

FORM C-2 and To-Go

Home-Delivered and To-Go Meals This form is designed to be completed by an intake staff. Items marked with an asterisk (*) are required.		Route:	Intake Date: _____ Active Date: _____ Inactive Date: _____ Active Date: _____ Inactive Date: _____ Active Date: _____ Inactive Date: _____
*Unique Participant ID:		*Termination Date: Reason:	
*Date of Birth: / /		<input type="checkbox"/> New client <input type="checkbox"/> Annual reassessment <input type="checkbox"/> Change in information	
First Name:		Last Name:	
Home Address		City:	*Zip Code
Home Phone: () Alternate Phone: ()		Emergency Contact Name: Address: Phone: () Relationship:	
*Living Arrangement # of household members: <input style="width:50px; height:20px;" type="text"/> <input type="checkbox"/> Declined/not stated	*What is your approximate household income? \$ _____ per <input type="checkbox"/> month <input type="checkbox"/> year <input type="checkbox"/> Declined/not stated		*Rural Area: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated
*What is your gender? (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	*What was your sex at birth? (Check only one) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated	*How do you describe your sexual orientation or sexual identity? (Check only one) <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	
*Have you ever served in the United States military? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated	*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." <input type="checkbox"/> Yes <input type="checkbox"/> 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.	
*Ethnicity: (Check one) Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/not stated		Language: <input type="checkbox"/> English Speaking <input type="checkbox"/> Need interpreter <input type="checkbox"/> Non-English/Language	
*Race: (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native Asian: <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 Hawaiian/Other Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined/not stated			

ADLs: ADLs and IADLs (Activities of Daily Living and Instrumental Activities of Daily Living)

Please rate your functional abilities for the following activities.

ADLs	Rated Value	IADLs	Rated Value	IADLs	Rated Value	RATING SCALE 1 – Independent 2 – Verbal Assistance 3 – Some Human Help 4 – Lots of Human Help 5 – Dependent 6 - Declined to State
Feeding		Meal Preparation		Light Housework		
Dressing		Shopping		Heavy Housework		
Bathing		Manage Medication		Notes:		
Transferring In/Out of Chair		Money Management				
Walking		Telephone				
Toileting		Transportation				

Eligibility:

- Are you homebound due to an illness, disability, or are otherwise isolated?
- Are you a spouse of a meal recipient?
- Are you an individual with a disability who resides with a meal recipient?

Prioritization:

*Nutritional Risk Assessment:	Circle if yes	
I have an illness or condition that made me change the kind and/or amount of food I eat.	2	
I eat fewer than 2 meals per day.	3	
I eat few 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 don't always have enough money to buy the food I need.	4	
I eat alone most of the time.	1	
I take 3 or more different prescribed or over-the-counter drugs a day.	1	
Without wanting to, I have lost or gained 10 pounds in the past 6 months.	2	
I am not always physically able to shop, cook, and/or feed myself.	2	
Total Score:		
*Is Nutrition Risk Total Score 0-5 or 6+ ?	0-5	6+
<input type="checkbox"/> Declined to State		

	Yes	No	Comments
Do you have any dietary restrictions?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a working refrigerator?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a working microwave?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you physically and mentally able to open the food containers?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you physically and mentally able to reheat a meal?	<input type="checkbox"/>	<input type="checkbox"/>	
Are there pets?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you recently been discharged from the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	

Referral(s) Made:

- Nutritional education/counseling for at risk client
- Other:
- Other:

Notes:

Staff Completing Assessment

Date