

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

<p align="center"><b>Congregate Meal Intake Amador County Senior Center Jackson Site</b></p> <p align="center">Please complete this form to the best of your ability. Items marked with asterisk (*) are required.</p>		<p align="center"><b>"OFFICE USE ONLY"</b></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"><b>"OFFICE USE ONLY"</b></p> <p>Eligibility: Age 60+ Spouse of ENP Participant Disabled person residing where the congregate site is located Disabled person who resides with &amp; accompanies an ENP participant Volunteer</p>	
<p>* <b>First Name:</b> _____</p> <p>* <b>Last Name:</b> _____</p> <p><b>Middle Initial:</b> _____</p> <p>* <b>Date of Birth:</b> ____/____/____</p> <p>Last 4 digits of Social Security # <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p><i>Optional</i></p>					
*Home Address: _____		*City: _____		*Zip Code: _____	
Mailing Address: Same As Residential? Yes		City: _____		Zip Code: _____	
*Home Phone: ( ) _____		Emergency Contact Name: _____			
Alternate Phone: ( ) _____		Phone: ( ) _____		Relationship: _____	
<p>*<b>Living Arrangement</b></p> <p>Alone _____</p> <p>Lives with _____</p> <p>Decline to state</p>		<p>*<b>What is your total monthly income?</b></p> <p>Less than \$1,073 per month for 1 person</p> <p>More than \$1,073 per month for 1 person</p> <p>Less than \$1,452 per month for 2 people</p> <p>More than \$1,452 per month for 2 people</p> <p>Decline to state</p>		<p>*<b>Rural Area?</b></p> <p>Yes                      No</p> <p>Decline to state</p> <hr/> <p>Are you a:</p> <p>Veteran                      Yes      No</p> <p>Spouse of Veteran      Yes      No</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
<b>Total</b>	
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/ Latino Yes No Decline to state	Language: English speaking Need interpreter Non-English / Language: _____
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<b>*What is your Gender?</b> (check only one) Male Female Transgender Female to Male Transgender Male to Female Genderqueer / Gender Non-binary Not listed, please specify: _____ Decline to state	<b>*What was your sex at birth?</b> (check only one) Male Female Decline to state	<b>How do you describe your sexual orientation or sexual identity?</b> (check only one) Straight/Heterosexual Bisexual Gay / Lesbian / Same-Gender Loving Questioning/Unsure Not listed, please specify: _____ Decline to state
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<b>*Race: (check all that apply)</b> White Cambodian Hawaiian Chinese Black Filipino Samoan Decline to state American Indian/Alaska Native Japanese Other Pacific Islander Asian Indian Korean Laotian Other Asian Guamanian Vietnamese
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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 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**