FORM C-1

Name of Congregate Meals Provider:

Site:

Please complete this form to the best of your ability.
Items Marked with asterisk (*) are required.

***Unique Participant ID**:_____
Referred by:_____
Intake Date: _____
Staff: _____
Beginning Date: _____
***Termination Date:** _____
***Reason**:_____

Eligibility:
☐ Age 60+
☐ Spouse of ENP Participant
☐ Disabled person residing where the congregate site is located
☐ Disabled person who resides with and accompanies an ENP participant
☐ Volunteer

Last 4 Digits Social Security # *Optional* | | | | |

First Name:	Last Name	***Date of Birth**: / /
Home Address:	City:	*Zip Code:
Mailing Address: Same As Residential? ☐ Yes	City:	* Zip Code:
Home Phone: ( ) Alternate Phone: ( )	Emergency Contact Name: Phone: ( ) Relationship:	

***Living Arrangement # of household members** ☐
☐ Declined to State

***What is your approximate household income?**
$_____ per ☐ month ☐ year ☐ Declined to State

***Rural Area?**
☐ Yes ☐ No
☐ Declined to State

*** What is your gender? (Check only one)**
☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female
☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated

*** What was your sex at birth? (Check only one)**
☐ Male ☐ Female
☐ Declined/not stated

*** How do you describe your sexual orientation or sexual identity (Check only one)**
☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving
☐ Questioning/Unsure ☐ Not Listed, please specify: _____
☐ Declined/not stated

***Ethnicity** (Check One)
Hispanic ☐ Yes ☐ No
☐ Decline to State

Language:
☐ English speaking ☐ Need interpreter
☐ Non-English/Language:

***Race**: (Check All that Apply)
☐ White ☐ Black ☐ American Indian/Alaska Native
☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese
☐ Other Asian ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander
☐ Declined to State

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)	
☐ **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