**Congregate Nutrition Assessment Form**

Welcome! Please tell us a bit about yourself so we can offer services that best meet your needs. We ask for demographic information to meet requirements from our funders. All your personal information is confidential. Please see the attached FAQs for more information and guidance on filling out this form.

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|  **Contact & Demographic Information:** |
| **Last Name:** |            |  **First Name:** |            |  **M.I.** |            |
| **Date of Birth:** |            |  **Age:** |            |
| **Gender:** [ ]  Male [ ]  Female [ ]  Other gender not listed:  |  |
| **Home Address** Line 1: |            |
| Line 2 (Apt/Unit/Floor #): |            | City: |            |
| Zip: |            |  County: |            |  State: |            |
| **Mailing Address** Line 1: |            |
| Line 2 (Apt/Unit/Floor #): |            | City: |            |
| Zip: |            |  County: |            |  State: |            |

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| **Location Comments** (additional directions for home or mailing address): |
|       |

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| **Home Phone:** |            | **Cell Phone:** |            |
| **Email:** |            |

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| **Primary language:** [ ]  English [ ]  Spanish [ ]  Other: |       |
| **Ethnicity:** [ ]  Hispanic or Latino [ ]  Not Hispanic or Latino  |
| **Race, select all that apply:** |
| [ ]  American Indian/Alaska Native | [ ]  Native Hawaiian or Pacific Islander |
| [ ]  Asian or Asian American | [ ]  White |
| [ ]  Black or African American | [ ]  Other not listed:  |       |
| **Do you live:** [ ]  Alone [ ]  With Others |
| **Number of people in your household** (including you):  |       |

**Is your income above or below the amount listed for your household size:**

[ ]  Above [ ]  At/Below

|  |  |  |
| --- | --- | --- |
| Household Size | Monthly Income | Annual Income |
| 1 | $1,073 | $12,880 |
| 2 | $1,452 | $17,420 |
| 3 | $1,830 | $21,960 |
| 4 | $2,208 | $26,500 |
| For each additional person, add $4,540 to annual income |

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|  **Emergency Contact:** |

**Primary Emergency Contact:**

|  |  |
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| Name: |            |
| Phone: |            |  Relationship:  |            |

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|  **Nutrition Screening:** |

Determine your nutritional health. If the statement is true for you, check the box in the “Yes” column and add the points in the “Yes Score” column to the total score.

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| **Nutrition Risk Score Questions** | **Yes** | **No** | **Yes Score** |
| Do you have an illness or condition that has made you change the kind and/or amount of food you eat? | [ ]  | [ ]  | 2 |
| Do you eat fewer than 2 meals per day? | [ ]  | [ ]  | 3 |
| Do you eat few fruits, vegetables, or milk products? | [ ]  | [ ]  | 2 |
| Do you have 3 or more drinks of beer, liquor, or wine almost every day? | [ ]  | [ ]  | 2 |
| Do you have tooth or mouth problems that make it hard for you to eat? | [ ]  | [ ]  | 2 |
| Are there times you do not have enough money to buy the food you need? | [ ]  | [ ]  | 4 |
| Do you eat alone most of the time? | [ ]  | [ ]  | 1 |
| Do you take 3 or more different prescribed or over the counter drugs a day? | [ ]  | [ ]  | 1 |
| Without wanting to, have you lost or gained 10 pounds in the last 6 months? | [ ]  | [ ]  | 2 |
| Are there times you’re physically unable to shop, cook, and/or feed yourself? | [ ]  | [ ]  | 2 |
| **Total Nutrition Risk Score** *Total “Yes” Score:*       |

Total Nutrition Risk Score: 0-2 = No Risk, 3-5 = Moderate Risk, 6 or more = High Risk

If you are at high nutrition risk – take action! Speak with a qualified health or social service professional about your nutritional health. Providers – if the client is at high nutrition risk, please make a case note and appropriate referral.

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|  **Interest in Other Services:** |

**Health Insurance** (select all that apply):[ ]  Medicaid [ ]  Medicare [ ]  Other [ ]  None

**Are you interested in receiving nutrition counseling?** [ ]  Yes [ ]  No

**Would you like to hear about other services?** [ ] Yes [ ]  No

**If yes, how can we contact you?** [ ]  Email [ ]  Mail [ ]  Phone

|  |  |
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| **What services are you interested in?** |       |
|       |

**Disclosures and Waivers**

*I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service provider and I herewith give my consent to do so.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:**  |            |  **Date:** |            |

***For Office Use Only –***

*(If filled out by assessor or via phone, please have assessor check here and sign below* [ ] )

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| --- | --- | --- | --- |
| **Filled Out By:**  |            |  **Date:** |            |

Congregate Nutrition Eligibility

[ ]  Individual Aged 60+

[ ]  Self-Declared Spouse of eligible individual

[ ]  Individual with disabilities living with eligible individual

[ ]  Individual with disabilities who resides in housing where meal site is located

[ ]  Long Term Care Facility resident 60+ or self-declared spouse of eligible individual (may have meal if not a substitute for meal provided by the facility)

[ ]  Meal Site Staff or Volunteer

Nutrition Counseling Eligibility:

[ ]  Individual Aged 60+

[ ]  Caregiver to an Individual Aged 60+