Congregate Meal Program Registration

Please complete this form to the best of your ability.

Site:_____

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)

$1,041/month or less $1,042- $1,561/month $1,562-$2,082/month More than $2,083/month

□ I live with my **spouse**……..and our monthly income is between (circle one)

$1,409/month or less $1,410-$2,114/month $2,115-$2,818/month More than $2,819/month

Section D. Contacts

Emergency Phone: ( )	Emergency Contact Name	Emergency Contact Relationship

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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:_____