



# COMMUNITY ACTION OF NAPA VALLEY

<b>Congregate Meals</b> Please complete this form to the best of your ability. Items marked with an asterisk (*) are required.		<b>*Unique Participate ID:</b> _____ <b>Referred by:</b> _____ <b>Intake Date:</b> _____ <b>Staff:</b> _____ <b>Beginning Date:</b> _____ <b>*Termination Date:</b> _____ <b>*Reason:</b> _____		<b>Eligibility:</b> ____ Age 60+ ____ Spouse of congregate meal participant ____ Disabled person residing where the congregate site is located. ____ Disabled person who resides with & accompanies a congregate meal participant. ____ Volunteer	
<b>First Name:</b> _____		<b>Last Name:</b> _____		<b>*Date of Birth:</b> _____	
<b>Home Address:</b> _____		<b>City:</b> _____		<b>*Zip Code</b> _____	
<b>Mailing Address: Same as Residential?</b> Yes		<b>City:</b> _____		<b>*Zip Code</b> _____	
<b>Home Phone:</b> ( ) _____ <b>Alternate Phone:</b> ( ) _____ <b>Email:</b> _____		<b>Emergency Contact Name:</b> _____ <b>Address:</b> _____ <b>Phone:</b> ( ) _____ <b>Relationship:</b> _____			
<b>*Living Arrangement # of household members:</b> _____ <input type="checkbox"/> Declined/not stated		<b>*What is your approximate household income?</b> \$ _____ per <input type="checkbox"/> month <input type="checkbox"/> year <input type="checkbox"/> Declined/not stated		<b>*Rural Area:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated	
<b>*Sex at birth?</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>*How do you describe your sexual orientation?</b> (Check only one) <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"/> Declined/not stated <input type="checkbox"/> Not Listed, please specify: _____			
<b>*Have you ever served in the United States military?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated		<b>*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?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated		<b>*If you identify as being military affiliated, check below if: "I consent to this agency and the California Department of Aging transmitting my name, email address, mailing 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."</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at <a href="http://www.calvet.ca.gov">www.calvet.ca.gov</a> or 1-800-952-5626.	
<b>*Ethnicity:</b> (Check one) Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated		<b>Language:</b> <input type="checkbox"/> English Speaking <input type="checkbox"/> Need interpreter <input type="checkbox"/> Non-English/Language			



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<b>*Race: (Check all that apply)</b>	
<input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native	
<input type="checkbox"/> Asian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian	
<input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Samoan	
<input type="checkbox"/> Other Race: _____ <input type="checkbox"/> Declined/not stated	

<b>*Nutritional Risk Assessment:</b>	<b>Circle if yes</b>	
I have an illness or condition that made me change the kind and/or amount of food I eat.	2	
I eat fewer than two meals per day.	3	
I eat few fruits, vegetables, or milk products.	2	
I have three or more drinks of beer, liquor, or wine every day.	2	
I have tooth or mouth problems that make it hard for me to eat.	2	
I do not always have enough money to buy the food I need.	4	
I eat alone all the time.	1	
I take three or more different prescribed or over-the-counter drugs a day.	1	
Without wanting to, I have lost or gained ten pounds in the past 6 months.	2	
I am not always physically able to shop, cook, and/or feed myself.	2	
Total Score:		
<b>Is Nutrition Risk a total score of 0-5 or 6+?</b>	<b>0 - 5</b>	<b>6+</b>
<input type="checkbox"/> Declined to State		

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 they may benefit.

\_\_\_\_\_  
Signature of participant or person completing the form

\_\_\_\_\_  
Date