Nutrition Program GNG Meal Site: _____ Date _____

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Age _____

Address _____

City_____ State _____ Zip Code _____

Home Phone _____ Cell Phone_____

Circle your response:			
	Gender	Male | Female	**Living Alone?** Yes | No
	Marital Status	Single | Married | Widowed | Divorced | Life Partner | Other	
	Race	American Indian/Native Alaskan | Black/African American | Asian | Hispanic	
		Native Hawaiian/Other Pacific Islander | White (Non-Hispanic) | Other	
	Ethnicity	Hispanic or Latino | Not Hispanic or Latino	
	Income Status	If you are a **one person** household, is your income: Above | Below **$1,041 per month?**	If there are **two people** in your household, is your income: Above | Below **$1,409 per month?**

Nutrition Check

	Circle each **YES** number that applies to you:	**YES**	**NO**
1.	I have an illness or condition that made me change the kind and/or amount of food I eat.	2	0
2.	I eat fewer than 2 meals per day.	3	0
3.	I eat few fruits or vegetables or milk products.	2	0
4.	I have 3 or more drinks of beer, liquor or wine almost every day.	2	0
5.	I have tooth or mouth problems that make it hard for me to eat.	2	0
6.	I don't always have enough money to buy the food I need.	4	0
7.	I eat alone most of the time.	1	0
8.	I take 3 or more different prescribed or over-the-counter drugs a day.	1	0
9.	Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2	0
10.	I am not always physically able to shop, cook and/or feed myself.	2	0
		Total	

Emergency Contact (available 10:30 AM - 1:00 PM):

Name _____ Relationship _____

Home Phone _____Cell _____ Work Phone _____

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 his information.

Nutrition Program Use Only (Circle if <60)

Living at Meal Site Spouse/Relative Volunteer Living with Elderly Caregiver Staff

ADL (Activities of Daily Living)

Do you have difficulty doing the following? If so, check √ if difficult.	Difficulty (✓)
Getting in and out of the bath or shower or preparing the bath, washing and drying	
Dressing and undressing	
Completing toilet activities and person hygiene	
Getting in and out of bed or a chair	
Using utensils and eating without help	
Walking up and down a flight of stairs or walking or walking without assistance	
CHECK √ TOTAL:	

IADL (Instrumental Activities of Daily Living)

Do you have difficulty doing the following? If so, check √ if difficult.	Difficulty (✓)
Preparing own meals	
Medication management	
Handling bill paying, banking, etc	
Doing heavy housework and outside chores	
Doing light housework	
Shopping for personal items and/or groceries	
Traveling in a van, taxi, bus or car	
Answering the telephone or calling out on the telephone	
CHECK √ TOTAL:	

_____

Participant Name

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