	**Responses (Please answer the majority of questions with Yes or No)**
REMINDER: Shelters require that pet owners have documentation verifying that all vaccinations are current.	
NYC Hurricane Zone	
Age	
Lives With	
Special Communication Needs	
Primary Language	
Oxygen Dependent	
Dialysis	
Insulin Dependent	
Lives in an elevator building	
Floor Number	
Wheelchair Dependent	
Uses a walker or cane	
Respirator	
Has a working air conditioner	
Uses the air conditioner	
History of heat insufficiency	
Lives in a private home and has someone to shovel snow from the sidewalk	
In a weather emergency, can get out and has food in the home	
Has someone to assist them in an emergency	