

Congregate/Take Out Meal

Nutrition Program Participant Registration Form **Site:** _____ **Date:** _____

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Transgender Unspecified <input type="checkbox"/> Gender Nonconforming <input type="checkbox"/> Gender Fluid/Not Exclusively Male or Female <input type="checkbox"/> Self-Describe (specify) _____ 	Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other _____ <hr style="border-top: 1px dashed black;"/> Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino 	Household: <input type="checkbox"/> I live alone. <input type="checkbox"/> I live with others. <hr style="border-top: 1px dashed black;"/> Income Status: Is your income at or below the following guidelines? <div style="text-align: right; margin-right: 20px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"># in Home</th> <th style="text-align: left;">Month / Year</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>\$1,073 \$12,880</td> </tr> <tr> <td>2</td> <td>\$1,452 \$17,420</td> </tr> <tr> <td>3</td> <td>\$1,830 \$21,960</td> </tr> <tr> <td>4</td> <td>\$2,208 \$26,500</td> </tr> </tbody> </table>	# in Home	Month / Year	1	\$1,073 \$12,880	2	\$1,452 \$17,420	3	\$1,830 \$21,960	4	\$2,208 \$26,500
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Nutrition Check

Circle each **YES** number that applies to you:

	Yes	No
1. I have an illness or condition that made me change the kind and/or amount of food I eat.	2	0
2. I eat fewer than 2 meals per day.	3	0
3. I eat few fruits or vegetables or milk products.	2	0
4. I have 3 or more drinks of beer, liquor or wine almost every day.	2	0
5. I have tooth or mouth problems that make it hard for me to eat.	2	0
6. I don't always have enough money to buy the food I need.	4	0
7. I eat alone most of the time.	1	0
8. I take 3 or more different prescribed or over-the-counter drugs a day.	1	0
9. Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2	0
10. I am not always physically able to shop, cook and/or feed myself.	2	0
<div style="display: flex; justify-content: space-between; align-items: center;"> Risk Level: 0-2 Low 3-5 Moderate 6+ High Total </div>		

Nutrition Program Use Only (Circle if <60)			
Spouse or domestic partner of meal recipient aged 60 or older	Disabled Living in Elderly Housing	Disabled Living with Elderly Person	Volunteer

Emergency Contact (available 10:30 AM - 1:00 PM):

Name _____ Relationship _____

Home Phone _____ Cell _____ Work Phone _____

Activities of Daily Living (ADLs)	No	Yes
Check Yes for each ADL that you/the client <i>need substantial assistance</i> to complete (including verbal reminding, physical cuing, or supervision). Check No for each ADL you <i>can</i> complete without substantial assistance.		
Bathing: Gets in and out of the bath or shower, uses faucets, washes, and dries oneself safely.		
Dressing: Dresses and undresses safely.		
Toileting: Uses toilet and cleans oneself.		
Transferring: Moves in and out of bed or chair.		
Feeding: Gets food or drink from plate, bowl, or cup into mouth and uses utensils.		
Continence: Exercises complete self-control.		

TOTAL Number of Yes ADLs _____

Instrumental Activities of Daily Living (IADLs)	No	Yes
Check Yes for each IADL that you/the client <i>need substantial assistance</i> to complete (including verbal reminding, physical cuing, or supervision). Check No for each IADL you <i>can</i> complete without substantial assistance.		
Food Preparation: Plans, prepares, and serves adequate meals independently.		
Shopping: Takes care of all shopping needs independently.		
Medication Management: Takes medication in correct dosages at correct time.		
Ability to Manage Finances: Handles financial matters and/or day-to-day purchases.		
Housekeeping: Participates in housekeeping tasks.		
Laundry: Launders some items independently.		
Mode of Transportation: Travels unassisted via personal vehicle, public transportation, or taxi.		
Ability to Use Telephone: Dials and/or answers the telephone.		

TOTAL Number of Yes IADLs _____**Participant Name**

PRIVACY STATEMENT: The information you are being asked to provide is needed to determine if you are eligible to receive Older Americans Act Services and to comply with federal reporting requirements. This information will be stored in a secure electronic database and will not be used for any other purpose. Your information will not be shared with another agency without your permission. This information will not be sold to anyone. You have the right to review your electronic record and request changes to assure accuracy. You will not be denied most services if you refuse to provide this information. If you have questions, please call the Outagamie County Aging & Disability Resource Center (ADRC) 920-832-5178.