|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Congregate Meal Program Registration** Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please complete this form to the best of your ability.  Shaded areas are for office use only. Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
| Contact Date | Status | | | AAA Region | | | Eligibility Category (Check one):   * Client ⁭ Spouse ⁭ Volunteer * Caregiver ⁭ Disabled under 60 | | | | | NAPIS ID Number  - - |
| **Section A. Basic Demographics** | | | | | | | | | | | | |
| Last Name: | | | | | | First Name: | | | | | | Middle Initial: |
| Lives in Rural Area (mark one):  □ Yes ⁭ No | | | | | | Gender: ⁮ Female ⁮ Male  □ Unspecified | | | | | | Date of Birth:  / / |
| Address: | | | | | | | | Address #2: | | | | |
| City: | | | | | State: | | | Zip Code: | | | | County: |
| Home Phone:  ( ) | | | Mobile Phone:  ( ) | | | | | | | Work Phone:  ( ) | | |
| **Section B. Social History** | | | | | | | | | | | | |
| Race (Circle one):  American Indian/Alaskan Asian  White Hispanic White not Hispanic  2 or More Races Black/African American  Native Hawaiian/Pacific Islander Other | | | | | | | | | Ethnicity (Circle one)   * Hispanic or Latino * Non-Hispanic | | | |
| Household Size (Circle One): I live alone. I live with others. | | | | | | | | | | | | |
| **Section C. Financial** | | | | | | | | | | | | |
| * I live alone and my monthly income is between (circle one)   $1,063/month or less $1,064 - $1,595/month $1,596-$2,127/month More than $2,128/month   * I live with my **spouse** and our monthly income is between (circle one)   $1,437/month or less $1,438-$2,155/month $2,156-$2,873/month More than $2,874/month | | | | | | | | | | | | |
| **Section D. Contacts** | | | | | | | | | | | | |
| Emergency Phone:  ( ) | | Emergency Contact Name | | | | | | | | | Emergency Contact  Relationship  **OVER→** | |

|  |  |
| --- | --- |
| **Section E. Nutrition Risk Assessment** | |
| Have you changed the way you eat due to illness or  medical condition?  Yes No | Are there times when you don’t have enough money to buy the food you need?  Yes No |
| Do you eat less than 2 meals a day?  Yes No | Do you eat alone most of the time?  Yes No |
| Do you eat few fruits or vegetables or milk products?  Yes No | Do you take 3 or more prescribed or over-the-counter drugs each day?  Yes No |
| Do you have 3 or more drinks of beer, liquor or wine  almost every day?  Yes No | Have you lost or gained 10 pounds in the last 6 months without wanting to?  Yes No |
| Do you have tooth or mouth problems that make it hard  to eat?  Yes No | Are there times when you are not physically able to shop, cook or feed yourself?  Yes No |
| **Section F. Use of Information** | |
| I understand that the information I am providing on this form is for registration purposes. The information will be used by the U.S. Health and Human Services Administration for Community Living (ACL), the Minnesota Board on Aging (MBA) and the local Area Agency on Aging, to create statistical reports. ACL, MBA and/or its assignees may use this information to conduct a study and/or survey of this service. In addition, information provided here, may be used by other service providers to help identify other services from which I may benefit, such as follow up to the Nutrition Risk Assessment. This information will not be released to anyone other than the above mentioned parties in a way that will identify me as an individual unless I sign a separate consent for that purpose.  Signature: Today’s Date: | |

MBA 2/2020