



Thank you for participating in the Café Costa Senior Nutrition Program. 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	
*Home Address		*Date of Birth	
*Home Address		*City	*Zip
Check if mailing address same as home address <input type="checkbox"/>		*Home Phone ()	Alternate Phone ()
Alternate Address		E-Mail Address	
*Emergency Contact:			
*Name:		*Phone: ()	*Relationship:
Address:			
*Living Arrangement # of members in household <input type="text"/>	*Approximate household income \$ _____ per <input type="checkbox"/> month <input type="checkbox"/> year		*Rural Area Resident?
<input type="checkbox"/> Declined/not stated	<input type="checkbox"/> Declined/not stated		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
*What is your gender? (Check only one)	*What was your sex at birth? (Check only one)	*How do you describe your sexual orientation or sexual identity? (Check only one)	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not listed, please specify: _____ <input type="checkbox"/> Declined/not stated	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated	<input type="checkbox"/> Straight/heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not listed, please specify: _____ <input type="checkbox"/> Declined/not stated	
*Ethnicity (Check one)		Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Neet interpretation	
Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated		<input type="checkbox"/> Other _____ <input type="checkbox"/> Declined/not stated	
*Race (Check all the apply)			
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian	<input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian	<input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan	<input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined/not stated

***Veterans Status**

Have you ever served in the United States military? Yes No

Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military? Yes No

I consent to this agency and the California Department of Aging transmitting my name, e-mail address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for 12 months. Yes No

Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or call toll free at 1-800-952-5626.

*Nutritional Risk Assessment:	Check One
I have an illness or condition that made me change the kind and/or amount of food I eat (2)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined
I eat fewer than 2 meals a day. (3)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined
I eat few fruits or vegetables or milk products. (2)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined
I have 3 or more drinks of beer, liquor, or wine almost every day. (2)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined
I have tooth or mouth problems that make it hard for me to eat. (2)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined
I don't always have enough money to buy the food I need. (4)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined
I eat alone most of the time. (1)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined
I take 3 or more different prescribed or over-the-counter drugs a day. (1)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined
Without wanting to, I have lost or gained 10 pounds or more in the past 6 months. (2)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined
I am not always physically able to shop, cook, and/or feed myself. (2)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined
Nutrition Risk Total Score	
Nutrition Risk Total Score (check one)	
<input type="checkbox"/> 0-5 <input type="checkbox"/> 6 or more	

I understand the information I am providing on this form is for registration purposes only and will be kept confidential. I understand the Area Agency on Aging and its nutrition program service providers may use it to help identify other services I may need and help me get connected to these resources.

Name and signature of Participant/Person completing this form

Date

For Office Use Only

Notes:	
*Unique Participant ID	*Eligibility (check all that apply): <input type="checkbox"/> Aged 60+ <input type="checkbox"/> Spouse of congregate meal participant aged 60+ <input type="checkbox"/> Disabled person who resides with and accompanies a congregate meal participant
Intake Date	
Beginning Date	
Termination Date	
Reason for Termination	