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 $12,880? ☐ Yes ☐ No

If No, is your annual household income more than:

If 2 people, is your annual household income more than $17,420? ☐ Yes ☐ No

If 3 people, is your annual household income more than $21,960? ☐ Yes ☐ No

If 4 people, is your annual household income more than $26,500? ☐ Yes ☐ No

If 5 people, is your annual household income more than $31,040? ☐ Yes ☐ No

If 6 or more people, is your annual household income more than $35,580? ☐ Yes ☐ No

Are you interested in learning about other services that you currently are not receiving?

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

☐ Options to stay at home ☐ Options to return to home ☐ Health & 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.

	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	☐	☐	☐	☐
Do Heavy Housework	☐	☐	☐	☐
Do Light Housework	☐	☐	☐	☐
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
Walk	☐	☐	☐	☐
Bathe	☐	☐	☐	☐
Dress	☐	☐	☐	☐
Get out of bed or	☐	☐	☐	☐
Use the toilet	☐	☐	☐	☐
Eat	☐	☐	☐	☐

IADL Data Entry: ☐ Independent ☐ 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)