SAN BERNARDINO COUNTY

Aging and Adult Services
Public Guardian

Title IIIC Congregate Meals Intake Sheet 2023/24

Provider Section — **Note:** All items marked with asterisk (*) are required fields.

* **Provider Name:** FSA-LOMA LINDA

* **Type:**
- ☐ New client
- ☐ Reassessment
- ☐ Update information

* **Eligibility:**
- ☐ Age 60 or older ☐ Spouse of ENP participant ☐ Volunteer
- ☐ Disabled person residing where the congregate site is located
- ☐ Disabled person who resides with and accompanies an ENP participant

* **Registration/Assessment Date:**	* **Termination Date:** * **Reason:**	* **Unique Participant ID:**

Participant Section

* **Date of Birth**: _____ /_____ /_____	Home Phone: (_____) _____ - _____	Cell Phone: (_____) _____ - _____

* **First Name**:	**Middle Initial:**	* **Last Name:**

Home Address:	City:	* **Zip Code:**

* **Do you live in a rural area?**
☐ Yes ☐ No ☐ Declined/not stated

* **Do you live alone?**
☐ Yes ☐ No ☐ Declined/not stated

Emergency Contact
Name: _____ Relationship: _____
Address: _____ Phone: ( ) _____-_____

* **Below Federal Poverty Level (FPL)?** Family Size: 1 = $14,580 2 = $19,720
☐ Yes (At/below FPL) ☐ No (Above FPL) ☐ Declined/not stated

* **What is your gender?**
(Check only one)
- ☐ Male ☐ Female
- ☐ Transgender Female to Male
- ☐ Transgender Male to Female
- ☐ Genderqueer/Gender Non-binary
- ☐ Not Listed, please specify: _____
- ☐ Declined/not stated

* **What was your sex at birth?**
(Check only one)
- ☐ Male
- ☐ Female
- ☐ Declined/not stated

* **How do you describe your sexual orientation or sexual identity?** (Check only one)
- ☐ Heterosexual/Straight ☐ Bisexual
- ☐ Gay/Lesbian/Same Gender Loving
- ☐ Questioning/Unsure
- ☐ Not listed, please specify: _____
- ☐ Declined/not stated

* **Race:** (Check only one)
- ☐ White ☐ Black or African American ☐ American Indian/Alaskan Native

Asian:
- ☐ Asian Indian ☐ Chinese ☐ Japanese ☐ Laotian ☐ Cambodian
- ☐ Filipino ☐ Korean ☐ Vietnamese ☐ Other Asian

Hawaiian/Other Pacific Islander:
- ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander
- ☐ Declined/not stated

***Ethnicity**:
(Check only one)
- ☐ Not Hispanic/Latino
- ☐ Hispanic/Latino
- ☐ Declined/not stated

***Have you ever served in the United States military?**
☐ Yes ☐ No ☐ Declined/not stated

***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 ☐ Declined/not stated

San Bernardino County
Department of Aging and Adult Services

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***If you identify as being military affiliated, check below if:**
"I consent to this agency and the California Department of Aging transmitting my name, email 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 1-800-952-5626.

Other: ☐ U.S. Veteran ☐ Need interpreter ☐ Non-English Language _____

Please choose your current health coverage:
☐ Kaiser ☐ Health Net ☐ IEHP ☐ Molina ☐ None ☐ Other (please specify): _____

* **Nutritional Risk Assessment (If score is 6 or greater, client is at high nutritional risk)**	**Circle if yes**
I have an illness or condition that made me change the kind and/or the amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few servings of fruits or vegetables or milk products.	2
I have 3 or more drinks of beer, liquor, or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I do not always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more prescribed or over-the-counter drugs a day.	1
Without wanting to, I have **lost** or **gained** 10 or more pounds in the last 6 months. (If yes, please **circle** either **lost** or **gained.**)	2
I am not always physically able to cook, shop and/or feed myself.	2

☐ **Declined/not stated**	**Is Nutritional Risk total score 0-5 or 6 + ?**	**0 - 5**	**6+**

_____ _____
Signature of participant or person completing the form Date