



Riverside County Office on Aging

Congregate Meals Intake Form



<p>Name of Service Provider - SODEXO</p> <h1 style="margin: 0;">LAKE ELSINORE</h1> <p>Please complete this form to the best of your ability. Items marked with asterisk (*) are required.</p>	Referred by: _____ Intake Date: _____ Staff: _____ Beginning Date: _____ *Termination Date: _____ *Reason: _____	Eligibility: <input type="checkbox"/> Age 60+ <input type="checkbox"/> Spouse of ENP Participant <input type="checkbox"/> Disabled person residing where the congregate site is located <input type="checkbox"/> Disabled person who resides with and accompanies an ENP participant <input type="checkbox"/> Volunteer
Unique Participant ID: _____		

*First Name:	*Last Name	MI:	*Date of Birth: / /
*Home Address:	*City:	*County:	*Zip Code:
Mailing Address: Same As Residential? <input type="checkbox"/> Yes	City:	County:	* Zip Code:

Best Contact Phone: () _____	Emergency Contact Name: _____
Alternate Phone: () _____	Phone: () _____ Relationship to you: _____

Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State	*What is your approximate household income? \$_____ per <input type="checkbox"/> month <input type="checkbox"/> year <input type="checkbox"/> Declined to State	*Rural Area? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
---	---	--

***Poverty Status:** (calculate from household income)
 At or Below 100% of the Federal Poverty Level (FPL) Above 100% of the FPL 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) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated	* How do you describe your sexual orientation or sexual identity? (Check only one) <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"/> Declined/not stated
--	---

***Marital Status:** Single (Never Married) Married Domestic Partnership Divorced Separated
 Widowed Since When: _____ Declined to State

*Ethnicity (Check One): Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State	Language: <input type="checkbox"/> English speaking <input type="checkbox"/> Need interpreter <input type="checkbox"/> Non-English/Language: _____
---	---

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

***Living Arrangement:**
 Live Alone Do Not Live Alone Decline to State # of Household Members _____

Receiving IHSS Services? Yes No Declined to State
 If yes, number of IHSS hours receiving? _____ Weekly _____ Monthly Declined to State

Read the statements below. Circle the number in the “yes” column for those that apply to you or someone you know. For each “yes” answer, score the number in the box. Total your nutritional score.

*Determine your Nutritional Health: <i>(for each item, circle the number in the appropriate column)</i>	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 yourself.	2
<i>(High Nutritional Risk = 6 or more points)</i> Total Points:	
Declined to State <input type="checkbox"/>	

Notes:

General Assessment:	Answer	Comments
1. Does the oven and/or microwave work?		
2. Does the refrigerator keep food \leq 40 degrees?		
3. Does the freezer keep food \leq 10 degrees?		
4. Does the client appear confused and/or forgetful?		
5. Can the client open their own milk cartons/containers?		
6. Are there any other physical or mental impairment noted?		
7. Are there pets living with Client?		
8. Was the Client recently discharged from the hospital?		

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 qualify.

Signature of participant or person completing the form

Date