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

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:

☐ Food Insecure ☐ High Need for Participation

☐ Low Income ☐ High Need for Socialization

Prioritization Level (See Prioritization Tool):

1 ☐ 2 ☐ 3 ☐ 4 ☐

Type of Client:

☐ Age 60+

☐ Spouse of an ENP Client

☐ Disabled person who lives with and accompanies an ENP client

Unique Participation ID:_____

Intake Date:_____ Staff:_____

Beginning Date:_____ Termination Date:_____

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