

All information is CONFIDENTIAL.

<p align="center">Congregate Meal Intake</p> <p>Please complete this form to the best of your ability. Items marked with asterisk (*) are required.</p> <p>* First Name: _____</p> <p>* Last Name: _____</p> <p>Middle Initial: _____</p> <p>* Date of Birth: ____/____/____</p>		<p align="center">"OFFICE USE ONLY"</p> <p>*Unique Participant ID: _____</p> <p>Referred by: _____</p> <p>Intake Date: _____</p> <p>Entered by: _____</p> <p>Beginning Date: _____</p> <p>*Termination Date: _____</p> <p>*Reason: _____</p>		<p align="center">"OFFICE USE ONLY"</p> <p>Eligibility:</p> <p><input type="checkbox"/> Age 60+</p> <p><input type="checkbox"/> Spouse of ENP Participant</p> <p><input type="checkbox"/> Disabled person residing where the congregate site is located</p> <p><input type="checkbox"/> Disabled person who resides with & accompanies an ENP participant</p> <p><input type="checkbox"/> Volunteer</p>	
<p>*Home Address: _____</p>		<p>*City: _____</p>		<p>*Zip Code: _____</p>	
<p>Mailing Address: Same As Residential? <input type="checkbox"/> Yes</p>		<p>City: _____</p>		<p>Zip Code: _____</p>	
<p>*Home Phone: () _____</p> <p>Alternate Phone: () _____</p>		<p>Emergency Contact Name: _____</p> <p>Phone: () _____ Relationship: _____</p>			
<p>*Living Arrangement</p> <p><input type="checkbox"/> Alone</p> <p><input type="checkbox"/> Lives with _____</p> <p><input type="checkbox"/> Decline to state</p>		<p>*What is your total monthly income?</p> <p><input type="checkbox"/> Less than \$1,255 / month for 1 person</p> <p><input type="checkbox"/> More than \$1,256 / month for 1 person</p> <p><input type="checkbox"/> Less than \$1,703 / month for 2 people</p> <p><input type="checkbox"/> More than \$1,704 / month for 2 people</p> <p><input type="checkbox"/> Decline to state</p>		<p>*Rural Area?</p> <p>X Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to state</p> <hr/> <p>*Veterans Status:</p> <p>Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Veteran Dependent <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Refer to VA Services? ** <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Decline to State <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p><small>**If you identify as military affiliated, check 'yes' if you consent to A12AA and the CDA transmitting your name and contact information to the Department of Veterans Affairs only for purpose of receiving info on veterans benefits. www.calvet.ca.gov or 1-800-952-5626</small></p>					

Nutritional Assessment

*Nutritional Assessment:	CIRCLE IF YES
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 pounds in the last 6 months.	2
I am not always physically able to shop, cook and/or feed myself.	2
Total	
<input type="checkbox"/> Decline to state (0-2: low risk; 3-5: moderate risk; 6 or more: high risk)	
Complete other side	

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*Ethnicity: (Check One) Hispanic/ Latino <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to state	Language: <input type="checkbox"/> English speaking <input type="checkbox"/> Need interpreter <input type="checkbox"/> Non-English / Language: _____
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*What is your gender? (Check one) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer / Gender Non-binary <input type="checkbox"/> Not listed, please specify: _____ <input type="checkbox"/> Decline to state	*What was your sex at birth? (Check one) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Decline to state	How do you describe your sexual orientation or sexual identity? (Check one) <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay / Lesbian / Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not listed, please specify: _____ <input type="checkbox"/> Decline to state
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*Race: (please check all that apply)				
<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Other Asian
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Filipino	<input type="checkbox"/> Japanese	<input type="checkbox"/> Korean	<input type="checkbox"/> Guamanian
<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Samoan	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Laotian	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Chinese	<input type="checkbox"/> Decline to state			

I understand that the information I am providing on this form is for registration purposes. I understand it will be kept confidential and the Area 12 Agency on Aging and Service Providers may use it to help identify other services for which I may benefit.

 Signature of participant or person completing the form

 Date