CONTRACOSTA COUNTY
EMPLOYMENT & HUMAN SERVICES

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**	***Date of Birth**
***Home Address**	***City**	***Zip**
Check if mailing address same as home address ☐	***Home Phone** ( )	**Alternate Phone** ( )
Alternate Address	**E-Mail Address**	

***Emergency Contact:** *Name: *Phone: ( ) *Relationship:

Address:

***Living Arrangement** # of members in household ☐ Declined/not stated	***Approximate household income** $_____ per ☐ month ☐ year ☐ Declined/not stated	***Rural Area Resident?** ☐ Yes ☐ No ☐ 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)**
☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Genderqueer/Gender Non-binary ☐ Not listed, please specify: _____ ☐ Declined/not stated	☐ Male ☐ Female ☐ Declined/not stated	☐ Straight/heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same Gender Loving ☐ Questioning/Unsure ☐ Not listed, please specify: _____ ☐ Declined/not stated

***Ethnicity (Check one)**	**Preferred Language** ☐ English ☐ Neet interpretation
Hispanic ☐ Yes ☐ No ☐ Declined/not stated	☐Other _____ ☐ Declined/not stated

***Race (Check all the apply)**

☐ White	☐ Chinese	☐ Vietnamese	☐ Other Pacific Islander
☐ Black	☐ Filipino	☐ Other Asian	☐ Declined/not stated
☐ American Indian/ Alaskan Native	☐ Japanese	☐ Guamanian	
☐ Asian Indian	☐ Korean	☐ Hawaiian	
☐ Cambodian	☐ Laotian	☐ Samoan	

***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)	☐ Yes ☐ No ☐ Declined
I eat fewer than 2 meals a day. (3)	☐ Yes ☐ No ☐ Declined
I eat few fruits or vegetables or milk products. (2)	☐ Yes ☐ No ☐ Declined
I have 3 or more drinks of beer, liquor, or wine almost every day. (2)	☐ Yes ☐ No ☐ Declined
I have tooth or mouth problems that make it hard for me to eat. (2)	☐ Yes ☐ No ☐ Declined
I don't always have enough money to buy the food I need. (4)	☐ Yes ☐ No ☐ Declined
I eat alone most of the time. (1)	☐ Yes ☐ No ☐ Declined
I take 3 or more different prescribed or over-the-counter drugs a day. (1)	☐ Yes ☐ No ☐ Declined
Without wanting to, I have lost or gained 10 pounds or more in the past 6 months. (2)	☐ Yes ☐ No ☐ Declined
I am not always physically able to shop, cook, and/or feed myself. (2)	☐ Yes ☐ No ☐ Declined
Nutrition Risk Total Score	
Nutrition Risk Total Score (check one)	☐ 0-5 ☐ 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):**
Intake Date		☐ Aged 60+
Beginning Date		☐ Spouse of congregate meal participant aged 60+
Termination Date		☐ Disabled person who resides with and accompanies a congregate meal participant
Reason for Termination		