ST. MARY'S DEPARTMENT OF AGING REGISTRATION FORM

FIRST NAME	MIDDLE NAME	LAST NAME	
NICK NAME	SSN	DATE OF BIRTH	SEX M ☐ F ☐
911 STREET ADDRESS		MAILING ADDRESS	
CITY	STATE	ZIP CODE	COUNTY

HOME PHONE # ( )

MARITAL STATUS MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SINGLE ☐ SEPARATED ☐

EMERGENCY CONTACT #	EMERGENCY CONTACT NAME	EM CT RELATIONSHIP
( )		

SPOUSE NAME	SPOUSE SSN	ETHNICITY Circle one
		Hispanic or Latino Not Hispanic or Latino

RACE WHITE ☐ 2 OR MORE RACES ☐ OTHER ☐ AFRICAN AMERICAN ☐
ASIAN ☐ HAWAIIAN/PACIFIC ISLANDER ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐

LIVING ARRANGEMENTS ☐ ALONE WITH SPOUSE/FRIEND ☐
WITH FAMILY/ADULT CHILD ☐ HIRED CAREGIVER/ASSISTED LIVING ☐
DISABLED ADULT CHILD ☐ REFUSED TO ANSWER ☐

MONTHLY INCOME	MEDICARE #	MEDICAID #	# IN HOUSEHOLD
$957.50 Single **Above / Below** **$1292.50 Couple** **Above / Below**			

DOCTOR NAME	DOCTOR PHONE #'S
	( ) ( )

REGISTERED VOTER
Please circle one
I AM REGISTERED **NO** I DECLINE **I** WANT TO REGISTER

NEWSLETTER
Do you want to receive
YES **NO**

SPECIAL ELIGIBILITY VOLUNTEER ☐ EMERGENCY ☐
SPOUSE OF CLIENT ☐ DISABLE UNDER 60 ☐

E-MAIL ADDRESS

CLIENT ☐ **CAREGIVER** ☐ **Who is care for/relationship?**

UNITED STATES MILITARY VETERAN
YES **NO**

Date: ____________________

STAFF SIGNATURE

5/22/2013