RIVERDALE SENIOR SERVICES
(PARTLY FUNDED BY NYC AGING)
CENTER FOR AGELESS LIVING

2600 Netherland Avenue, Bronx, NY 10463 | (718) 884-5900 | rssny.org

New Member Application Packet

Riverdale Senior Services, Inc. | Center for Ageless Living

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

This packet collects information needed for participation in programs and services, including name, address, phone number, date of birth, emergency information, required consents, and signature pages.

Some information is requested for statistical and service-planning purposes. If you do not wish to provide doctor, medication, or emergency contact information, please write "Refused" in the applicable space.

Please read, initial where applicable, and sign the Consent to Collect Data form. To be a member of RSS, you must be 60 years of age or older and live in one of the five boroughs of New York City.

For questions, please contact RSS at 718-884-5900.

New York City Department for the Aging

MEMBER INFO

Last Name: ______________________________ First Name: ______________________________	Home Phone: ________________________ Cellphone: ________________________
Address: _________________________ Apt ____ City _____________ State _____ Zip _________	Email: ____________________________

APPLICATION CHECKLIST

☐ Consent to Collect Data initialed and dated	☐ Emergency Preparedness Consent initialed and dated
☐ Member application completed	☐ Declaration of Age signed
☐ Exercise/Dance waiver signed, if participating	☐ Photo Authorization completed
☐ Emergency Preparedness/Risk Factors completed	☐ Staff attestation completed, if applicable

FOR OFFICE USE

Date Received: ________________	Staff Initials: ________________	Member/Client ID: ________________
Program ID: #C61	Application Status: ☐ Complete ☐ Incomplete	Follow-up Needed: ________________

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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 signing this authorization is voluntary and can be revoked at any time. If I refuse to sign, RSS may 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 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: ________

Legal Representative Authorization

______________________________ Signature of Individual or Legal Representative	______________ Date
______________________________ Individual's Name (Print)	
______________________________ Legal Representative Name (Print)	☐ Power of Attorney (POA) ☐ Guardianship

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Relationship between legal representative and client:

FOR OFFICE USE ONLY

ATTESTATION (To be completed by the worker)

I attest that informed consent 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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Member Application

Date: _______________

Member/Client ID: ________________		Program ID: #C61
Name: ____		Date of Birth: ___________
Address: ________________________________	City: ________________ State:______	Zip: __________________
Phone #: ____________________________	Cell Number: ________________________	Email Address: ____________________________

DEMOGRAPHIC INFORMATION

Gender: ☐ Male ☐ Female ☐ Self-describe: _______________________	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 ☐ $29,686-31,970 ☐ $31,971+ ☐ Refuse	
Frail/Handicapped: ☐ Yes ☐ No	Primary Language: ____	Number in Household: __________________________
Ethnicity: ☐ Hispanic ☐ Non-Hispanic	Race: ☐ White-Non-Hispanic ☐ White-Hispanic ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander	
Marital Status:	☐ Married ☐ Widowed ☐ Divorced ☐ Single ☐ Never Married	

PRIMARY PHYSICIAN INFORMATION

Name: ____	Hospital Affiliation: _____________________________
Phone (1): ____	Phone (2): ___________________________________
Address: ____ City: ________________ State:______ Zip: _________________	

EMERGENCY CONTACT INFORMATION

Family Member / Friend / Aide (Please indicate under Relation)

Name: ____		Relation: ___________________________
Phone #: ______________________	Cell Number: ______________________	Email Address: ____
Address: ____ City: ________________ State:______ Zip: _________________		

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MEDICATIONS: NAME, DOSE/FREQUENCY AND REASON		
Name	**Dose/Frequency**	**Reason**
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________

Nutrition Screening Checklist

Name: ______________________

READ THE STATEMENTS. PLEASE CHECK YES or NO

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

VOTER REGISTRATION AND EMAIL NOTIFICATION		
Are you a registered voter?	☐ Yes	☐ No
Can you provide your email for program notifications? Email Address: ______________________________		

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Exercise/Dance Class Participation Waiver

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 myself 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: ______________

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 Member'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: ______________

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Emergency Preparedness / Risk Factors

Reminder: Shelters require that pet owners have documentation verifying that all vaccinations are current.

Risk Factor	Response / Details	Yes	No
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		☐	☐

STAFF REVIEW	
Reviewed By: ____________________	Date: __________
Notes:	