

CONGREGATE MEAL AND NUTRITION COUNSELING ASSESSMENT

Name (First, MI, Last):		Assessment Date:															
Residential Address (Fire No. & Street):		Date of Birth (month/day/year): / /															
City/State/Zip:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female															
Mailing Address (if different from resident/street address):		Telephone Number:															
City/State/Zip:		Email Address:															
Race: <input type="checkbox"/> American Indian/Native Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White (non-Hispanic) <input type="checkbox"/> Other _____	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino ----- Living Arrangement: Lives Alone <input type="checkbox"/> Yes <input type="checkbox"/> No	Income Status: Is your income below the following Federal Income Guidelines? <input type="checkbox"/> Yes <input type="checkbox"/> No <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th># in Home</th> <th>Month</th> <th>Year</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>\$1,012</td> <td>\$12,140</td> </tr> <tr> <td>2</td> <td>\$1,372</td> <td>\$16,460</td> </tr> <tr> <td>3</td> <td>\$1,732</td> <td>\$20,780</td> </tr> <tr> <td>4</td> <td>\$2,092</td> <td>\$25,100</td> </tr> </tbody> </table>	# in Home	Month	Year	1	\$1,012	\$12,140	2	\$1,372	\$16,460	3	\$1,732	\$20,780	4	\$2,092	\$25,100
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Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Life Partner <input type="checkbox"/> Other _____																	

Nutrition Risk Screening Questions

No Yes

	No	Yes
I have an illness or condition that made me change the kind and/or amount of food I eat.	0	2
I eat fewer than 2 meals a day.	0	3
I eat few fruits or vegetables or milk products.	0	2
I have three or more drinks of beer, liquor or wine almost every day.	0	2
I have tooth or mouth problems that make it hard for me to eat.	0	2
I don't always have enough money to buy the food that I need.	0	4
I eat alone most of the time.	0	1
I take 3 or more different prescribed or over-the-counter drugs daily.	0	1
Without wanting to, I have lost or gained 10 pounds in the last six months.	0	2
I am not always able to physically shop, cook and/or feed myself.	0	2

Risk Level: ___ 0-2 Low ___ 3-5 Moderate ___ 6+ High TOTAL ___

Emergency Contact: _____ Relationship: _____

Phone: _____ Email: _____

Allergies or Special Dietary Needs: _____

Privacy Statement: "The information you are being asked to provide is needed to determine if you are eligible to receive Older Americans Act Services and to comply with federal reporting requirements. This information will be stored in a secure electronic database and will not be used for any other purpose. Your information will not be shared with another agency without your permission. This information will not be sold to anyone. You have the right to review your electronic record and request changes to assure accuracy. You will not be denied most services if you refuse to provide this information. If you have questions regarding this, please ask the aging unit staff."