

# Congregate Meals Intake Form

<b>Mizell Center</b> <b>{FY 2025-26 Mizell Indio Senior Center}</b> Please complete this form to the best of your ability. Items Marked with asterisk (*) are required.		Referred by: _____ Intake Date: _____ Staff: _____ Beginning Date: _____ *Termination Date: _____ *Reason: _____		<b>Eligibility:</b> <input type="checkbox"/> Age 60+ <input type="checkbox"/> Spouse of ENP Participant <input type="checkbox"/> Disabled person residing where the congregate site is located <input type="checkbox"/> Disabled person who resides with and accompanies an ENP participant <input type="checkbox"/> Volunteer	
Unique Participant ID: _____					
*First Name: _____		*Last Name _____		MI: _____	*Date of Birth: / /
*Home Address: _____		*City: _____	*County: _____	*Zip Code: _____	
Mailing Address: Same As Residential? <input type="checkbox"/> Yes		City: _____	County: _____	* Zip Code: _____	
Best Contact Phone: ( ) _____		Emergency Contact Name: _____			
Alternate Phone: ( ) _____		Phone: ( ) _____ Relationship to you: _____			
<b>*Veteran</b>					
*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 <a href="http://www.calvet.ca.gov">www.calvet.ca.gov</a> or 1-800-952-5626			
*What is your approximate household income? \$ _____ per <input type="checkbox"/> month <input type="checkbox"/> year <input type="checkbox"/> Declined to State			*Rural Area? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State		
*Poverty Status: (calculate from household income) <input type="checkbox"/> At or Below 100% of the Federal Poverty Level (FPL) <input type="checkbox"/> Above 100% of the FPL <input type="checkbox"/> Declined to State					
* What is your gender? (Check only one) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <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			
*Marital Status: <input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed Since When: _____ <input type="checkbox"/> Declined to State					
*Ethnicity (Check One): Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State			Language: <input type="checkbox"/> English speaking <input type="checkbox"/> Need interpreter <input type="checkbox"/> Non-English/Language: _____		

**\*Race:** (Check One)  White  Black  American Indian/Alaska Native  
 Asian Indian  Cambodian  Chinese  Filipino  Japanese  Korean  Laotian  Vietnamese  
 Other Asian  Guamanian  Hawaiian  Samoan  Other Pacific Islander  
 Multiple Race  Other Race \_\_\_\_\_  Declined to State

**\*Living Arrangement:**  
 Live Alone  Do Not Live Alone  Decline to State  # of Household Members

Receiving IHSS Services?  Yes  No  Declined to State  
 If yes, number of IHSS hours receiving? \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly  Declined to State

Read the statements below. Circle the number in the “yes” column for those that apply to you. For each “yes” answer, score the number in the box. Total your nutritional score.

<b>*Determine your Nutritional Health:</b> (for each item, circle the number in the appropriate column)	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 yourself.	2
(High Nutritional Risk = 6 or more points) <b>Total Points:</b>	
Declined to State <input type="checkbox"/>	

**Notes:**

<b>General Assessment:</b>	<b>Answer</b>	<b>Comments</b>
1. Does the oven and/or microwave work?		
2. Does the refrigerator keep food ≤ 40 degrees?		
3. Does the freezer keep food ≤ 10 degrees?		
4. Does the client appear confused and/or forgetful?		
5. Can the client open their own milk cartons/containers?		
6. Are there any other physical or mental impairment noted?		
7. Are there pets living with Client?		
8. Was the Client recently discharged from the hospital?		

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 I may qualify.

\_\_\_\_\_  
 Signature of participant or person completing the form

\_\_\_\_\_  
 Date