

# FORM C-1

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|---|--|--|--|---|--|
| <b>Name of Congregate Meals Provider:</b><br><br><b>Site:</b><br>Please complete this form to the best of your ability.<br>Items Marked with asterisk (*) are required.   |  | <b>*Unique Participant ID:</b> _____<br>Referred by: _____<br>Intake Date: _____<br>Staff: _____<br>Beginning Date: _____<br><b>*Termination Date:</b> _____<br><b>*Reason:</b> _____  |  | Eligibility:<br><input type="checkbox"/> Age 60+<br><input type="checkbox"/> Spouse of ENP Participant<br>Disabled person residing where the congregate site is located<br>Disabled person who resides with and accompanies an ENP participant<br>Volunteer |  |
| Last 4 Digits Social Security #<br><i>Optional</i>  |  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>  |  |   |  |
| First Name:   |  | Last Name  |  | <b>*Date of Birth:</b><br>/ /   |  |
| Home Address:   |  | City:  |  | <b>*Zip Code:</b>   |  |
| Mailing Address: Same As Residential? <input type="checkbox"/> Yes  |  | City:  |  | <b>* Zip Code:</b>  |  |
| Home Phone: ( )   |  | Emergency Contact Name:  |  |   |  |
| Alternate Phone: ( )  |  | Phone: ( )   |  | Relationship:   |  |
| <b>*Living Arrangement # of household members</b><br><input type="checkbox"/> Declined to State   |  | <b>*What is your approximate household income?</b><br>\$ _____ per <input type="checkbox"/> month <input type="checkbox"/> year <input type="checkbox"/> Declined to State   |  | <b>*Rural Area?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Declined to State   |  |
| <b>* What is your gender? (Check only one)</b><br><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female<br><input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated   |  |  |  |   |  |
| <b>* What was your sex at birth? (Check only one)</b><br><input type="checkbox"/> Male <input type="checkbox"/> Female<br><input type="checkbox"/> Declined/not stated  |  | <b>* How do you describe your sexual orientation or sexual identity (Check only one)</b><br><input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving<br><input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not Listed, please specify: _____<br><input type="checkbox"/> Declined/not stated |  |   |  |
| <b>*Ethnicity (Check One)</b><br>Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Decline to State   |  | Language:<br><input type="checkbox"/> English speaking <input type="checkbox"/> Need interpreter<br><input type="checkbox"/> Non-English/Language:   |  |   |  |
| <b>*Race: (Check All that Apply)</b><br><input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native<br><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<br><input type="checkbox"/> Other Asian <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander<br><input type="checkbox"/> Declined to State |  |  |  |   |  |

**Notes:**

| <b>*Nutritional Assessment:</b>  | <b>Circle if yes</b> |
|--|----------------------|
| 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 past 6 months?                      | 2                    |
| I am not always physically able to shop, cook, and/or feed myself.                             | 2                    |
| <b>Total Score:</b><br>(If equal to or greater than 6, the client is at high nutritional risk) |                      |
| <input type="checkbox"/> <b>Declined to State</b>  |                      |

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 may benefit.

\_\_\_\_\_  
Signature of participant or person completing the form

\_\_\_\_\_  
Date