"All Information is Confidential"

Congregate Meal Intake
Amador Senior Center – Amador County

Please complete this form to the best of your ability.
Items marked with asterisk (*) are required.

"OFFICE USE ONLY"

***Unique Participant ID**:_____
Referred by:_____
Intake Date: _____
Entered by:_____
Beginning Date: _____
***Termination Date:** _____
***Reason**:_____

"OFFICE USE ONLY"

Eligibility:
- ☐ Age 60+
- ☐ Spouse of ENP Participant
- ☐ Disabled person residing where the congregate site is located
- ☐ Disabled person who resides with & accompanies an ENP participant
- ☐ Volunteer

*** First Name**:_____

*** Last Name:**_____

Middle Initial:_____

*** Date of Birth:** _____/_____/_____

Last 4 digits of Social Security # *Optional* | | | | |

***Home Address**:	***City**:	***Zip Code**:
Mailing Address: Same As Residential? ☐ Yes	City:	Zip Code:

***Home Phone**: ( )
Alternate Phone: ( )

Emergency Contact Name:
Phone: ( ) Relationship:

***Living Arrangement**
- ☐ Alone
- ☐ Lives with _____
- ☐ Decline to state

***What is your total monthly income?**
- ☐ Less than $1,133 per month for 1 person
- ☐ More than $1,134 per month for 1 person
- ☐ Less than $1,526 per month for 2 people
- ☐ More than $1,527 per month for 2 people
- ☐ Decline to state

***Rural Area?**
- ☐ Yes ☐ No
- ☐ Decline to state

Are you a:
Veteran ☐ Yes ☐ No
Spouse of Veteran ☐ Yes ☐ 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
Total	

☐ Decline to state (0-2: low risk; 3-5: moderate risk: 6 or more: high risk)

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Please Complete Other Side

***Ethnicity:** (Check One) Hispanic/ Latino ☐ Yes ☐ No ☐ Decline to state	Language: ☐ English speaking ☐ Need interpreter ☐ Non-English / Language: _____

***What is your Gender? (check only one)**	***What was your sex at birth? (check only one)**	**How do you describe your sexual orientation or sexual identity? (check only one)**
☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer / Gender Non-binary ☐ Not listed, please specify:_____ ☐ Decline to state	☐ Male ☐ Female ☐ Decline to state	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay / Lesbian / Same-Gender Loving ☐ Questioning/Unsure ☐ Not listed, please specify:_____ ☐ Decline to state

***Race**: **(check all that apply)**

☐ White	☐ Black	☐ American Indian/Alaska Native	☐ Asian Indian	☐ Other Asian
☐ Cambodian	☐ Filipino	☐ Japanese	☐ Korean	☐ Guamanian
☐ Hawaiian	☐ Samoan	☐ Other Pacific Islander	☐ Laotian	☐ Vietnamese
☐ Chinese	☐ 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 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**