INSERT LOGO HERE

Sign up today to enjoy wholesome meals with friends!

Today's Date: / /	**Preferred Phone: (** **)**	
First Name:	**Last Name:**	**MI:**
Date of Birth: / /	**Email:**	
Address:	**City:** **State:**	**Zip:**

The following data is asked by our funders and will not be disclosed by name.

Gender: ☐ Female ☐ Male ☐ Other | **Primary Language:** ☐ English ☐ Other:

Check the racial categories that apply to you:

☐ White ☐ Asian ☐African American/Black ☐ American Indian/Alaskan Native

☐ Native Hawaiian/Other Pacific Islander ☐ Other:

Are you Hispanic or Latino? ☐ Yes ☐ No | **Are you a veteran?** ☐ Yes ☐ No

Do you live alone? Yes No

If Yes, is your annual household income more than $13,590?	Yes	No
If No, is your annual household income more than:		
If 2 people, is your annual household income more than $18,310?	Yes	No
If 3 people, is your annual household income more than $23,030?	Yes	No
If 4 people, is your annual household income more than $27,750?	Yes	No
If 5 people, is your annual household income more than $32,470?	Yes	No
If 6 or more people, is your annual household income more than $37,190?	Yes	No

Are you interested in learning about any other services?

☐ Meals ☐ Transportation ☐ Nutrition Counseling ☐ Legal Assistance ☐ Caregiver Support

☐ Options to stay at home ☐ Options to return to home ☐ Health and Wellness Classes

Measure your Nutrition Risk!		
1. Have there been any changes in your eating habits because of health problems?	Yes	No
2. Do you eat less than 2 meals a day?	Yes	No
3. Do you eat few fruits, vegetables, or milk products?	Yes	No
4. Do you have 3 or more drinks of beer, wine, or liquor almost every day?	Yes	No
5. Do you have a tooth or mouth problem that makes it hard to eat?	Yes	No
6. Do you always have enough money to buy the food you need?	Yes	No
7. Do you eat alone most of the time?	Yes	No
8. Do you take 3 or more different prescribed or over-the-counter drugs a day?	Yes	No
9. Have you had unexpected weight gain or loss of 10+ pounds in the past 6 months?	Yes	No
10. Are there times your physically unable to shop, cook, or feed yourself?	Yes	No
11. In the past 30 days, have you worried about whether your food would run out before you got money to buy more?	Yes	No
12. In the past 30 days, did the food you buy just not last and you didn't have money to buy more?	Yes	No
13. Do you feel lonely sometimes or often?	Yes	No

Home Delivered Meal participants, continue to page 3 and 4.
All other service participants, stop here.

This section to be completed by staff.

Service Received:

- ☐ Congregate Nutrition
- ☐ Home Delivered Nutrition
- ☐ Health Promotion: Evidence Based
- ☐ Health Promotion: Non-Evidence Based
- ☐ Nutrition Counseling
- ☐ Nutrition Education

Help us serve you better by answering the following questions.

Do you need help with any of these?

	I didn't need help	I needed help sometimes	I always needed help	Activity did not occur
Shop				
Manage Medications				
Prepare Meals				
Use Transportation				

IADL Data Entry: Independent Sometimes dependent/limited assistance Totally dependent

	I don't need help	I need help sometimes	I always need help	Activity did not occur
Manage Money				
Complete Housekeeping				
Complete Laundry				
Use the Telephone				

IADL Data Entry: Independent Sometimes dependent/limited assistance Totally dependent

	I didn't need help	I needed help sometimes	I always needed help	Activity did not occur
Continence				
Bathe				
Dress				
Get out of bed or chair				
Use the toilet				
Eat				

IADL Data Entry: **I**ndependent Sometimes dependent/limited assistance Totally dependent

The following questions are for home delivered meals.

Please check one:

☐ Are you homebound by illness, incapacitating disability, and/or inadequate access to safe transportation?

OR

☐ Are you a spouse of a homebound eligible person?

How often do you require meals?

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Does Medicaid pay for some of your services like transportation, meals, organizing medications, case manager, or chores? ☐ Yes ☐ No

Emergency Contacts

Contact 1	Contact 2
Name:	Name:
Address:	Address:
Phone:	Phone:
Relationship:	Relationship:

(AAA may add additional questions here)