



Senior Nutrition Program CONGREGATE Meals (C1) – Client Intake Form FY2017-2018

CONFIDENTIAL

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

TO PARTICIPATE IN CONGREGATE MEALS: Person must be aged 60 or older. There is no charge for meals; however, donations are accepted. A person will not be denied services if he/she chooses not to donate.

Date:		Phone:		Birth Date: (Required)	
Last Name:			First Name: (No nicknames)		
Street Address:					
City:		ZIP: (Required)		Rural: (91307, 93066, 93040)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
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"/> Declined to State				
<b>RACE - PLEASE CHOOSE (X) ONE:</b>					
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black or African American <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino		<input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Multiple Race		<input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> OTHER RACE – Includes Hispanic /Latino <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> White <input type="checkbox"/> Declined to State	
Ethnicity:	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino		Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Woman <input type="checkbox"/> Declined to State <input type="checkbox"/> Transgender Man	
Veteran Status:	<input type="checkbox"/> Yes <input type="checkbox"/> No		Client Lives:	<input type="checkbox"/> Alone <input type="checkbox"/> Not Alone	
Preferred Language:			Number of Persons Living in Household:		
Applicant's Income Level (approximate):				Local Emergency Contact:	
<b>IF MARRIED:</b> <input type="checkbox"/> At or below Federal Poverty Level (at or below \$16,240/year) <input type="checkbox"/> Above Federal Poverty Level (at or above \$16,241/year) <input type="checkbox"/> Declined to State		<b>IF SINGLE:</b> <input type="checkbox"/> At or below Federal Poverty Level (at or below \$12,060/year) <input type="checkbox"/> Above Federal Poverty Level (at or above \$12,061/year) <input type="checkbox"/> Declined to State		NAME: _____ PHONE: _____	
<b>Nutritional Assessment Of Applicant:</b>					<b>Check All That Apply</b>
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"/>
<b>(If equal to or greater than 6, the client is at high nutritional risk →)</b> Total Score:					
Declined to State:					<input type="checkbox"/>
I certify that all statements on this form are true and correct → _____				Applicant's Signature	
<b>DO NOT WRITE IN THIS BOX – OFFICIAL USE ONLY</b>					
Client Care Access (Q) Database Number:			<input type="checkbox"/> Senior <input type="checkbox"/> Spouse <input type="checkbox"/> Volunteer <input type="checkbox"/> Private Pay <input type="checkbox"/> Non-Senior Disabled w Senior		
Reviewed by: <input type="checkbox"/> Staff <input type="checkbox"/> Volunteer					



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## CONSENT TO REMOVE MEALS

Ventura County Area Agency on Aging in partnership with cities in Ventura County provides hot, nutritious lunches at congregate meal sites to seniors age 60 and over. Meals are available in most cities Monday through Friday. In the event you would like to take a meal home, or any portion of a meal home, you are accepting all responsibility for the food. Please sign below to release any and all liability.

The undersigned \_\_\_\_\_ desires to remove a frozen and/or  
(Participant's Name)  
take home the remainder of his/her lunch. In doing so, he/she accepts full responsibility for this food. In consideration for agreeing to surrender this food, the participant or his/her authorized agent agrees to release VCAAA, Senior Nutrition Program, the volunteers, directors, officers, agents and employees from any consequences. The participant acknowledges that he/she has been advised that hot food items held below 140°F for longer than 2 hours must be discarded, and frozen meals should remain frozen at all times and be placed in the refrigerator or freezer immediately.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Family Member/Guardian/Caregiver Signature

\_\_\_\_\_  
Date