



RIVERSIDE COUNTY OFFICE ON AGING

TOLL-FREE SENIOR HELPLINK (800) 510-2020

Congregate Meals Intake Form

PLEASE PRINT

INTAKE DATE: ____/____/____

PROVIDER # _____	SITE # _____
SERVICE DATE: ____/____/____	
PROGRAM # _____	UNIT # _____

TRANSACTION TYPE: NEW CORRECTION RE-ASSESSMENT

(Please highlight correction)

FIRST NAME	M.I.	SOCIAL SECURITY NUMBER (Optional)	
LAST NAME			
NUMBER & STREET ADDRESS			
CITY	STATE	ZIP CODE	
MAILING ADDRESS			
CITY	STATE	ZIP CODE	
HOME PHONE NUMBER	OTHER PHONE NUMBER		
DATE OF BIRTH	AGE		

HOW WERE YOU REFERRED?

- | | |
|---|---|
| <input type="checkbox"/> Case Worker | <input type="checkbox"/> Service Provider |
| <input type="checkbox"/> Church/Church Bulletin | <input type="checkbox"/> Relative/Friend |
| <input type="checkbox"/> Doctor/Hospital | <input type="checkbox"/> Senior Center |
| <input type="checkbox"/> Newspaper, Radio, TV | <input type="checkbox"/> Senior Publication |
| <input type="checkbox"/> Peer Volunteer | <input type="checkbox"/> Self |

(Please complete reverse side)

Gender		Rural	
<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Rural	<input type="checkbox"/> Urban <input type="checkbox"/> Declined To State
Ethnicity			
<input type="checkbox"/> Not Hispanic/Latino	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Declined To State	
Race			
<input type="checkbox"/> White	<input type="checkbox"/> Black Or African American		
<input type="checkbox"/> Amer. Indian Or Alaska Native	<input type="checkbox"/> Guamanian		
<input type="checkbox"/> Chinese	<input type="checkbox"/> Hawaiian		
<input type="checkbox"/> Japanese	<input type="checkbox"/> Samoan		
<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Pacific Islander		
<input type="checkbox"/> Korean	<input type="checkbox"/> Asian Indian		
<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Samoan		
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Other Race		
<input type="checkbox"/> Laotian	<input type="checkbox"/> Multiple Race		
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Declined To State		
<input type="checkbox"/> Other Asian			
Living Arrangement			
<input type="checkbox"/> Alone	<input type="checkbox"/> Not Alone	<input type="checkbox"/> Declined To State	
Poverty Status			
<input type="checkbox"/> At Or Below 100% FPL	<input type="checkbox"/> Above 100% FPL	<input type="checkbox"/> Declined To State	

EMERGENCY CONTACT INFORMATION

NAME _____

ADDRESS _____

CITY _____

PHONE NUMBER _____

NUTRITIONAL RISK SCREENING

Circle the points of all that apply and enter total.

	POINTS
Has illness or condition that changed the kind and/or amount of food eaten.	2
Eats fewer than 2 meals per day.	3
Eats few fruits, vegetables, or milk products.	2
Have 3 or more drinks of beer, liquor or wine almost everyday.	2
Has tooth or mouth problems that make it hard for me to eat.	2
Doesn't always have enough money to buy the food needed.	4
Eats alone most of the time.	1
Takes 3 or more different prescribed or over-the-counter drugs a day.	1
Has lost or gained 10 pounds in the last 6 months.	2
Not always physically able to shop, cook, and/or feed self.	2
TOTAL	

TOTAL YOUR NUTRITIONAL SCORE. IF IT'S -

0-2 Low Nutritional Risk

3-5 Moderate Nutritional Risk

6 OR MORE: High Nutritional Risk

PRIMARY PHYSICIAN INFORMATION

NAME _____

ADDRESS _____

CITY _____

PHONE NUMBER _____