



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.

Date:		Phone:		Birth Date: (Required)	
Last Name:		First Name: (No nicknames)			
APPLICANT ELIGIBILITY				YES	NO
Is applicant homebound due to illness or disability?				<input type="checkbox"/>	<input type="checkbox"/>
Is applicant 60 or older, and/or the spouse of an eligible senior?				<input type="checkbox"/>	<input type="checkbox"/>
Is applicant able to prepare meals?				<input type="checkbox"/>	<input type="checkbox"/>
Does applicant drive?				<input type="checkbox"/>	<input type="checkbox"/>
Can applicant attend a congregate meal site if transportation is provided?				<input type="checkbox"/>	<input type="checkbox"/>
Street Address:				City:	ZIP:
Email:		Rural: (91307, 93066, 93040)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State		
Local Emergency Contact Name:				Phone:	
RACE – PLEASE CHOOSE (X) ONE:					Ethnicity:
<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			
Marital Status:	<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				
Veteran Status:	<input type="checkbox"/> Yes <input type="checkbox"/> No		Preferred Language:		
Client Lives:	<input type="checkbox"/> Alone <input type="checkbox"/> Not Alone <input type="checkbox"/> Decline to State		Number of Persons Living in Household:		
Applicant's Income Level (approximate):					
IF MARRIED:			IF SINGLE:		
<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		
What was your sex at birth?	What is your Gender?		How do you describe your sexual orientation or sexual identity?		
<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:		
THIS BOX FOR SERVICE PROVIDER ASSESSMENT					
About the Applicant:	YES	NO	Over the Past 3 Months, Does the Client...	YES	NO
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"/>
Comments:			Comments:		



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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"/>
(If equal to or greater than 6, the client is at high nutritional risk→)		Total Score:

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
A D L S	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"/>
I A D L S	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