

***"All Information is Confidential"***

<b>Congregate Meal Intake Amador County Senior Center Jackson Site</b>		<b>"OFFICE USE ONLY"</b>		<b>"OFFICE USE ONLY"</b>					
Please complete this form to the best of your ability. Items marked with asterisk (*) are required.		*Unique Participant ID: _____ Referred by: _____ Intake Date: _____ Entered by: _____ Beginning Date: _____ *Termination Date: _____ *Reason: _____		Eligibility: <input type="checkbox"/> Age 60+ <input type="checkbox"/> Spouse of ENP Participant <input type="checkbox"/> Disabled person residing where the congregate site is located <input type="checkbox"/> Disabled person who resides with & accompanies an ENP participant <input type="checkbox"/> Volunteer					
* First Name: _____ * Last Name: _____ Middle Initial: _____ * Date of Birth: ____ / ____ / ____ Last 4 digits of Social Security # <table border="1" style="display: inline-table; width: 100px; height: 20px; vertical-align: middle;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> </tr> </table> <i>Optional</i>									
*Home Address: _____		*City: _____		*Zip Code: _____					
Mailing Address: Same As Residential? <input type="checkbox"/> Yes		City: _____		Zip Code: _____					
*Home Phone: (    ) Alternate Phone: (    )		Emergency Contact Name: _____ Phone: (    )                      Relationship: _____							
*Living Arrangement <input type="checkbox"/> Alone <input type="checkbox"/> Lives with _____ <input type="checkbox"/> Decline to state		*What is your total monthly income? <input type="checkbox"/> Less than \$1,063 per month for 1 person <input type="checkbox"/> More than \$1,063 per month for 1 person  <input type="checkbox"/> Less than \$1,437 per month for 2 people <input type="checkbox"/> More than \$1,437 per month for 2 people <input type="checkbox"/> Decline to state		*Rural Area? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to state <hr/> Are you a: Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse of Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No					

**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
<b>Total</b>	
<input type="checkbox"/> Decline to state	(0-2: low risk; 3-5: moderate risk; 6 or more: high risk)

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**Please Complete Other Side**

<b>*Ethnicity:</b> (Check One) Hispanic <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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<b>*What is your Gender?</b> (please check only 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	<b>*What was your sex at birth?</b> (please check only one) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Decline to state	<b>How do you describe your sexual orientation or sexual identity?</b> (please check only 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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<b>*Race:</b> (Please Check One) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Multiple Race <input type="checkbox"/> Other Race <input type="checkbox"/> Decline to state
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I understand that the information I am providing on this form is for registration purposes. I understand it will be kept confidential and that the Area 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