DINE AROUND TOWN | AGENCY ON AGING AREA 4

# Enrollment Application

MEALS on WHEELS YUBA & SUTTER COUNTIES

## Section 1. Contact Information:

Last Name:

First Name:

Address:

City: Zip Code:

County: Phone: - -

Date of Birth: - - Email Address:_____@_____

**Emergency Contact:**

Name:

Relationship:

Phone: - -

**Is English your primary language? If not, what is? (please list)**

☐ Yes ☐ No Language: _____ Need Translator? ☐ Yes ☐ No

## Section 2. Race: (please check)

| | | | |
|---|---|---|---|
| ☐ White or Caucasian | ☐ American | ☐ European American | ☐ Middle Eastern |
| | ☐ North African | ☐ South African | ☐ Other White: |
| ☐ Black or African American | | | |
| ☐ American Indian or Alaskan Native | ☐ Cherokee | ☐ Mexican American Indian | |
| | ☐ Other Native American: | | |
| ☐ Asian | ☐ Asian Indian | ☐ Cambodian | ☐ Chinese |
| | ☐ Filipino | ☐ Japanese | ☐ Korean |
| | ☐ Laotian | ☐ Vietnamese | ☐ Other Asian: |
| ☐ Pacific Islander | ☐ Guamanian | ☐ Hawaiian | ☐ Samoan |
| | ☐ Other Pacific Islander: | | |
| ☐ Multiple Race: | ☐ African American & Caucasian | | |
| | ☐ Asian & Caucasian | ☐ American Indian & Caucasian | |
| | | ☐ American Indian & African American | |
| | ☐ Decline to State | | |

**1. Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to State

**Section 2: (Continued) (please check)**

**2. What was your sex at birth?**

☐ Male ☐ Female ☐ Decline to State

**3. What is your gender?**

☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female

☐ Genderqueer/Gender Non-Binary ☐ Not Listed:_____ ☐ Decline to State

**4. How do you describe your sexual orientation or sexual identity?**

☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Straight/Heterosexual

☐ Questioning/Unsure ☐ Not Listed: ☐ Decline to state

**5. Living Arrangements**

☐ Not Alone ☐ Alone ☐ Decline to State

**6. Rural Status: (Determine by Zip Code)**

☐ Rural ☐ Urban ☐ Decline to State

**7. What is your monthly income: (Please fill or check)**

$_____ # in household:_____ ☐ Decline to state

**8. Poverty Status**

☐ Above 100% of Federal Poverty Level (FPL) ☐ At or below FPL ☐ Decline to state

**9. Relationship Status**

☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Widowed
☐ Single (Never married) ☐ Decline to state

**10. Employment Status**

☐ Disabled ☐ Full-time ☐ Unemployed ☐ Volunteer ☐ Part-time
☐ Retired ☐ Decline to state

## 11. Military Affiliation and Veterans Benefits

**Have you ever served in the United States military?** ☐ Yes ☐ No ☐ Decline to state

**Are you the spouse, legal partner, parent, or child of a person who is serving in or has served in the United States military?** ☐ Yes ☐ No ☐ Decline to state

Veteran # (optional): _____

**Consent to be contacted about veterans benefits**

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.

☐ I consent to the information sharing described above. ☐ I do not consent.

Consent date: _____

**Veterans benefits information**

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.

| **Section 3. Nutritional Risk Assessment:** (Please circle applicable response for each statement) | | | |
|---|---|---|---|
| 1. I have an illness or condition that made me change the kind and/or amount of food I eat. | Yes – 2 | No | Decline to State |
| 2. I eat fewer than 2 meals per day. | Yes – 3 | No | Decline to State |
| 3. I eat few fruits or vegetables or milk products. | Yes – 2 | No | Decline to State |
| 4. I have 3 or more drinks of beer, liquor or wine almost every day. | Yes – 2 | No | Decline to State |
| 5. I have tooth or mouth problems that make it hard for me to eat. | Yes – 2 | No | Decline to State |
| 6. I don't always have enough money to buy the food I need. | Yes – 4 | No | Decline to State |
| 7. I eat alone most of them time. | Yes – 1 | No | Decline to State |
| 8. I take 3 or more different prescribed or over-the-counter drugs a day. | Yes – 1 | No | Decline to State |
| 9. Without wanting to, I have lost or gained 10 pounds in the last 6 months. | Yes – 2 | No | Decline to State |
| 10. I am not always physically able to shop, cook and/or feed myself. | Yes – 2 | No | Decline to State |
| **Total:** | | High Nutritional Risk = 6 or more points | |

| **Client Prioritization Status:** | **Prioritization Level (See Prioritization Tool):** |
|---|---|
| ☐ Food Insecure ☐ High Need for Participation<br>☐ Low Income ☐ High Need for Socialization | 1 ☐ 2 ☐ 3 ☐ 4 ☐ |
| **Type of Client:**<br>☐ Age 60+<br>☐ Spouse of an ENP Client<br>☐ Disabled person who lives with and accompanies an ENP client | Unique Participation ID:_____<br>Intake Date:_____ Staff:_____<br>Beginning Date:_____ Termination Date:_____<br>Reason: |

I understand the information I am providing will be kept confidential and that it may be used to identify other services for which I qualify.

_____ _____

Signature of the client (or the person completing this form on the client's behalf) Date