



# The Klamath Tribes Community Services Department Elder Program Application

Today's Date \_\_\_\_\_

**\*Director Approval/Date** \_\_\_\_\_

Name \_\_\_\_\_  
*Last First & nickname Middle Initial*

Physical Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

Phone # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Tribal Affiliation \_\_\_\_\_

Roll Number \_\_\_\_\_

Monthly Income Amount \$ \_\_\_\_\_

Source of Income \_\_\_\_\_

Single or  Couple

Are you disabled? . . . . .  YES  NO

Do you have a Chronic Illness? . . . . .  YES  NO

If yes, what is it? \_\_\_\_\_

Do you have a Caregiver? . . . . .  YES  NO

If yes, who is your Primary Caregiver \_\_\_\_\_

Are you a Caregiver? . . . . .  YES  NO

Are you interested in being a Volunteer? . . .  YES  NO

Would you like to be on the Elders Committee?  YES  NO

Answer **Yes** or **No** to the following questions.

YES  NO Do you have an illness or condition that changed the kind or amount of food you eat?

YES  NO Do you eat fewer than 2 meals a day?

YES  NO Do you eat few fruits, vegetables or milk products?

YES  NO Do you have 3 or more drinks of beer, wine, or liquor daily?

- YES     NO    Do you have a tooth or mouth problem that makes it hard to eat?
- YES     NO    Do you have enough money to buy food?
- YES     NO    Do you eat alone most of the time?
- YES     NO    Do you take 3 or more prescribed or over the counter drugs a day?
- YES     NO    Have you lost or gained 10 LBS. In the last 6 months, without wanting to?
- YES     NO    Are you physically unable to shop, cook or feed yourself?
- YES     NO    Are you currently receiving Commodities?

**Do you need help with any of the following activities? (Mark all that apply)**

<input type="checkbox"/> Bathing	<input type="checkbox"/> Incontinent	<input type="checkbox"/> Dressing
<input type="checkbox"/> Eating	<input type="checkbox"/> Food Preparation	<input type="checkbox"/> Housework
<input type="checkbox"/> Managing Finances	<input type="checkbox"/> Medication	<input type="checkbox"/> Personal Care
<input type="checkbox"/> Shopping	<input type="checkbox"/> Transportation	<input type="checkbox"/> Walking

**Mark all that apply.**

<u><b>Mobility</b></u>	<u><b>Ethnicity</b></u>	<u><b>Marital Status</b></u>	<u><b>Household Composition</b></u>
<input type="checkbox"/> Bathing	<input type="checkbox"/> Tribal Member	<input type="checkbox"/> Divorced	<input type="checkbox"/> Live alone
<input type="checkbox"/> Cane	<input type="checkbox"/> Other Tribe	<input type="checkbox"/> Married	<input type="checkbox"/> With Caregiver
<input type="checkbox"/> Walker	<input type="checkbox"/> Asian	<input type="checkbox"/> Separated	<input type="checkbox"/> With Child
<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Black	<input type="checkbox"/> Single	<input type="checkbox"/> With Spouse
<input type="checkbox"/> Other	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Widowed	<input type="checkbox"/> Other
	<input type="checkbox"/> Hispanic		

**Emergency Contact Person** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone** \_\_\_\_\_

**Relationship to Client** \_\_\_\_\_

**Client's Doctor** \_\_\_\_\_

**Doctor's Phone #** \_\_\_\_\_



	Name of Medicine	Number of Milligrams	How many times a day do you take this medication?	List medication side effects that you have
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				