



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
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*Poverty Status: (calculate from household income)		
<input type="checkbox"/> At or Below 100% of the Federal Poverty Level (FPL)	<input type="checkbox"/> Above 100% of the FPL	<input type="checkbox"/> Declined to State

* What is your gender? (Check only one)	
<input type="checkbox"/> Male	<input type="checkbox"/> Female
<input type="checkbox"/> Transgender Female to Male	<input type="checkbox"/> Transgender Male to Female
<input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> 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
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*Marital Status: <input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed Since When: _____ <input type="checkbox"/> Declined to State	
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*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: _____
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*Race: (Check One) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Multiple Race <input type="checkbox"/> Other Race _____ <input type="checkbox"/> Declined to State	
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*Living Arrangement: <input type="checkbox"/> Live Alone <input type="checkbox"/> Do Not Live Alone <input type="checkbox"/> Decline to State <input type="checkbox"/> # of Household Members _____

Receiving IHSS Services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State If yes, number of IHSS hours receiving? _____ Weekly _____ Monthly <input type="checkbox"/> 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: (for each item, circle the number in the appropriate column)	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