



Senior Nutrition Program HOME-DELIVERED Meals (C2) – Client Intake Form FY2020-2021

**CONFIDENTIAL**

**PROVIDER LOCATION:** \_\_\_\_\_

**TO RECEIVE HOME DELIVERED MEALS:** Person must be aged 60 or older, homebound due to illness or disability, unable to prepare meals, unable to drive, and unable to attend a congregate meal site if transportation were provided. There is no charge for meals; however, donations are accepted. A person will not be denied services if that individual chooses not to donate.

<b>Date:</b>		<b>Phone:</b>		<b>Birth Date: (Required)</b>	
<b>Last Name:</b>		<b>First Name: (No nicknames)</b>			
<b>APPLICANT ELIGIBILITY</b>				<b>YES</b>	<b>NO</b>
<b>Is applicant homebound due to illness or disability?</b>				<input type="checkbox"/>	<input type="checkbox"/>
<b>Is applicant 60 or older, and/or the spouse of an eligible senior?</b>				<input type="checkbox"/>	<input type="checkbox"/>
<b>Is applicant able to prepare meals?</b>				<input type="checkbox"/>	<input type="checkbox"/>
<b>Does applicant drive?</b>				<input type="checkbox"/>	<input type="checkbox"/>
<b>Can applicant attend a congregate meal site if transportation is provided?</b>				<input type="checkbox"/>	<input type="checkbox"/>
<b>Street Address:</b>				<b>City:</b>	<b>ZIP:</b>
<b>Email:</b>		<b>Rural: (91307, 93066, 93040)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State		
<b>Local Emergency Contact Name:</b>				<b>Phone:</b>	
<b>RACE – PLEASE CHOOSE (X) ONE:</b>					<b>Ethnicity:</b>
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Laotian	<input type="checkbox"/> Samoan	<input type="checkbox"/> Not Hispanic/Latino	
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Multiple Race	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Hispanic/Latino	
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Other Asian	<input type="checkbox"/> White	<input type="checkbox"/> Decline to State	
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Decline to State	<input type="checkbox"/> Decline to State	
<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Other Race			
<b>Marital Status:</b>	<input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Decline to State				
<b>Veteran Status:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Preferred Language:</b>		
<b>Client Lives:</b>	<input type="checkbox"/> Alone <input type="checkbox"/> Not Alone <input type="checkbox"/> Decline to State		<b>Number of Persons Living in Household:</b>		
<b>Applicant's Income Level (approximate):</b>					
<b>IF MARRIED:</b>			<b>IF SINGLE:</b>		
<input type="checkbox"/> At or below Federal Poverty Level (\$16,910/year or less)			<input type="checkbox"/> At or below Federal Poverty Level (\$12,490/year or less)		
<input type="checkbox"/> Above Federal Poverty Level (\$16,911/year or more)			<input type="checkbox"/> Above Federal Poverty Level (\$12,491/year or more)		
<input type="checkbox"/> Decline to State			<input type="checkbox"/> Decline to State		
<b>What was your sex at birth?</b>	<b>What is your Gender?</b>		<b>How do you describe your sexual orientation or sexual identity?</b>		
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Decline to State	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Decline to State <input type="checkbox"/> Not listed, please specify:		<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"/> Decline to State <input type="checkbox"/> Not listed, please specify:		
<b>THIS BOX FOR SERVICE PROVIDER ASSESSMENT</b>					
<b>About the Applicant:</b>	<b>YES</b>	<b>NO</b>	<b>Over the Past 3 Months, Does the Client...</b>	<b>YES</b>	<b>NO</b>
Any dietary restrictions? (If yes, explain)	<input type="checkbox"/>	<input type="checkbox"/>	Have trouble using the microwave or oven?	<input type="checkbox"/>	<input type="checkbox"/>
A working refrigerator?	<input type="checkbox"/>	<input type="checkbox"/>	Repeat some things over and over?	<input type="checkbox"/>	<input type="checkbox"/>
Freezer space to store five frozen meals?	<input type="checkbox"/>	<input type="checkbox"/>	Have trouble recalling appointments?	<input type="checkbox"/>	<input type="checkbox"/>
A working oven/microwave?	<input type="checkbox"/>	<input type="checkbox"/>	Have conversations that don't make sense?	<input type="checkbox"/>	<input type="checkbox"/>
Interested in weekend meals, if available?	<input type="checkbox"/>	<input type="checkbox"/>	Appear confused at times?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Comments:</b>			<b>Comments:</b>		



**CONFIDENTIAL**

Nutritional Assessment of Applicant:		Check All That Apply:
I have an illness or condition that made me change the kind and/or amount of food I eat.	(2pts)	<input type="checkbox"/>
I eat fewer than 2 meals per day.	(3pts)	<input type="checkbox"/>
I eat few fruits or vegetables or milk products.	(2pts)	<input type="checkbox"/>
I have 3 or more drinks of beer, liquor or wine almost every day.	(2pts)	<input type="checkbox"/>
I have tooth or mouth problems that make it hard for me to eat.	(2pts)	<input type="checkbox"/>
I don't always have enough money to buy the food I need.	(4pts)	<input type="checkbox"/>
I eat alone most of the time.	(1pt)	<input type="checkbox"/>
I take 3 or more different prescribed or over-the-counter drugs a day.	(1pt)	<input type="checkbox"/>
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	(2pts)	<input type="checkbox"/>
I am not always physically able to shop, cook and/or feed myself.	(2pts)	<input type="checkbox"/>
Decline to State:		<input type="checkbox"/>
<b>(If equal to or greater than 6, the client is at high nutritional risk→)</b>		<b>Total Score:</b>

**CALIFORNIA ACTIVITIES & INSTRUMENTAL ACTIVITIES (IADLS) OF DAILY LIVING (ADLS)**

Please Check (✓) One of the Columns for Each Activity

TYPE OF ASSISTANCE CARE RECEIVER NEEDS TO PERFORM TASK →		1 INDEPENDENT Needs No Help	2 VERBAL QUE Needs verbal reminders	3 STAND BY Needs some human help	4 HANDS ON Needs lots of human help	5 DEPENDENT Cannot perform task	Decline to State
<b>A D L S</b>	Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>I A D L S</b>	Light Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Shopping/Errands	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Meal Prep/Cleanup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Using Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Managing Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Managing Money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Heavy Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Applicant is:  Blind  Deaf      Applicant uses:  Walker  Wheelchair  Cane

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.

\_\_\_\_\_  
Applicant's Signature

**DO NOT WRITE IN THIS BOX – OFFICIAL USE ONLY**

Client Q Database/Unique Participant ID Number:  Senior  Spouse  Non-Senior Disabled

Reviewed by:  Staff  Volunteer      Type of Meals:  Hot  Frozen