

St. Anthony Senior Center
1703 West 10th Street
Wilmington, DE 19805

Required Forms & Acknowledgments

To ensure a safe, welcoming, and well-organized experience for all members, the following forms are required or may apply to participation at the St. Anthony Senior Center.

- **Membership & Intake Form:** This form collects basic contact information, emergency contact details, and optional health information to support member safety and communication. It also includes acknowledgments of the Senior Center's policies, Code of Conduct, hours of operation, and participation guidelines. Completion of this form is required for new and renewing members.
- **Acknowledgment of Policies & Code of Conduct:** This acknowledgment confirms that members have received and understand the Senior Center's policies and expectations, including behavior standards, facility use, and safety requirements. Signing this form helps maintain a respectful and supportive community environment.
- **Photography, Video & Social Media Consent:** This form allows the Senior Center to use photos or videos taken during programs and events for newsletters, social media, and promotional materials. Members may consent or opt out, and reasonable efforts will be made to honor opt-out requests.
- **Exercise & Physical Activity Waiver:** This waiver applies to participation in exercise classes, open gym use, and recreational activities. It outlines potential risks, clarifies that participation is voluntary, and confirms that the Senior Center does not provide medical supervision. Acknowledgment is required to participate in physical activity programs.
- **Congregate Nutrition Form:** This form is required for members who participate in the Senior Center's congregated meal program. It collects information needed to meet funding, reporting, and nutrition program requirements and must be completed prior to meal participation.

If you have questions or need assistance completing any forms, Senior Center staff are happy to help!

Acknowledgment of Policies & Code of Conduct

I acknowledge that I have received, read, and understand the Senior Center's policies, procedures, and Code of Conduct. I agree to comply with all rules, guidelines, and expectations outlined in this document, including but not limited to hours of operation, appropriate use of facilities, safety requirements, and standards of behavior.

I understand that these policies are in place to ensure the safety, comfort, and well-being of all members, visitors, and staff. I further understand that failure to comply with these policies may result in corrective action, including suspension or termination of membership, at the discretion of the Senior Center.

I acknowledge that Senior Center policies are subject to change and agree to abide by the most current version.

Participant Name (Print): _____

Participant Signature: _____

Date: _____

Photography, Video, & Social Media Policy

The Senior Center may occasionally take photographs or video recordings during programs, activities, and events for promotional, educational, and informational purposes. These images or recordings may be used in print materials, on the Senior Center's website, social media platforms, newsletters, grant reports, and other communications. Participation in Senior Center activities may result in incidental inclusion in photographs or videos taken in public or group settings. The Senior Center will not identify individuals by name without prior consent.

Opt-Out Option

Members and visitors who do not wish to be photographed or recorded must notify Senior Center staff and complete the opt-out section below. Reasonable efforts will be made to honor opt-out requests; however, complete exclusion from background or group images cannot be guaranteed.

Acknowledgment & Consent

By signing below, I acknowledge that I have read and understand the Senior Center's Photography, Video, and Social Media Policy. I understand that images may be used as described unless I have formally opted out.

☐ I **consent** to the use of my image and/or likeness as described above. _____

☐ I **opt out** of being photographed or recorded for promotional or social media purposes.

Name (Print): _____

Signature: _____

Date: _____

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Name (Print): _____

Signature: _____

Date: _____

St. Anthony Senior Center Membership Form

Date of Membership: _____ ☐ New ☐ Renewing

Last Name: _____

First Name: _____

Middle Initial: _____

Date of Birth: _____

Include my name in the newsletter of my birthday month: ☐ Yes ☐ No

Street Address: _____

City: _____

State: _____

Zip Code: _____

Preferred Language: _____

Home Phone: _____

Cell Phone: _____

Email (optional): _____

Emergency Contact Information

Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Health Information (Optional) – Emergency Use Only

The information requested below is voluntary and is collected solely to assist staff in the event of an emergency.

The Senior Center does not provide medical care, diagnosis, or treatment. This information will be accessed only by authorized staff and will not be shared except as necessary during an emergency.

Providing or declining to provide this information will not affect membership or participation in any programs or activities.

(next page)

Medical Conditions

Are there any medical conditions we should be aware of in an emergency?

☐ No

☐ Yes (optional – please describe):

☐ Prefer not to answer

Medications

Are you currently taking any medications that emergency personnel should be aware of?

☐ No

☐ Yes (optional – please list):

☐ Prefer not to answer

Physician Information

Physician's Name (optional): _____

Physician's Phone (optional): (____) _____

☐ Prefer not to answer

If you choose **not** to provide medical or medication information above, you may indicate whether you carry or store emergency medical information in another accessible location that emergency responders can reference if needed.

In the event of an emergency, is your medical or medication information available elsewhere?

☐ Yes (for example: wallet card, medical ID bracelet, phone emergency information, etc.)

☐ No

Congregate Nutrition Form

Meal Program Acknowledgment

I understand that participation in the congregate meal program requires completion of the OAAPS form and adherence to the meal reservation policy. I further understand that all meals, menus, and offerings are subject to change and that availability cannot be guaranteed without a reservation.

☐ I acknowledge and agree

Signature: _____ Date: _____

OAAPS form will be provided on the following pages.



Division of Services for Aging and Adults with Physical Disabilities

Congregate Nutrition Screening Tool

OAAPS COLLECTION					COLLECTION DATE: / /		
Client First	Client Last	DOB	Sex (M/F/Other /Unk)	Lives Alone (Y/N/Unk)	Below Poverty (Y/N/Unk)	Hispanic (Y/N)	Race Code(s)*

* Race Codes: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, White, and/or Other.

ADDITIONAL DEMOGRAPHIC COLLECTION														
Provider Name / Address	Provider:			Address:										
Client Physical Address														
Client Mailing Address (if different)														
Client Phone / Email	Phone:			Email:										
Preferred Method of Communication	<input type="checkbox"/> Phone			<input type="checkbox"/> Email		<input type="checkbox"/> Mail								
Referral Source/Contact (if applicable)	Name:			Relationship:		Phone:								
Regular Helper (family/neighbor/etc.)	Name:			Relationship:		Phone:								
Emergency Contact (if applicable)	Name:			Relationship:		Phone:								
Primary Language	<input type="checkbox"/> English		<input type="checkbox"/> Spanish		<input type="checkbox"/> Haitian Creole		<input type="checkbox"/> Chinese		<input type="checkbox"/> Other:					
Household Status	<input type="checkbox"/> Lives Alone			<input type="checkbox"/> Lives with Others			<input type="checkbox"/> Unknown							
Marital Status	<input type="checkbox"/> Never Married		<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		<input type="checkbox"/> Partner / Sig Other		<input type="checkbox"/> Widowed		<input type="checkbox"/> Unknown		<input type="checkbox"/> Declined to Disclose	
Veteran Status	<input type="checkbox"/> Yes		<input type="checkbox"/> No		<input type="checkbox"/> Spouse is Veteran			<input type="checkbox"/> Unknown		<input type="checkbox"/> Declined to Disclose				

SERVICE DETERMINATION(S)	
I. DETERMINE Your Nutritional Health Screening	
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits or vegetables or milk products.	2
I have 3 or more drinks of beer, liquor, or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2

I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 lbs. in the last 6 months.	2
I am not always physically able to shop, cook, and/or feed myself.	2
* Total DETERMINE Score	
<p>* An answer of "yes" = circle the # provided in scoring column. An answer of "no" = 0, do not circle.</p> <p>* Score Guide: 6+ = High Risk. Recommend a consultation with their Primary Care Provider and refer them for further Malnutrition Risk Screening and Nutritional Counseling by the Provider Site's Registered Dietitian (Nutritional Counseling).</p>	
II. Malnutrition Screening	
Have you lost weight recently without trying?	Y N
Have you been eating poorly because of decreased appetite?	Y N
* If answers "yes" to both questions, refer the client to the Provider Site's Registered Dietitian for further intervention (Nutrition Counseling).	
III. Food Insecurity	
"We worried whether our food would run out before we got money to buy more."	O S N
"In the past month, the food that we bought just didn't last, and we didn't have money to get more."	O S N
<p>* Read the 2 statements above and indicate if the client would state O = "often true," S = "sometimes true," or N = "never true."</p> <p>* If "often true" or "sometimes true" is selected, refer the client to: SNAP, food banks or pantries, or other community-based food assistance.</p>	
IV. <60 Recognized Spouse	Y N
V. <60 SSI Living in Home	Y N
VI. Eligible Spouse >60	Y N
VII. Does the client need transportation?	Y N
<p>* DSAAPD ADRC: Any participant who qualifies for Congregate, must be offered referral to DSAAPD's ADRC to be assessed for additional services (i.e. personal care, transportation, nursing care, etc.) under "Section XVIII." ADRC Phone #: 1-(800)-223-9074</p> <p>* GRAB-AND-GO: A participant whose score determines eligibility for "Congregate Nutrition," may be offered "Grab-and-Go Meals" under "Section VIII" so long as these meals do not exceed 25% of the total OAA Title III C1 funding expended per 11.3.1.2.1.2. Provide justification below under "Section VIII."</p>	

VIII. PROVIDER PERSONNEL COLLECTION		Referral(s) / Recommendation(s)
Notes/Justification:		<p>Check all that apply:</p> <p><input type="checkbox"/> Congregate Nutrition <input type="checkbox"/> Grab-And-Go Meals</p> <p><input type="checkbox"/> Nutritional Counseling <input type="checkbox"/> Consultation with their PCP</p> <p><input type="checkbox"/> Additional DSAAPD Services via the ADRC: 1-(800)-223-9074</p>
Provider Personnel Name:	Signature:	Date: / /
<p>* All contracted providers by DSAAPD are responsible for maintaining a complete record of completed "Congregate Nutrition Screening Eligibility Tools" for all active participants, as well as participants discontinued from services for a minimum period of three (3) years. These completed tools are to be made available to DSAAPD <i>upon request</i> for compliance auditing/monitoring purposes and submitted to DSAAPD's Registered Dietitian for review via DHSS_DSAAPD_SNP@delaware.gov.</p>		