CONTRACOSTA COUNTY
EMPLOYMENT & HUMAN SERVICES

Thank you for participating in the Senior Nutrition Program at Café Costa. As a participant of this program, it is important that we gather complete and accurate information from diners to ensure that we are reaching Contra Costa residents eligible for this program and to demonstrate the need for continued funding for senior nutrition services. Please complete this form to the best of your ability. Items marked with an asterisk (*) are required. Your information is kept completely confidential and safe. Your personal information will never be shared with anyone. Thank you for completing this form.

Congregate Meal Provider/Café Costa Site: **Fiscal Year:**

***First Name:**	***Last Name:**	***Date of Birth:**

***Home Address**	***City:**	***Zip Code**
Mailing Address: Same As Residential? ☐ Yes	City:	Zip Code

***Home Phone: ( )**
Alternate Phone: ( )

***Emergency Contact**
***Name:**
Address:
***Phone:** ( ) ***Relationship:**

***Living Arrangement**
# of household members: ☐
☐ Declined/not stated

***What is your approximate household income?**
$__________ per ☐ month ☐ year ☐ Declined/not stated

***Rural Area:**
☐ Yes ☐ No
☐ Declined/not stated

***What is your gender? (Check only one)**
☐ Male ☐ Female
☐ Transgender Male to Female
☐ Transgender Female to Male
☐ Genderqueer/Gender Non-binary
☐ Not Listed, please specify: __________
☐ Declined/not stated

***What was your sex at birth? (Check only one)**
☐ Male
☐ Female
☐ Declined/not stated

***How do you describe your sexual orientation or sexual identity? (Check only one)**
☐ Straight/Heterosexual
☐ Bisexual
☐ Gay/Lesbian/Same-Gender Loving
☐ Questioning/Unsure
☐ Not Listed, please specify: __________
☐ Declined/not stated

***Ethnicity:** (Check one)
Hispanic ☐ Yes ☐ No ☐ Declined/not stated

Language:
☐ English Speaking ☐ Need interpreter ☐ Non-English/Language

***Race: (Check all that apply)**
☐ White ☐ Black ☐ American Indian/Alaska Native Asian:
☐ Asian Indian ☐ Cambodian ☐ Other Asian ☐ Korean
☐ Chinese ☐ Filipino ☐ Laotian ☐ Vietnamese ☐ Guamanian
☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Japanese
☐ Declined/not stated

*Nutritional Risk Assessment:	Check if yes	
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 past 6 months. (2)	☐	
I am not always physically able to shop, cook, and/or feed myself. (2)	☐	
Total Score:		
Is Nutrition Risk total score 0-5 or 6+ ?	**0 - 5**	**6+**
☐ **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 may benefit.

______________________________________ ______________________

Signature of participant or person completing the form Date

For Office Use only:

Notes:

***Unique Participant ID:** ______________	*Eligibility:
Intake Date: ______________________	☐ Age 60+ ☐ Spouse of congregate meal participant
Beginning Date: ____________________	☐ Disabled person residing where the congregate site is located
***Termination Date:**________________ ***Reason:** ________________________	☐ Disabled person who resides with and accompanies a congregate meal participant