Senior Nutrition Program HOME-DELIVERED Meals (C2) – Client Intake Form FY2018-2019

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 or disability?	☐	☐	If answer is NO, stop here; applicant is not eligible for home-delivered meals.
Is applicant 60 or older, and/or the spouse of an eligible senior?	☐	☐	
Is applicant able to prepare meals?	☐	☐	If answer is YES, stop here; applicant is not eligible for home-delivered meals.
Does applicant drive?	☐	☐	
Can applicant attend a congregate meal site if transportation is provided?	☐	☐	

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

RACE – PLEASE CHOOSE (X) ONE:

				Ethnicity:
☐ American Indian or Alaska Native	☐ Filipino	☐ Laotian	☐ Samoan	☐ Not Hispanic/ Latino
☐ Asian Indian	☐ Guamanian	☐ Multiple Race	☐ Vietnamese	☐ Hispanic/ Latino
☐ Black or African American	☐ Hawaiian	☐ Other Asian	☐ White	☐ Decline to State
☐ Cambodian	☐ Japanese	☐ Other Pacific Islander	☐ Decline to State	
☐ Chinese	☐ Korean	☐ Other Race		

Marital Status:	☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Decline to State		
Veteran Status:	☐ Yes ☐ No	**Preferred Language:**	
Client Lives:	☐ Alone ☐ Not Alone ☐ Decline to State	**Number of Persons Living in Household:**	

Applicant's Income Level (approximate):

IF MARRIED:	**IF SINGLE:**
☐ At or below Federal Poverty Level *($16,460/year or less)*	☐ At or below Federal Poverty Level *($12,140/year or less)*
☐ Above Federal Poverty Level *($16,461/year or more)*	☐ Above Federal Poverty Level *($12,141/year or more)*
☐ Decline to State	☐ Decline to State

The Gay Bisexual and Transgender Disparities Reduction Act of 2016 (AB 959)

The State of CA requires that we ask you some demographic questions followed by three questions under the new CA State AB 959 Law, the Gay, Bisexual and Transgender Disparities Reduction Act of 2016. VCAAA values your privacy and you have the option to decline to state.

What was your sex at birth?	☐ Female ☐ Male ☐ Decline to State
What is your Gender?	☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Decline to State ☐ Not listed, please specify: _____
How do you describe your sexual orientation or sexual identity?	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Decline to State ☐ Not listed, please specify: _____

ABOUT THE APPLICANT:	**YES**	**NO**	**COMMENTS:**
Any dietary restrictions? (If yes, explain)	☐	☐	
A working refrigerator?	☐	☐	
Freezer space to store five (5) frozen meals?	☐	☐	
A working oven/microwave?	☐	☐	
Physically and mentally able to reheat a meal?	☐	☐	
Interested in weekend meals, if available?	☐	☐	
Applicant is: ☐ Blind ☐ Deaf Applicant uses: ☐ Walker ☐ Wheelchair ☐ Cane			

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	☐	☐	☐	☐	☐	☐
	Bathing	☐	☐	☐	☐	☐	☐
	Toileting	☐	☐	☐	☐	☐	☐
	Walking	☐	☐	☐	☐	☐	☐
IADLS	Light Housework	☐	☐	☐	☐	☐	☐
	Shopping/Errands	☐		☐		☐	☐
	Meal Prep/Cleanup	☐	☐	☐	☐	☐	☐
	Transportation	☐	☐	☐		☐	☐
	Using Telephone	☐	☐	☐		☐	☐
	Managing Medications	☐	☐	☐	☐	☐	☐
	Managing Money	☐	☐	☐		☐	☐
	Heavy Housework	☐	☐	☐	☐	☐	☐

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:	☐ Senior ☐ Spouse ☐ Non-Senior Disabled
Reviewed by: ☐ Staff ☐ Volunteer	Type of Meals: ☐ Hot ☐ Frozen