



# Healthy Aging Association

## Young at Heart Registration Form

July 1, 2019 – June 30, 2020

- Strength Training
- Tai Chi
- Aerobics
- New Participant

**Class Location:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Telephone Number:** (209) \_\_\_\_\_

**Address:** \_\_\_\_\_ **Apt:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Number:** (\_\_\_\_) \_\_\_\_\_

**Relationship:** Spouse Partner Son/Daughter Friend/Neighbor Sibling Parents Other \_\_\_\_\_

The information being requested below is only for monitoring and auditing purposes, as required by grant funding, and is not intended for public dissemination.

**Please provide ALL information requested below.** Thank you for your cooperation.

1. **Age (circle one):** Under 50    50-59    60-64    65-69    70-79    80-89    90-99    100+

2. **What is your gender?**     Male     Female     Transgender     Declined to state

3. **What was your sex at birth?**     Male     Female     Declined to state

4. **How do you describe your sexual orientation or sexual identity?**  
 Straight/Heterosexual     Bisexual     Gay/Lesbian     Unsure     Declined to state

5. **Please check all that apply:**     Disabled     Veteran     Head of Household     None

6. **Do you receive income from any of the following sources?**  
 Food Stamps     General Assistance     Supplemental Security Income (SSI)     None

7. **Race:**    \_\_\_\_\_ African American    \_\_\_\_\_ American Indian/Alaskan Native    \_\_\_\_\_ Asian  
 \_\_\_\_\_ Hispanic Origin    \_\_\_\_\_ Native Hawaiian/Pacific Islander    \_\_\_\_\_ White    \_\_\_\_\_ Multi-Racial

8. **Select your insurance:**     Medicare     Medi-Cal     Both     Neither

a. **If you have HMO/Medicare Advantage Plan, which one do you have? (circle one)**  
 AARP/Secure Horizons    Alignment Health Plan    Anthem Blue Cross – CareMore Health  
 Kaiser Permanente Senior Advantage    Golden State    Health Net    Humana

9. **Please fill in the chart below (this must be completed to participate in the class)**

Directions: On the **same row** that has your household size, check your total annual household income.

Household Size	Total Annual Household Income			
	E.L.	V.L.	L	M
<b>1 Person</b>	<input type="checkbox"/> \$13,650 or less	<input type="checkbox"/> \$13,651 - \$22,700	<input type="checkbox"/> \$22,701 - \$36,300	<input type="checkbox"/> \$36,301 or more
<b>2 People</b>	<input type="checkbox"/> \$16,910 or less	<input type="checkbox"/> \$16,911 - \$25,950	<input type="checkbox"/> \$25,951 - \$41,500	<input type="checkbox"/> \$41,501 or more
<b>3 People</b>	<input type="checkbox"/> \$21,330 or less	<input type="checkbox"/> \$21,331 - \$29,200	<input type="checkbox"/> \$29,200 - \$46,700	<input type="checkbox"/> \$46,701 or more
<b>4 People</b>	<input type="checkbox"/> \$25,750 or less	<input type="checkbox"/> \$25,751 - \$32,400	<input type="checkbox"/> \$32,400 - \$51,850	<input type="checkbox"/> \$51,851 or more
<b>Other</b> _____	<b>Annual Income</b> _____			

**(REQUIRED) CONSENT TO PARTICIPATE IN YOUNG AT HEART: I hereby certify that the above information is true and correct.**  
 I, the undersigned, acknowledge that the Young at Heart class is an exercise class which may involve aerobic activity, resistance training for strength and mobility, as well as stretching and balance. Participation at a class location, with the cable show, or home video, is at my own risk. I understand that I should be seen by a physician before beginning any exercise program to ensure my participation is appropriate. I understand the facilities hosting the classes are doing so on a volunteer basis without compensation and participation at a class at any given location is of my own accord. I also grant full permission to the Healthy Aging Association to use my photograph in any publication or advertising materials. I agree that the Healthy Aging Association, their employees, and agents, shall not be responsible in any way for the content of news media coverage in which the photography authorized herein is used.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**All information is confidential!**    Participant ID Number: \_\_\_\_\_    Duplicate: Y | N    Verified by: \_\_\_\_\_