

Date of Registration _____

Name (First, MI, Last): _____

Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Transgender Unspecified <input type="checkbox"/> Gender Nonconforming <input type="checkbox"/> Gender Fluid/Not Exclusively Male or Female <input type="checkbox"/> Self-Describe (specify) <hr/>	Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other _____ <hr/>	Household: <input type="checkbox"/> I live alone. <input type="checkbox"/> I live with others. <hr/> Income Status: Is your income at or below the following guidelines? <input type="checkbox"/> Above <input type="checkbox"/> Below # in Home Month / Year 1 \$1,215 \$14,580 2 \$1,643 \$19,720 3 \$2,072 \$24,860 4 \$2,500 \$30,000
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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

Risk Level: 0-2 Low 3-5 Moderate 6+ High Total _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Email: _____

Nutrition Program Use Only (Circle if <60)

Spouse or domestic partner of meal recipient aged 60 or older	Disabled Living in Elderly Housing	Disabled Living with Elderly Person	Volunteer
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For each of the following statements, please tell me which one is "often true," "sometimes true" or "never true" for the past 12 months.	Often True	Sometimes True	Never True
1. We (I) worried whether our food would run out before we (I) got money to buy more.	<input type="checkbox"/> Yes*	<input type="checkbox"/> Yes*	<input type="checkbox"/> Yes
2. The food that we (I) bought just didn't last and we (I) didn't have money to get more.	<input type="checkbox"/> Yes*	<input type="checkbox"/> Yes*	<input type="checkbox"/> Yes

1. Have you recently lost weight without trying?

- No (0)
- Unsure (2)
- Yes

If yes, how much weight have you lost?

- 2-13 pounds (1)
- 14-23 pounds (2)
- 24-33 pounds (3)
- 34 pounds or more (4)
- Unsure (2)

2. Have you been eating poorly because of a decreased appetite?

- No (0)
- Yes (1)

Weight loss score: ____ Appetite Score: ____ MST Score (Total): ____

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."