

FORM C-1

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

Notes:

*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 past 6 months?	2
I am not always physically able to shop, cook, and/or feed myself.	2
Total Score: (If equal to or greater than 6, the client is at high nutritional risk)	
<input type="checkbox"/> Declined 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 may benefit.

Signature of participant or person completing the form

Date