

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 that individual chooses not to donate.

Date:		Phone:		Birth Date: <i>(Required)</i>	
Last Name:		First Name: <i>(No nicknames)</i>			
Street Address:				City:	ZIP:
Email:			Rural: (91307, 93066, 93040)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing	
Local Emergency Contact Name:				Phone:	
RACE – PLEASE CHOOSE (X) ONE:					Ethnicity:
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian <input type="checkbox"/> Samoan <input type="checkbox"/> Asian Indian <input type="checkbox"/> Guamanian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Black or African American <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other Asian <input type="checkbox"/> White <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Decline to State <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Missing					<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing
MARITAL STATUS:	<input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Widowed <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing				
VETERAN STATUS: <input type="checkbox"/> I consent to this agency and the California Department of Aging transmitting my name, email address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for 12 months.	<input type="checkbox"/> Have you ever served in the United States military? <input type="checkbox"/> Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military? <input type="checkbox"/> No <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing		Preferred Language:		
Client Lives:	<input type="checkbox"/> Alone <input type="checkbox"/> Not Alone <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing			Number of Persons Living in Household:	
Applicant's Income Level (approximate):					
IF MARRIED:			IF SINGLE:		
<input type="checkbox"/> At or below Federal Poverty Level (\$19,720/year or less) <input type="checkbox"/> Above Federal Poverty Level (\$19,721/year or more) <input type="checkbox"/> Decline to State			<input type="checkbox"/> At or below Federal Poverty Level (\$14,580/year or less) <input type="checkbox"/> Above Federal Poverty Level (\$14,581/year or more) <input type="checkbox"/> Decline to State		
What was your sex at birth?	What is your Gender?		How do you describe your sexual orientation or sexual identity?		
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing <input type="checkbox"/> Not listed, please specify:		<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"/> Decline to State <input type="checkbox"/> Missing <input type="checkbox"/> Not listed, please specify:		
Nutritional Assessment of Applicant: Check All That Apply:					
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"/>
	Decline to State:	<input type="checkbox"/>
	Missing:	<input type="checkbox"/>
(If equal to or greater than 6, the client is at high nutritional risk→)	Total Score:	
I certify that all statements on this form are true and correct. _____ Applicant's Signature		
DO NOT WRITE IN THIS BOX – OFFICIAL USE ONLY		
Client Q Database/Unique Participant ID Number:	<input type="checkbox"/> Senior <input type="checkbox"/> Spouse <input type="checkbox"/> Volunteer <input type="checkbox"/> Private Pay	
Reviewed by: <input type="checkbox"/> Staff <input type="checkbox"/> Volunteer	<input type="checkbox"/> Non-Senior Disabled with Senior	

CONSENT TO REMOVE MEALS

Ventura County Human Services Agency, 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