



2025-26 Membership Application/Renewal

Dues are due April 1, 2025 for the year 4/1/2025-3/31/2026

Senior Center Kingsbury Fort Edward Area, Inc.
78 Oak Street, Hudson Falls, NY 12839 Phone: (518) 747-9352
Facebook: @seniorcenterkingsburyfortedward
maxmcdonnelyahoo.com
seniorcenterkfe.com



Do you participate in any of the following Washington County Nutrition Programs:

Restaurant Dining Program Community Events ("Pop-Ups")

Check all that apply: (Health Promotion)

Cardio Drumming Osteobusters

Silver Sneakers Monday Silver Sneakers Friday Silver Sneakers Yoga

(Rec & Ed) Art Class Bingo Knitting Pickleball

Pool League Other Tabletop Games Ukulele Club

Meals Transportation

Official Use

K/Ft Ed Senior Center

Date: _____

Initials: _____

N _____ R _____

NSI _____ Referral _____

New Member Returning Member

First Name _____ MI _____ Last Name _____

D/O/B _____ Phone _____ Circle Gender Female Male Other

Street _____ City _____ Zip _____

Mailing Address (if different from above) _____

Email _____

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

Please check all that apply:

White Black or African American Hispanic or Latino

American Indian or Alaska Native Native Hawaiian or Other Pacific Non Hispanic or Latino

Asian

How many people reside in your home including yourself?

Please tell us who you live with:

Alone Domestic Partner Only Non-Relative

Spouse Only Domestic Partner & Other(s) Relative (Not Spouse or Child(ren))

Spouse & Other(s) Child(ren) Others Not Listed



Income Range - Requested by the Administration on Aging

Please circle your approximate monthly income level (2025)

1-Person Household

Below \$1304

Below \$1630

Below \$1956

Below \$2412

2-Person Household

Below \$1762

Below \$2203

Below \$2643

Below \$3260

Are you a veteran? Yes No

Are you the spouse or child of a veteran? Yes No

Are you frail or disabled? Yes No

Emergency Contact Information

Name _____ Relationship _____

Home Phone _____ Cell Phone _____ Work Phone _____

Address _____

Primary Care Physician _____ Phone _____

Address _____

You may pay your member dues with cash or check. Please mail your completed form with check in the amount of \$15.00 made payable to:

Senior Center Kingsbury & Fort Edward Area, Inc
78 Oak Street
Hudson Falls, NY 12839

Our goal is to create an environment that meets the needs of our seniors. We look forward to seeing you often and hope that you take advantage of the many offerings that the Center has for you. If you have suggestions for possible programs or needs that you feel the Center could meet, please leave a comment below. Do you have a hobby or talent you would like to share or teach to your fellow seniors? Suggestions for restaurants to visit? Games to play? Let us know. We are continuously striving to evolve and do our best to meet the needs of our growing community of seniors.



Client must initial each section that applies and sign at the end. Worker must complete attestation.

Informed Consent to Collect and Record Personal Information

I consent to the Washington County Office for the Aging saving personal information provided by me or my authorized representative in the Client Data System maintained by the New York State Office for the Aging (NYSOFA). Saving my information like this allows other agencies that use the Client Data System to see my information if a referral is made, but this will only happen with my permission.

I understand that this information is being collected to help in providing services under the State Office for the Aging and local Offices for the Aging. It also helps to identify other services that I may need. I understand that this information is needed in order for some services to be provided. The authority to provide these services and to collect my information for these purposes is found in the Older Americans Act and the New York State Elder Law.

I understand that, per New York State's Personal Privacy Protection Law, my personal information will be kept confidential. It will not be shared without my permission.

I understand what information will be recorded, the need for the information, and that there are laws and regulations protecting my information.

I understand that signing this authorization is voluntary, but that refusal to do so may limit options available to me.

Client Initial _____

Informed Consent to Refer and Share Personal Information

I request and consent to the release by Washington County Office for the Aging of all requested records, including but not limited to, personal information, health information, and any other information concerning me that I have provided to Washington County Office for the Aging to the following entities so they can make referrals for services that I may need, or for the purposes identified as follows:

Nutritionist - Kristin Stewart RDN - Only if Nutrition Screening Score
is above 6 pts.

I understand what information will be released, the need for the information and that there are laws and regulations protecting the confidentiality of this information.

I understand that signing this authorization is voluntary, but that refusal to do so may limit options available to me.

I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and in such an event may no longer be protected by federal or state law.

Client Initial _____

Informed Consent to Share Certain Information in the event of a Disaster or Emergency

In the event of a disaster or emergency, I consent to the release of information about services I receive, my housing situation and who I live with, medical equipment or services needed daily, prescription medications taken daily, special dietary needs, special communication needs, blindness or other visual impairments, and information about my general condition and mobility.

I understand that this information will only be given to those who will use it to respond to an emergency, such as government agencies, law enforcement, or those acting on their behalf if there is a disaster or emergency situation.

I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and in such an event may no longer be protected by federal or state law.

Client Initial _____

I consent to actions above where I have initialed. The authorizations provided shall not expire unless revoked.

Signature of individual or legal representative

Date

Individual's name (Print)

If legal representative, provide name and relationship to individual

----- FOR OFFICE USE ONLY -----

ATTESTATION

To be completed by worker

I attest that informed consent, as indicated, was obtained from the above individual, who provided his/her signature above. All appropriate processes were followed, and consent was provided voluntarily.

Signature

Date

Print

Federal Nutritional Screening for OFA Nutrition Program Participants

		No	/ Yes
Do you have an illness/condition that has made you change the kind and/or the amount of food you eat? (2 pts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you eat fewer than 2 meals per day? (3 pts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you eat few fruits, vegetables, or milk product daily? (2 pts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have more than 3 drinks of beer, wine, or liquor daily or almost daily? (2 pts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have tooth or mouth problems that make it hard to eat? (2 pts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you sometimes not have enough money to buy food? (4 pts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you eat alone most of the time? (1 pt)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you take 3 or more different prescribed or over-the-counter drugs per day? (1 pt)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Without wanting to, have you gained/lost 10lbs or more in the past 6 months? (2 pts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you not always physically able to shop, cook, and/or feed yourself? (2 pts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Points in Yes Column _____

What does this score mean?

0-2 Good! Recheck in one year.

3-5 You are at moderate nutritional risk. See what you can do to improve eating habits and make lifestyle changes.

6+ You are at high nutritional risk. Our dietician will be calling you. You can also take this checklist to a doctor, dietician, or any qualified health profession and talk to them. Ask for definite ways to improve your health.

Signature: _____

Date: _____