COUNTY of VENTURA
Area Agency on Aging

Senior Nutrition Program HOME-DELIVERED Meals (C2) – Client Intake Form FY2022-2023

CONFIDENTIAL

PROVIDER LOCATION: _____

TO RECEIVE HOME DELIVERED MEALS: Person must be aged 60 or older, homebound due to illness or disability, unable to prepare meals, unable to drive, and unable to attend a congregate meal site if transportation were provided. There is no charge for meals; however, donations are accepted. A person will not be denied services if that individual chooses not to donate.

Date:		**Phone:**		**Birth Date:** *(Required)*	
Last Name:		**First Name:** *(No nicknames)*			

APPLICANT ELIGIBILITY	**YES**	**NO**	**NOTE:**
Is applicant homebound due to illness or disability?	☐	☐	If answer is NO, stop here; applicant is not eligible for home-delivered meals.
Is applicant 60 or older, and/or the spouse of an eligible senior?	☐	☐	
Is applicant able to prepare meals?	☐	☐	If answer is YES, stop here; applicant is not eligible for home-delivered meals.
Does applicant drive?	☐	☐	
Can applicant attend a congregate meal site if transportation is provided?	☐	☐	

Street Address:		**City:**		**ZIP:**	
Email:		**Rural:** (91307, 93066, 93040)	☐ Yes ☐ No ☐ Decline to State		
Local Emergency Contact Name:		**Phone:**			

RACE – PLEASE CHOOSE (X) ONE:

☐ American Indian or Alaska Native	☐ Filipino	☐ Laotian	☐ Samoan	☐ Not Hispanic/ Latino
☐ Asian Indian	☐ Guamanian	☐ Other Asian	☐ Vietnamese	☐ Hispanic/ Latino
☐ Black or African American	☐ Hawaiian	☐ Other Pacific Islander	☐ White	☐ Decline to State
☐ Cambodian	☐ Japanese		☐ Decline to State	
☐ Chinese	☐ Korean			

Ethnicity:

Marital Status:	☐ Divorced	☐ Domestic Partner	☐ Married	☐ Separated	☐ Single	☐ Widowed	☐ Decline to State
Veteran Status:	☐ Yes ☐ No		**Preferred Language:**				
Client Lives:	☐ Alone ☐ Not Alone ☐ Decline to State		**Number of Persons Living in Household:**				

Applicant's Income Level (approximate):

IF MARRIED:	**IF SINGLE:**
☐ At or below Federal Poverty Level *($18,310/year or less)*	☐ At or below Federal Poverty Level *($13,590/year or less)*
☐ Above Federal Poverty Level *($18,311/year or more)*	☐ Above Federal Poverty Level *($13,591/year or more)*
☐ Decline to State	☐ Decline to State

What was your sex at birth?	**What is your Gender?**	**How do you describe your sexual orientation or sexual identity?**
☐ Female	☐ Female ☐ Male	☐ Straight/Heterosexual
☐ Male	☐ Transgender Female to Male	☐ Bisexual
☐ Decline to State	☐ Transgender Male to Female	☐ Gay/Lesbian/Same-Gender Loving
	☐ Genderqueer/Gender Non-binary	☐ Questioning/Unsure
	☐ Decline to State	☐ Decline to State
	☐ Not listed, please specify:	☐ Not listed, please specify:

THIS BOX FOR SERVICE PROVIDER ASSESSMENT

About the Applicant:	**YES**	**NO**	**Over the Past 3 Months, Does the Client…**	**YES**	**NO**
Any dietary restrictions? (If yes, explain)	☐	☐	Have trouble using the microwave or oven?	☐	☐
A working refrigerator?	☐	☐	Repeat some things over and over?	☐	☐
Freezer space to store five frozen meals?	☐	☐	Have trouble recalling appointments?	☐	☐
A working oven/microwave?	☐	☐	Have conversations that don't make sense?	☐	☐
Interested in weekend meals, if available?	☐	☐	Appear confused at times?	☐	☐
Comments:			**Comments:**		

Senior Nutrition Program HOME-DELIVERED Meals (C2) – Client Intake Form FY2022-2023

CONFIDENTIAL

Nutritional Assessment of Applicant:		**Check All That Apply:**
I have an illness or condition that made me change the kind and/or amount of food I eat.	(2pts)	☐
I eat fewer than 2 meals per day.	(3pts)	☐
I eat few fruits or vegetables or milk products.	(2pts)	☐
I have 3 or more drinks of beer, liquor or wine almost every day.	(2pts)	☐
I have tooth or mouth problems that make it hard for me to eat.	(2pts)	☐
I don't always have enough money to buy the food I need.	(4pts)	☐
I eat alone most of the time.	(1pt)	☐
I take 3 or more different prescribed or over-the-counter drugs a day.	(1pt)	☐
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	(2pts)	☐
I am not always physically able to shop, cook and/or feed myself.	(2pts)	☐
	Decline to State:	☐
(If equal to or greater than 6, the client is at high nutritional risk→)	**Total Score:**	

CALIFORNIA ACTIVITIES & INSTRUMENTAL ACTIVITIES (IADLS) OF DAILY LIVING (ADLS)
Please Check (✓) One of the Columns for Each Activity

	TYPE OF ASSISTANCE CARE RECEIVER NEEDS TO PERFORM TASK ➔	1 INDEPENDENT Needs No Help	2 VERBAL QUE Needs verbal reminders	3 STAND BY Needs some human help	4 HANDS ON Needs lots of human help	5 DEPENDENT Cannot perform task	Decline to State
ADLS	**Eating**	☐	☐	☐	☐	☐	☐
	Dressing	☐	☐	☐	☐	☐	☐
	Transferring	☐	☐	☐	☐	☐	☐
	Bathing	☐	☐	☐	☐	☐	☐
	Toileting	☐	☐	☐	☐	☐	☐
	Walking	☐	☐	☐	☐	☐	☐
IADLS	**Light Housework**	☐	☐	☐	☐	☐	☐
	Shopping/Errands	☐		☐		☐	☐
	Meal Prep/Cleanup	☐	☐	☐	☐	☐	☐
	Transportation	☐	☐	☐		☐	☐
	Using Telephone	☐	☐	☐		☐	☐
	Managing Medications	☐	☐	☐	☐	☐	☐
	Managing Money	☐	☐	☐		☐	☐
	Heavy Housework	☐	☐	☐	☐	☐	☐

Applicant is:	☐ Blind ☐ Deaf	Applicant uses:	☐ Walker ☐ Wheelchair ☐ Cane

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 I may benefit.

_____
Applicant's Signature

DO NOT WRITE IN THIS BOX – OFFICIAL USE ONLY

Client Q Database/Unique Participant ID Number:	☐ Senior ☐ Spouse ☐ Non-Senior Disabled
Reviewed by: ☐ Staff ☐ Volunteer	Type of Meals: ☐ Hot ☐ Frozen