**2020 Consumer Congregate Nutrition Assessment Form** Updated March 10, 2020

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| Basic Client Information: Date of Assessment: / / | | | | | | | | | | | | | |
| \*Last Name: | | \*First Name: | | | | | | Middle Initial: | | | | | |
| \*Gender: □Male □Female □Other | | \*Date of Birth: / / | | | | | | \*Age: | | | | | |
| **Residential Address:** | | | | | | | | | | | | | |
| \*Address Line 1: | | | | | \*Address Line 2(Apt #, Unit #, Floor #): | | | | | | | | |
| \*City: | | | | | \*State: | | | | | | | | \*Zip: |
| \*County: | | | | | Phone (Home): | | | | | | | | |
| Phone (Mobile): | | | | | Phone (Work): | | | | | | | | |
| Location Comments (Directions): | | | | | | | | | | | | | |
| Email Address: | | | | | | | | Are you receiving Medicaid? □Yes □No | | | | | |
| What is your marital status ? □Married/Domestic Partner □Single □ Widowed | | | | | | | | Are you a veteran? □Yes □No | | | | | |
| \*Lives : □Alone □ With others | | | | | | | What is your primary language? | | | | | | |
| \*What is your race? | | | | | | \*Ethnicity? □Hispanic/Latino □ Not Hispanic/Latino | | | | | | | |
| \*Are you visually impaired (cannot be corrected with glasses)? □Yes □No | | | | | | | | | | | | | |
| Are you caregiver to anybody? □Yes □No | | | | | | \*Are you a grandparent, raising grandchildren: )? □Yes □No | | | | | | | |
| Are you working?  □Full-time □Part-time □Retired □Volunteering □Seeking employment □No | | | | | | | | | Are you willing to volunteer? □Yes □No | | | | |
| How many people live in your household? | | | | | | | | | | | | | |
| What is your monthly individual income? | | | | | | What is your monthly household income? | | | | | | | |
| \*What is your monthly income range? | □ $1,063 or less  □ $1,064 to $1,327  □ $1,328 to $1,965  □ $1,966 or more | | | | | \*What is you and your spouse’s combined monthly income range? | | | |  | □ $1,437 or less  □ $1,438 to $1,796  □ $1,797 to $2,658  □ $2,659 or more | | |
| **Mailing Address, if different from physical Address:** | | | | | | | | | | | | | |
| Mailing Address Line 1 (if different from physical address): | | | | | | | | | | | | | |
| Mailing Address Line 2 (Apt #, Unit #, Floor #): | | | | | | | | | | | | | |
| Mailing City: | | | | Mailing State: | | | | Mailing Zip Code: | | | | | |
| Are you interested in receiving nutrition counseling? □Yes □No | | | | | | | | | | | | | |
| How did you hear about our services?  □AAA Brochure □AAA Newsletter □Channel 9 Senior Source (TV) □Congregate Meal Site □From a Current Client □From a Friend/Relative □Senior Fair □Walk-In □Web Site □Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| Do you want to hear about other services? □ Yes □ No | | | | | | | If yes, how can we contact you? □ Email □ Mail □ Phone | | | | | | |
| When is the best time to contact you? | | | | | | | Please tell us what services you would like to receive: | | | | | | |
|  | | | | | | | | | | | | | |
| Emergency contact name: | | | | | | Relationship: | | | | | | Phone Number: | |
| Physician’s first name: | | | Physician’s last name: | | | | | | | | | Phone Number: | |

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| --- | --- | --- | --- | --- |
| **Nutrition Questions - Please fill out if you receive meals at a meal site:** | | **Yes** | **No** | Yes Score |
| \*I have an illness or condition that made me change the kind and/or amount of food I eat. | |  |  | 2 |
| \*I eat fewer than 2 meals per day. | |  |  | 3 |
| \*I eat few fruits or vegetables or milk products. | |  |  | 2 |
| \*I have 3 or more drinks of beer, liquor, or wine almost every day. | |  |  | 2 |
| \*I have tooth or mouth problems that make it hard for me to eat. | |  |  | 2 |
| \*I don’t always have enough money to buy the food I need. | |  |  | 4 |
| \*I eat alone most of the time. | |  |  | 1 |
| \*I take 3 or more different prescribed or over the counter drugs a day. | |  |  | 1 |
| \*Without wanting to, I have lost or gained 10 pounds in the last 6 months. | |  |  | 2 |
| \*I am not always physically able to shop, cook and/or feed myself. | |  |  | 2 |
| What is the consumer's nutritional risk score?  (0-2 = No Risk 3-5 = Moderate Risk 6 or more = High Risk) | **Total ‘Yes’ Score \_\_\_\_\_\_\_** | | | |
|  |  | | | |

*I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service provider and I herewith give my consent to do so.*

*(If filled out by assessor or via phone, please have assessor check here and sign below* □).

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office use only:** Information filled out by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_