Riverside County Office on Aging
Congregate Meals Intake Form

Mizell Center
Indio Senior Center
FY 2024-2025
Please complete this form to the best of your ability.
Items Marked with asterisk (*) are required.

Unique Participant ID:

Referred by:_____
Intake Date: _____
Staff: _____
Beginning Date: _____
***Termination Date:** _____
***Reason**:_____

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

***First Name:**	***Last Name**	MI:	***Date of Birth**: / /

***Home Address:**	***City:**	***County**:	***Zip Code:**
Mailing Address: Same As Residential? ☐ Yes	City:	County:	* Zip Code:

Best Contact Phone: ( )
Alternate Phone: ( )

Emergency Contact Name:
Phone: ( ) Relationship to you:

***Veteran**

***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

***What is your approximate household income?**
$_____ per ☐ month ☐ year ☐ Declined to State

***Rural Area?** ☐ Yes ☐ No
☐ Declined to State

***Poverty Status:** (calculate from household income)
☐ At or Below 100% of the Federal Poverty Level (FPL) ☐ Above 100% of the FPL ☐ Declined to State

*** 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)**
☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving
☐ Questioning/Unsure ☐ Not Listed, please specify: _____
☐ Declined/not stated

***Marital Status:** ☐ Single (Never Married) ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Separated
☐ Widowed Since When: _____ ☐ Declined to State

***Ethnicity** (Check One): Hispanic ☐ Yes ☐ No ☐ Decline to State	Language: ☐ English speaking ☐ Need interpreter ☐ 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.

***Determine your Nutritional Health:** *(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) **Total Points:**	
Declined to State ☐	

Notes:

General Assessment:	**Answer**	**Comments**
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