COUNTY of VENTURA
Area Agency on Aging

Senior Nutrition Program HOME-DELIVERED Meals (C2) – Client Intake Form FY2023-2024

CONFIDENTIAL

PROVIDER LOCATION: _____

TO RECEIVE HOME DELIVERED MEALS: Person must be aged 60 or older, homebound due to illness or disability, unable to prepare meals, unable to drive, and unable to attend a congregate meal site if transportation were provided. 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:** *(Required)*	
Last Name:		**First Name:** *(No nicknames)*			

APPLICANT ELIGIBILITY	**YES**	**NO**	**NOTE:**
Is applicant homebound due to illness, disability, or isolation?	☐	☐	If you answer Yes, to any of these questions, applicant is eligible for home-delivered meals.
Are you a spouse of a person who is homebound?	☐	☐	
Are you an individual with a disability who resides with a homebound meal recipient?	☐	☐	

Street Address:		**City:**		**ZIP:**	
Email:		**Rural:** (91307, 93066, 93040)	☐ Yes ☐ No ☐ Decline to State ☐ Missing		
Local Emergency Contact Name:		**Phone:**			

RACE – PLEASE CHOOSE (X) ONE:

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

Ethnicity:

☐ Not Hispanic/ Latino
☐ Hispanic/ Latino
☐ Decline to State
☐ Missing

MARITAL STATUS: ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Decline to State ☐ Missing

VETERAN STATUS:

☐ **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.**

☐ Have you ever served in the United States military?
☐ 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?
☐ No
☐ Decline to State
☐ Missing

Preferred Language:

Client Lives:	☐ Alone ☐ Not Alone ☐ Decline to State ☐ Missing	**Number of Persons Living in Household:**	

Applicant's Income Level (approximate):

IF MARRIED:
☐ At or below Federal Poverty Level *($19,720/year or less)*
☐ Above Federal Poverty Level *($19,721/year or more)*
☐ Decline to State

IF SINGLE:
☐ At or below Federal Poverty Level *($14,580/year or less)*
☐ Above Federal Poverty Level *($14,581/year or more)*
☐ Decline to State

What was your sex at birth?	**What is your Gender?**	**How do you describe your sexual orientation or sexual identity?**

☐ Female ☐ Male ☐ Decline to State ☐ Missing	☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Decline to State ☐ Missing ☐ Not listed, please specify:	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Decline to State ☐ Missing ☐ Not listed, please specify:

THIS BOX FOR SERVICE PROVIDER ASSESSMENT

About the Applicant:	**YES**	**NO**	**Over the Past 3 Months, Does the Client…**	**YES**	**NO**
Any dietary restrictions? (If yes, explain)	☐	☐	Have trouble using the microwave or oven?	☐	☐
A working refrigerator?	☐	☐	Repeat some things over and over?	☐	☐
Freezer space to store five frozen meals?	☐	☐	Have trouble recalling appointments?	☐	☐
A working oven/microwave?	☐	☐	Have conversations that don't make sense?	☐	☐
Interested in weekend meals, if available?	☐	☐	Appear confused at times?	☐	☐
Comments:			**Comments:**		

COUNTY of VENTURA
Area Agency on Aging

Senior Nutrition Program HOME-DELIVERED Meals (C2) – Client Intake Form FY2023-2024

CONFIDENTIAL

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)	☐
I eat fewer than 2 meals per day.	(3pts)	☐
I eat few fruits or vegetables or milk products.	(2pts)	☐
I have 3 or more drinks of beer, liquor or wine almost every day.	(2pts)	☐
I have tooth or mouth problems that make it hard for me to eat.	(2pts)	☐
I don't always have enough money to buy the food I need.	(4pts)	☐
I eat alone most of the time.	(1pt)	☐
I take 3 or more different prescribed or over-the-counter drugs a day.	(1pt)	☐
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	(2pts)	☐
I am not always physically able to shop, cook and/or feed myself.	(2pts)	☐
	Decline to State:	☐
(If equal to or greater than 6, the client is at high nutritional risk→)	**Total Score:**	

CALIFORNIA ACTIVITIES & INSTRUMENTAL ACTIVITIES (IADLS) OF DAILY LIVING (ADLS)
Please Check (✓) One of the Columns for Each Activity

	TYPE OF ASSISTANCE CARE RECEIVER NEEDS TO PERFORM TASK ➔	1 INDEPENDENT Needs No Help	2 VERBAL QUE Needs verbal reminders	3 STAND BY Needs some human help	4 HANDS ON Needs lots of human help	5 DEPENDENT Cannot perform task	Decline to State
ADLS	**Eating**	☐	☐	☐	☐	☐	☐
	Dressing	☐	☐	☐	☐	☐	☐
	Transferring In/Out of Bed/Chair	☐	☐	☐	☐	☐	☐
	Bathing	☐	☐	☐	☐	☐	☐
	Toileting	☐	☐	☐	☐	☐	☐
	Walking	☐	☐	☐	☐	☐	☐
IADLS	**Light Housework**	☐	☐	☐	☐	☐	☐
	Shopping/Errands	☐		☐		☐	☐
	Meal Prep/Cleanup	☐	☐	☐	☐	☐	☐
	Transportation	☐	☐	☐		☐	☐
	Using Telephone	☐	☐	☐		☐	☐
	Managing Medications	☐	☐	☐	☐	☐	☐
	Managing Money	☐	☐	☐		☐	☐
	Heavy Housework	☐	☐	☐	☐	☐	☐

Applicant is:	☐ Blind ☐ Deaf	Applicant uses:	☐ Walker ☐ Wheelchair ☐ Cane

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 benefit.

_____
Applicant's Signature

DO NOT WRITE IN THIS BOX – OFFICIAL USE ONLY

Client Q Database/Unique Participant ID Number:	☐ Senior ☐ Spouse ☐ Non-Senior Disabled
Reviewed by: ☐ Staff ☐ Volunteer	Type of Meals: ☐ Hot ☐ Frozen