Dear Seniors,

NYS has reached the 70% vaccination rate!

The new Community Center is making progress but, in the meantime, there are a couple of things you can do to help get your Eastchester Senior Nutrition Center open this summer.

Before returning, all participants need to comply with the Westchester County program guidelines and update your documentation! Please see below:

- **Physicians Consent Form**
  - You must have your physician sign, stamp and fax this form to us before you can participate in any exercise class.

- **NAPIS Form**
  - You must drop off the completed form on or before your first day back for lunch. 
    
    Emergency Contact information and list of medications are typically the information that needs revision.

- **Additional Information**
  - Email address is the best way for you to receive the latest information.
    Send us a brief email to Seniors@eastchester.org including your name, address and phone number.
    Also include in this email if you are interested in any Zoom programing.

- The Town of Eastchester website will continue to post menus, activity calendars and updates.

**Early Morning Swim is back!**
August 9th up to Labor Day Weekend!

**Registration and Physicians Consent Form required.**
See the flyer included with this letter.

Looking forward to seeing you again,

Peter Basha
Nutrition Program Director
Town of Eastchester
BASIC DEMOGRAPHICS / SOCIAL HISTORY

Last Name: ___________________________ First Name: ___________________________

Gender: □ Female □ Male

Address: _____________________________ City: _____________________________ State: __________ Zip: __________

County: Westchester Rural: No □ Yes □ Tel: H:( ) Cel: ( )

Marital Status: Divorced □ Domestic Partner/Significant Other □ Married □ Single □ Separated □ Widowed □

Frail: No □ Yes □ Disabled: No □ Yes □ Veteran: No □ Yes □

Primary Language: ___________________________ Speaks □ Reads □ Understands Orally □

Client does not speak English as their primary language and has ONLY a limited ability to read, speak, write or understand English: No □ Yes □

Lives With: Alone □ Children □ Domestic Partner Only □ Non-Relatives in a community based setting □
Non-Relatives in a facility/institution or group setting □ Others Not listed □ Parent/Guardian □
With Domestic Partner & Others □ With Non-Relatives □ With Relatives (excludes spouse) □
With Spouse □ With Spouse and Others □

Race: Two or more races □ American Indian/Native Alaskan □ Asian □ Black/African American □
White, not Hispanic □ Native Hawaiian/Other Pacific Islander □ White Hispanic □

Ethnicity: Hispanic or Latino □ Not-Hispanic or Latino □

FINANCIAL:

Monthly Income (MUST ANSWER ALL FOUR QUESTIONS):

1. Is the Client's income below national poverty level (see Guidelines Below)? No □ Yes □
2. Is the Client's income 100% of the national poverty level (see Guidelines Below)? No □ Yes □
3. Is the Client's income 150% of the national poverty level (see Guidelines Below)? No □ Yes □
4. Is the Client's income 185% of the national poverty level (see Guidelines Below)? No □ Yes □

2021 Annual Poverty Guidelines

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Below 100%</th>
<th>Btw 100 - 124%</th>
<th>Btw 125 - 149%</th>
<th>Btw 150 - 184%</th>
<th>185% &amp; Above</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$12,880</td>
<td>$12,881-$16,099</td>
<td>$16,100-$19,319</td>
<td>$19,320-$23,827</td>
<td>$23,828</td>
</tr>
<tr>
<td>2</td>
<td>$17,420</td>
<td>$17,421-$21,774</td>
<td>$21,775-$26,129</td>
<td>$26,130-$32,226</td>
<td>$32,227</td>
</tr>
<tr>
<td>3</td>
<td>$21,960</td>
<td>$21,961-$27,449</td>
<td>$27,450-$32,939</td>
<td>$32,940-$40,625</td>
<td>$40,526</td>
</tr>
</tbody>
</table>

Low Income Minority: No □ Yes □

# of people in household: ______

Medical (In PeerPlace: Enter the information below in "Medical Comments" of the Medical Coverage section.)

Medical Conditions: ____________________________________________________________

Are you taking any prescribd medicine? Yes □ No □

Please List Medications _________________________________________________________

Are you allergic to any medication? Yes □ No □ If Yes, specify below: ________________

Please select the diet that best suits your needs: Regular/No Added Salt □ Heart Healthy □ Diabetic □

Other: Please Specify: _________________________________________________________

Do you have a food allergy? Yes □ No □ If Yes, specify below: __________________________

__________________________________________
CONTACTS

| Primary Name: | | Relationship: |
|--------------|--------------|
| Home Tel: ( ) - | Cell Phone ( ) - | Work Phone: ( ) - |
| | | |

| Secondary Name: | | Relationship: |
|----------------|--------------|
| Home Tel: ( ) - | Cell Phone: ( ) - | Work Phone: ( ) - |
| | | |

<table>
<thead>
<tr>
<th>Physician:</th>
<th>Facility:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>City/State/Zip:</td>
</tr>
<tr>
<td>Tel: ( )</td>
<td>Fax: ( )</td>
</tr>
</tbody>
</table>

**NSI Scale (In PeerPlace: Enter in “Encounter History / Client Registration” section.)**

Please answer the following Nutrition screening questions. Total all the “Yes” responses and add up score; review the nutritional health results below.

1. Do you have an illness or condition that made you change the kind and/or amount of food eaten? (i.e. Answer “YES” if you have a condition such as diabetes, high blood pressure, high cholesterol or kidney disease)
   - No ○ Yes ○ 2

2. Do you eat fewer than 2 meals per day?
   - No ○ Yes ○ 3

3. Do you eat few fruits or vegetables or milk products per day? (Fruits/Veg: Answer YES if you eat LESS than 5 servings each day. 1 serving = 1 cup of raw vegetables, 1 medium fruit, 1/2 cup canned fruit or cooked vegetables) (Milk Portions: Answer Yes if you drink/eat LESS than 2 cups of milk or yogurt, cottage cheese or 2 ounces of sliced cheese daily)
   - No ○ Yes ○ 2

4. Do you have trouble eating due to problems with teeth/mouth?
   - No ○ Yes ○ 2

5. Do you sometimes have problems buying food because of income?
   - No ○ Yes ○ 2

6. Do you eat alone most of the time?
   - No ○ Yes ○ 4

7. Do you take 3 or more different prescribed or OTC drugs daily?
   - No ○ Yes ○ 1

8. Without wanting to, have you lost or gained 10 pounds in the past 6 months?
   - No ○ Yes ○ 1

9. Are you not always physically able to shop, cook and/or feed yourself?
   - No ○ Yes ○ 2

10. Do you have 3 or more drinks of beer, liquor or wine daily?
    - No ○ Yes ○ 2

<table>
<thead>
<tr>
<th>CIRCLE NUTRITIONAL HEALTH SCALE RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 2</td>
</tr>
<tr>
<td>3 - 5</td>
</tr>
<tr>
<td>6 +</td>
</tr>
</tbody>
</table>

Do you require assistance with grocery shopping? Yes ○ No ○

**Services:** Congregate Meals □ Nutrition Education □ Transportation □ Nutrition Counseling □

I GIVE PERMISSION TO THE NUTRITION PROGRAM TO CONTACT MY PHYSICIAN OR OTHER MEDICAL PERSONNEL IN CASE OF AN EMERGENCY. THE DATA PROVIDED THROUGH THIS FORM WILL BE TREATED IN A CONFIDENTIAL MANNER.

**SIGNED:** ___________________________ **DATED:** _______________
Town of Eastchester
Senior Programs and Services
FAX 914-337-2584

PHYSICIAN: ____________________________

ADDRESS: ____________________________

PHONE: ______________________________

I give permission for ____________________________
to participate in all programs and activities of a physical nature at the Town of Eastchester Senior Centers including but not limited to walking, aquatics exercise, dancing, tai chi, zumba and yoga

________________________________________________________________________
PHYSICIAN’S SIGNATURE

________________________________________________________________________
PHYSICIAN’S STAMP

________________________________________________________________________
DATE

NAME OF PARTICIPANT: ____________________________

ADDRESS: ______________________________________

TELEPHONE: ________________________________
EARLY BIRD SWIM

WEEKDAYS 8:00 AM TO 9:30 AM
AUGUST 9th to September 3rd

OPEN TO SENIOR RESIDENTS AGE 60 AND OLDER
of
EASTCHESTER, BRONXVILLE AND TUCKAHOE
&
EASTCHESTER NUTRITION CENTER REGULAR MEMBERS

REGISTRATION REQUIRED
July 15th - 30th
9AM to Noon Weekdays
Mulino’s Lobby @ Lake Isle

CURRENT PHYSICIAN CONSENT FORM REQUIRED