

Senior Nutrition Program HOME-DELIVERED Meals (C2) – Client Intake Form FY2024-2025 THIS INFORMATION IS STRICTLY CONFIDENTIAL.

prepare meals	, to drive	, or to atten	EALS: Applicant must d a congregate meal si ed. A person will not b	ite if tr	ranspo	rtation were prov	ided. Ther	e is no ch	arge for m	neals; ho	
Provider Locat	ion:		Date:								
Preferred Lan	guage:					Birthdate (<i>R</i>	equired):				
Last Name:			First Name (<i>No Nicknames</i>):								
APPLICANT ELIGIBILITY									YES	NO	
(a) Is applicant frail and homebound by reason of illness, disability, or isolation?											
(b) Are you a spouse of (a) who is frail, and homebound by reason of illness, disability, or isolation and it is in their best interest that you also receive a meal? Name of person (a)											
NOTE: If the answer is YES to any of the questions above, applicant is eligible for home-delivered meals.											
ADDRESS & CO	ADDRESS & CONTACT INFORMATION										
Address: City: Zip:											
Phone:				Ema	ail:						
Local Emerger	Local Emergency Contact Name: # of Persons in Household:										
Lives Alone?	Lives Alone? Yes I No I Decline to State I Missing Lives in Rural Area? (91307, 93066, 93040) I Yes I No I Decline to State I Missing										
APPLICANT SIGNATURE:											
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.											

These are used to ensure that services are distributed equitably and do NOT affect eligibility.

DEMOGRAPHIC INFORMATION							🗆 DE	ECLINE TO STA	ATE 🗆 MISSING
What is your marital status?		ced 🛛 Domestic Partnership 🖾 Married 🖾 Never Married 🖾 Separated 🖾 Widowed							
what is your mantar status:	🗆 Decli	ne to State 🛛 Missing							
What is your approximate anr	oual incor	IF single □ \$15,060 o		0 or less		At or below Federal Poverty	□ \$15,	,061 or more	Above Federal Poverty
what is your approximate and		IF marri	ed 🗆 \$20,44	0 or less		Level		,441 or more	Level
Do you think of yourself a	as:	What sex were you assigned at birth?				Do you think of yourself as:			
Nonbinary Genderqueer	Female	Female Male Intersex			□ Straigł	□ Straight/Heterosexual □ Bisexual □ Don't know			
🗆 Male 🗆 Trans male 🗆 Tran	is female	□ Other; please specify:			🗆 Lesbia	🗆 Lesbian or gay 🖾 Queer, pansexual, questioning			
□ Other; please specify:	ļ				□ Somet	□ Something else; please specify:			
Decline to answer D Missir	ng	🗌 Decline t	🗆 Declin	Decline to answer D Missing					
How do you identify your eth	nicity?	How do you				Decline f	to State □Missing		
🗆 Hispanic/Latino		🗌 American Indian or Alaska 🛛 🛛		a 🗌 Ch	ninese	inese 🗌 Hmon		🗌 Samoa	Other Asian
Not Hispanic/Latino		Native 🗆	Asian Indian	🗌 Fil	lipino	ipino 🛛 Jap		🗌 Other Pa	cific Islander
Decline to Answer		🗆 Black or African American 🛛 🖸		n 🗌 Gı	uamanian 🗌 Ko		orean	🗌 Vietnam	iese
□ Missing		🗌 Cambodian 🛛 🗍 Hay		awaiian	🗆 La	otian	🗌 White		

Have you ever served in the United States military? Image: YES 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? Image: Image: YES								-		
Do you consent to this agency and the California Department of Aging transmitting your name, email address, and telephone number to the Department of Veterans Affairs, only for the purpose of receiving additional information on veterans benefits for which you may be eligible? Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.										
SERVICE PROVIDER ASSESSMENT Please ask these questions at the FIRST home-delivered meal.										
Applicant is: □ Blind □ Deaf Applicant uses: □ Walker □ Wheelchair □ Cane								ne		
Does the applicant have:					YES			NO		
a working refrigerator?										
freezer space to store five fr	ozen meals?									
a working oven or microwav	e?									
any dietary restrictions? (If	yes, explain below))								
interest in weekend meals, if available?										
Comments:							•			
Determine Your Nutritional Health Check All That Apply to Applicant:										
I don't always have enough money to buy the food I need.									4 pts	
I eat fewer than 2 meals per day.									3 pts	
I have an illness or condition that made me change the kind and/or amount of food I eat.									2 pts	
I eat few fruits or vegetables or milk products.									2 pts	
I have 3 or more drinks of beer, liquor, or wine almost every day.									2 pts	
I have tooth or mouth problem	ns that make it har	d for me to eat.							2 pts	
Without wanting to, I have los			onths.						2 pts	
I am not always physically able	e to shop, cook and	/or feed myself.							2 pts	
I eat alone most of the time.									1 pt	
I take 3 or more different pres		-	-						1 pt	
Decline to state. unable to score Check if total score is equal to or greater than 6 and the client is at high nutritional risk .										
CALIFORNIA ACTIVITIES AND INSTRUMENTAL ACTIVITIES (IADLS) OF DAILY LIVING (ADLS) For each activity, mark the level of assistance you (or the client) need.										
Level of assistance needed to perform the task of				3 4 ND BY HANDS ON ds some needs lots of an help human help			5 PENDENT cannot rform task	Decline to State		
		ADL	S							
Eating]						

	ADI	- J		
Eating				
Dressing				
Moving In or Out of Bed or Chair				
Bathing				
Toileting				
Walking				

IADLS								
Light Housework								
Shopping or Errands								
Meal Prep and Cleanup								
Transportation								
Using the Telephone								
Managing Medications								
Managing Money								
Heavy Housework								

DO NOT WRITE IN THIS BOX – OFFICIAL USE ONLY								
Q Database/Unique Participa	int ID Number:	Senior Spouse Non-Senior Disabled						
Reviewed by:	□ Staff	□ Volunteer	Type of Meals: 🛛 Hot 🖾 Frozen					