Contra Costa County Department of Aging and Adult Services
Area Agency on Aging & Public Health Senior Nutrition
Title IIIC-1 Congregate Meal Program
Intake Form

Fiscal Year 2022-2023

NOTE: Items marked with asterisk (*) are required

***First Name:** **Middle Initial:** ***Last Name:**

***Date of Birth:** ____/____/____ Preferred Name

Home Address:_____

***City:** ***Zip Code:**

*Home Phone: (_____) _____-_____

Alternate Phone: (_____) _____-_____

Email Address: _____

***Cafe Costa Meal Site:** _____

***Reason for Assessment:** ***Start Date:**

☐ New client ____/____/____

☐ Annual Reassessment/Rollover/Change of information

***Unique Participant ID:** _____

***Termination Date:** ____/____/____

***Reason:** _____

NOTE: Unique Participant ID is obtained after entry into GetCare

*Emergency Contact Name/Relation:_____ Phone:(_____) _____-_____

Emergency Contact Name/Relation: _____ Phone: (_____) _____ - _____

***What is your gender? (Check one only)**

☐ Male
☐ Female
☐ Transgender Female to Male
☐ Transgender Male to Female
☐ Genderqueer/Gender Non-binary
☐ Not Listed, please specify:

_____

☐ Decline to state

***What was your sex at birth? (Check one only)**

☐ Male
☐ Female
☐ Decline to state

***How do you describe your sexual orientation or sexual identity? (Check one only)**

☐ Straight/Heterosexual
☐ Bisexual
☐ Gay/Lesbian/Same Gender Loving
☐ Questioning/Unsure
☐ Not Listed, please specify:

_____

☐ Decline to state

***Race:** (Check all that apply)

☐ White
☐ Black or African
☐ American Indian/Alaska Native
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Laotian
☐ Vietnamese
☐ Other Asian
☐ Guamanian
☐ Hawaiian
☐ Samoan
☐ Other Pacific Islander
☐ Decline to state

***Ethnicity** (Check only one)

Hispanic: ☐ Yes ☐ No ☐ Decline to state

Preferred spoken or written language: _____

Need interpreter: ☐ Yes ☐ No ☐ Decline to state

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*# of people included in household: _____ ☐ Decline to state	
***Approximate Monthly Household income** $_____ ☐ Decline to State	***Do you live alone?** ☐ Yes ☐ No ☐ Decline to state
Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Single (Never Married) ☐ Separated ☐ Decline to state	
Veteran Status: ☐ Veteran ☐ Veteran Dependent ☐ No ☐ Decline to State	
If <60 year of age, Reason for service ☐ Live with Client ☐ Meal Volunteer ☐ Spouse ☐ Disabled ☐ Lives in Elder Housing (disabled) ☐ Meal site staff ☐ Other _____ ☐ Decline to state	
Employment Status: ☐ Full Time ☐ Part Time ☐ Disabled ☐ Retired ☐ Volunteer ☐ Unemployment ☐ Decline to state	

NOTE: Items marked with asterisk (*) are required.

***Nutritional Assessment (If score is 6 or greater, client is at high nutritional risk)**	**Yes**	**No**	**Decline to State**
I have an illness or condition that made me change the kind and/or the amount of food I eat. (2)	☐	☐	☐
I eat fewer than 2 meals per day. (3)	☐	☐	☐
I eat few servings of 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 do not always have enough money to buy the food I need. (4)	☐	☐	☐
I eat alone most of the time. (1)	☐	☐	☐
I take 3 or more 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 cook, shop and/or feed myself. (2)	☐	☐	☐

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.

_____ _____
Participant Completing Assessment (if applicable) Date

_____
Staff Completing Assessment (if applicable)