

**Contra Costa County Department of Aging and Adult Services
Area Agency on Aging & Public Health Senior Nutrition
Title IIIC-1 Congregate Meal Program
Intake Form**



Fiscal Year

NOTE: Items marked with asterisk (*) are required		FOR OFFICE USE ONLY	
*First Name: _____ Middle Initial: _____ *Last Name: _____		*Cafe Costa Meal Site: _____	
*Date of Birth: ____/____/____ <small>Preferred Name</small>		*Reason for Assessment: *Start Date: ____/____/____ <input type="checkbox"/> New client <input type="checkbox"/> Annual Reassessment/Rollover/Change of information	
Home Address: _____		*Unique Participant ID: _____	
*City: _____ *Zip Code: _____		*Termination Date: ____/____/____	
*Home Phone: (____) _____ - _____		*Reason: _____	
Alternate Phone: (____) _____ - _____		<i>NOTE: Unique Participant ID is obtained after entry into GetCare</i>	
Email Address: _____			
*Emergency Contact Name/Relation: _____ Phone: (____) _____ - _____			
*Emergency Contact Name/Relation: _____ Phone: (____) _____ - _____			
*What is your gender? (Check one only) <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"/> Decline to state	*What was your sex at birth? (Check one only) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Decline to state	*How do you describe your sexual orientation or sexual identity? (Check one only) <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"/> Decline to state	
*Race: (Check all that apply)			
<input type="checkbox"/> White <input type="checkbox"/> Black or African <input type="checkbox"/> American Indian/Alaska Native <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 <input type="checkbox"/> Other Asian <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan	<input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Decline to state
*Ethnicity (Check only one) Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to state		Preferred spoken or written language: _____ Need interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to state	

Fiscal Year

*# of people included in household: _____		<input type="checkbox"/> Decline to state
*Approximate Monthly Household income \$ _____	*Do you live alone?	
Decline to State	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to state	
Marital Status:		
<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Separated <input type="checkbox"/> Decline to state		
Veteran Status: <input type="checkbox"/> Veteran <input type="checkbox"/> Veteran Dependent <input type="checkbox"/> No <input type="checkbox"/> Decline to State		
If <60 year of age, Reason for service <input type="checkbox"/> Live with Client <input type="checkbox"/> Meal Volunteer <input type="checkbox"/> Spouse <input type="checkbox"/> Disabled		
<input type="checkbox"/> Lives in Elder Housing (disabled) <input type="checkbox"/> Meal site staff <input type="checkbox"/> Other _____ Decline to state		
Employment Status:		
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Volunteer <input type="checkbox"/> Unemployment <input type="checkbox"/> Decline to state		

NOTE: Items marked with asterisk (*) are required.

*Nutritional Assessment (If score is 6 or greater, client is at high nutritional risk)	Yes	No	Decline to State
I have an illness or condition that made me change the kind and/or the amount of food I eat. (2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I eat fewer than 2 meals per day. (3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I eat few servings of fruits or vegetables or milk products. (2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have 3 or more drinks of beer, liquor or wine almost every day. (2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have tooth or mouth problems that make it hard for me to eat. (2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I do not always have enough money to buy the food I need. (4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I eat alone most of the time. (1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take 3 or more prescribed or over-the-counter drugs a day. (1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Without wanting to, I have lost or gained 10 pounds in the past 6 months. (2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am not always physically able to cook, shop and/or feed myself. (2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.

Participant Completing Assessment (if applicable)

Date

Staff Completing Assessment