FORM C-1

Name of Congregate Meal Provider
{Provider Name}
Please complete this form to the best of your ability.
Items marked with an asterisk (*) are required.

EBC

*Unique Participate ID: _____
Referred by: _____
Intake Date: _____
Staff: _____
Beginning Date: _____
*Termination Date: _____
*Reason: _____

Eligibility:
☐ Age 60+
☐ Spouse of congregate meal participant
☐ Disabled person residing where the congregate site is located
☐ Disabled person who resides with and accompanies a congregate meal participant
☐ Volunteer

First Name:	Last Name:	*Date of Birth:
Home Address	City:	*Zip Code
Mailing Address: Same As Residential? ☐ Yes	City:	*Zip Code
Home Phone: ( ) Alternate Phone: ( )	Emergency Contact Name: Address: Phone: ( ) Relationship:	

***Living Arrangement # of household members:** ☐
☐ Declined/not stated

***What is your approximate household income?**
$ _____ per ☐ month ☐ year
☐ Declined/not stated

***Rural Area:**
☐ Yes ☐ No
☐ Declined/not stated

***What is your gender? (Check only one)**
☐ Male ☐ Female
☐ Transgender Male to Female
☐ Transgender Female to Male
☐ 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)**
☐ Straight/Heterosexual
☐ Bisexual
☐ Gay/Lesbian/Same-Gender Loving
☐ Questioning/Unsure
☐ Not Listed, please specify:
_____
☐ 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

***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 for12 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.

***Ethnicity:** (Check one)
Hispanic ☐ Yes ☐ No ☐ Declined/not stated

Language:
☐ English Speaking ☐ Need interpreter ☐ Non-English/Language

***Race: (Check all that apply)**
☐ White ☐ Black ☐ American Indian/Alaska Native Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian
☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander ☐ Declined/not stated

*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+
☐ Declined to State		

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 may benefit.

Signature of participant · person completing the form

Date