CONFIDENTIAL INFORMATION

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Bureau of Aging, Community Living and Supports

NAPIS – NATIONAL AGING PROGRAM INFORMATION SYSTEM
Client Registration Application

Area Agency on Aging	Vendor ID No./Name*	Site ID No.
Form Date*	Client NAPIS ID No.	

PERSONAL IDENTIFYING INFORMATION

Intake Date*	Client Registration Type*		Date of Birth*
	Care Recipient ☐	Caregiver ☐	

First Name	Middle Initial	Last Name

Street Address

City	State	Zip code

Mailing Address (if different)

County of Residence	Township of Residence
Telephone	**E-mail**

Gender
○ Female ○ Male ○ Other ○ Prefer not to say ○ Unknown

Do you consider yourself to be transgender or gender non-conforming?
○ Yes ○ No ○ Unknown

Does client live alone?
○ Yes ○ No ○ Unknown

Client Sexual Orientation:
○ Straight/Heterosexual ○ Lesbian ○ Gay ○ Bisexual ○ Prefer not to say ○ Other ○ Unknown

Household Size
○ Two people ○ Three people ○ Four or more people

Ethnic Origin/Race
○ White ○ Black/African American ○ American Indian/Alaskan Native ○ Asian ○ Native Hawaiian/Other Pacific Islander ○ Unknown

Is the client Hispanic?
○ Yes ○ No ○ Unknown

Is client multi-racial?
○ Yes ○ No ○ Unknown

If client multi-racial (check all that apply):
○ White ○ Black/African American ○ American Indian/Alaskan Native ○ Asian ○ Native Hawaiian/Other Pacific Islander ○ Unknown

Is client below poverty?
○ Yes ○ No ○ Unknown

Does client a speak language other than English at home? If yes, enter language (see application instructions for list).
○ Yes ○ No ○ Unknown _____

How well does the client speak English?
○ Very well ○ Well ○ Not well ○ Not at all ○ Unknown

Has the client ever served on active duty in the U.S. Armed Forces, Reserves or National Guard?
○ Yes ○ No ○ Unknown

REGISTERED SERVICES

CARE RECIPIENT SERVICES Clusters 1 & 2			
Case Management	Start Date mm/dd/yyyy	Home Health Aide	Start Date mm/dd/yyyy
Case Coordination & Support	Start Date mm/dd/yyyy	Homemaker	Start Date mm/dd/yyyy
Chore Services	Start Date mm/dd/yyyy	Options Counseling	Start Date mm/dd/yyyy
Home Delivered Meals	Start Date mm/dd/yyyy	Personal Care	Start Date mm/dd/yyyy
Assisted Transportation	Start Date mm/dd/yyyy	Nutrition Counseling	Start Date mm/dd/yyyy
Congregate Meals	Start Date mm/dd/yyyy		
CAREGIVER SERVICES Cluster 4			
Adult Day Care	Start Date mm/dd/yyyy	Caregiver Counseling	Start Date mm/dd/yyyy
Caregiver Supplemental Service	Start Date mm/dd/yyyy	Caregiver Support Group	Start Date mm/dd/yyyy
Caregiver Training	Start Date mm/dd/yyyy	Chore Service – Respite	Start Date mm/dd/yyyy
Home Delivered Meals – Respite	Start Date mm/dd/yyyy	Home Health Aide – Respite	Start Date mm/dd/yyyy
Homemaker Respite	Start Date mm/dd/yyyy	In-Home Respite	Start Date mm/dd/yyyy
Kinship Respite	Start Date mm/dd/yyyy	Out of Home Respite	Start Date mm/dd/yyyy
Overnight Respite	Start Date mm/dd/yyyy	Personal Care Respite	Start Date mm/dd/yyyy
Volunteer Respite	Start Date mm/dd/yyyy		

CARE RECIPIENT AND CAREGIVER NON-REGISTERED SERVICES Clusters 3 & 5			
Client identifying information is not required in NAPIS for Clusters 3 and 5 services. No client registration is required. Unit and client counts are reported in the aggregate. The option to include client details in NAPIS is for area agency tracking only. For your record, enter date for start of service.			
Non-Registered Care Recipient			
Assistance Hear Impaired/Deaf	Start Date mm/dd/yyyy	Medicare Medicaid Assist/Prog	Start Date mm/dd/yyyy
Assistive Devices & Technology	Start Date mm/dd/yyyy	Legal Assistance	Start Date mm/dd/yyyy
Counseling	Start Date mm/dd/yyyy	Medication Management	Start Date mm/dd/yyyy
Disaster Advocacy & Outreach	Start Date mm/dd/yyyy	Nutrition Education	Start Date mm/dd/yyyy
Disease Prev/Health Promotion	Start Date mm/dd/yyyy	Ombudsman	Start Date mm/dd/yyyy
Elder Abuse Prevention	Start Date mm/dd/yyyy	Outreach	Start Date mm/dd/yyyy
Friendly Reassurance	Start Date mm/dd/yyyy	Senior Center Operations	Start Date mm/dd/yyyy
Health Screening	Start Date mm/dd/yyyy	Senior Center Staffing	Start Date mm/dd/yyyy
Home Injury Control	Start Date mm/dd/yyyy	Transportation	Start Date mm/dd/yyyy
Home Repair	Start Date mm/dd/yyyy	Vision Services	Start Date mm/dd/yyyy
Information & Assistance	Start Date mm/dd/yyyy		
Non-Registered Caregiver			
Caregiver Case Management	Start Date mm/dd/yyyy	Caregiver Transportation	Start Date mm/dd/yyyy
Caregiver Education	Start Date mm/dd/yyyy	Creating Confident Caregiver	Start Date mm/dd/yyyy
Caregiver Info & Assistance	Start Date mm/dd/yyyy	Home Injury Control	Start Date mm/dd/yyyy
Caregiver Outreach	Start Date mm/dd/yyyy		

NUTRITIONAL RISK INFORMATION

Nutritional Risk Assessment is required for HDM, Congregate Meals, Case Coordination, and Care Management.	Client at high risk: ○ Yes ○ No ○ Unknown	Nutritional Risk Score

Nutritional Risk Check *Nutritional Risk Score is required for Home-delivered Meals, Congregate Meals, Case Coordination, and Care Management. Circle the number in the 'yes' column for those that apply. Total the nutritional score. (Six or more, you are at high nutritional risk.)*		**YES**
1. Does care recipient have an illness or condition that made them change the kind and/or amount of food eaten?	**2**	☐
2. Does care recipient eat fewer than two meals per day?	**3**	☐
3. Does care recipient eat few fruits, vegetable, or milk products?	**2**	☐
4. Does care recipient have three or more drinks of beer, liquor or wine almost every day?	**2**	☐
5. Does care recipient have tooth or mouth problems that make it hard to eat?	**2**	☐
6. Does care recipient lack enough money to buy foods that they need?	**4**	☐
7. Does care recipient eat alone most of the time?	**1**	☐
8. Does care recipient take three or more different prescribed or over-the-counter drugs per day?	**1**	☐
9. Has care recipient lost or gained ten pounds in the last six months without wanting to?	**2**	☐
10. Is care recipient sometimes unable to physically shop, cook or feed self?	**2**	☐
	TOTAL	

DAILY LIVING ACTIVITIES

This information must be completed if client receives Cluster I services.

Activities of Daily Living (ADLs)	**Instrumental Activities of Daily Living (IADLs)**
Client requires assistance with the following ADLs:	*Client requires assistance with the following IADLs:*
☐ No ADLs ☐ All ☐ Eating/Feeding ☐ Dressing ☐ Bathing ☐ Walking ☐ Stair Climbing ☐ Bed Mobility ☐ Toileting ☐ Bladder Function ☐ Bowel Function ☐ Wheeling ☐ Transferring ☐ Mobility Level	☐ No IADLs ☐ All ☐ Shopping ☐ Handling Finances ☐ Heavy Cleaning ☐ Light Cleaning ☐ Using Public Transportation ☐ Using Private Transportation ☐ Cooking Meals ☐ Reheating Meals ☐ Taking Medication ☐ Using Telephone ☐ Doing Laundry ☐ Keeping Appointments ☐ Heating Home

CARE RECIPIENT STATUS

This information is requested for the person who is being cared for by a Caregiver. NAPIS does not require or capture the name of the individual who is being cared for. Only the date of birth is required for qualification purpose. For your record, you may enter the care recipient's name below.

Care Recipient Date of Birth	Care Recipient Name
1. Does the Care Recipient need assistance with completing two or more activities of daily living?	○ Yes ○ No ○ Unknown
2. Does the Care Recipient have a cognitive impairment? (i.e., Alzheimer's dementia, etc.)	○ Yes ○ No ○ Unknown

How did the Care Recipient hear about this program?

○ Newspaper ○ Television ○ Brochure ○ Friend ○ Agency
○ Web site ○ Physician ○ Health Care Provider ○ Other ○ Unknown

CAREGIVER HISTORY

How did the Caregiver hear about this program?

○ Newspaper ○ Television ○ Brochure ○ Friend ○ Agency
○ Web site ○ Physician ○ Health Care Provider ○ Other ○ Unknown

Caregiver relationship to Care Recipient (check all that apply):

○ Wife ○ Husband ○ Brother ○ Sister ○ Daughter ○ Son ○ Daughter-in-Law
○ Son-in-Law ○ Domestic partner/civil union ○ Parent ○ Grandparent ○ Other relative
○ Non-relative ○ Unknown

How long has the Caregiver provided care to the Care Recipient?

○ 0-6 months ○ 7-12 months ○ 13-36 months ○ 37+ months ○ Unknown

How long does it take to get to the Care Recipient's home?

○ Less than 1 hour ○ 1-2 hours ○ More than 3 hours ○ Caregiver lives with Care Recipient
○ Unknown

Caregiver provides care to the Care Recipient:

○ Daily ○ Several times a week ○ Weekly ○ Less than one day per week
○ Monthly ○ Occasionally ○ Unknown

Doe the Caregiver provide hands-on care to the Care Recipient?

○ Yes ○ No ○ Unknown

If Yes, hands-on care is provided, check the appropriate number of hours and frequency (e.g., 1-3 hours, per week).

○ Less than 1 hour ○ 1-3 hours ○ More than 3 hours ○ Unknown

○ Per Day ○ Per Week ○ Per Month ○ Unknown

Caregiver is employed:

○ Full time ○ Part time ○ Not employed ○ Unknown

Caregiver's health is:

○ Excellent ○ Good ○ Fair ○ Poor ○ Unknown

The caregiver provides care to (how many) care recipients? ☐

Is this a Kinship Respite Care family situation? If Yes, complete the Kinship Respite Care Child information section on next page.

○ Yes ○ No ○ Unknown

KINSHIP RESPITE CARE CHILD INFORMATION	
Older adult raising child(ren) no more than 18 years old **Total children receiving care:**	*Parent/caregiver of Individual with Disabilities* **Total persons with disabilities receiving care:**

Status of child(ren) in care (Check all that apply):

○ Informal ○ Adoption ○ Guardianship ○ Foster Care

○ Legal Custody ○ Unknown ○ Other _____

Are any of the child(ren)'s parents living with the Caregiver?

○ Yes ○ No ○ Unknown

Reason for Kinship Care

○ Abandonment ○ Divorce ○ Illness ○ Substance Abuse ○ Incarceration ○ Unemployment

○ Teen Pregnancy ○ Mental or emotional illness ○ Death ○ Unknown ○ Other _____

Special Needs:

○ Learning Disability ○ Emotional Impairment ○ Physical Handicap
○ Developmental Disability ○ Unknown

Notes

Signature and Confirmation

I understand that the information provided on this form is confidential and will be used for state and federal reporting requirements, program management, quality assurance, public safety and research. No other use of personal identifying information on this form is intended unless authorized by the Bureau of Aging, Community Living and Supports or by a court order. I understand that client information will not be permitted for review by any unauthorized persons. I understand that a client cannot be refused services based on willingness to provide information for NAPIS.

Signature	Print name of person completing the application
Agency Name	Date