Project Open Hand

SAN FRANCISCO HUMAN SERVICES AGENCY
Department of Disability and Aging Services

STAFF USE ONLY
◯ New Gold Card
◯ Update GetCare only

DAS-OCP INITIAL AND ANNUAL CONSUMER INTAKE FORM

The information that you provide will be entered into SF DAS GetCare, an online database. Your information will not be sold and will only be used for service coordination and reporting purposes. You have the right to decline the requested information on this intake form. If you prefer to be enrolled anonymously, please inform a staff member.

Nutrition – Congregate Meal Program

Intake Date: _____ Agency/Meal Site: (select meal site below)

Form completed by: ☐ Agency Representative ☐ Consumer

For Office Use Only:
SF DAS GetCare ID:_____ Agency Internal ID:_____ Gold Card ID:_____
(if applicable) (if issued)

Identification

1. *Name _____
Last Name First Name Middle Initial

_____
AKA Last Name AKA First Name

2. *Date of Birth: _____/_____/_____ 3. SSN (*not required*): _____-____-_____
Month Day Year

4. *If <60 Years Old Reason for Service: ☐ Adult with Disabilities ☐ Disabled and Lives with Client ☐ Disabled and Lives in Elder Housing ☐ Spouse or Domestic Partner of Client ☐ N/A (Client Age 60+)

5. Address Type: ☐Home ☐Office ☐Other ☐Alternative Home ☐Mailing ☐Main ☐Temporary

*Address: _____

*City: _____*State: _____*Zip Code_____

6. a. Phone 1 : _____
☐ Home ☐ Cell/Mobile ☐ Alternate Home ☐ Other_____

b. Phone 2: _____
☐ Home ☐ Cell/Mobile ☐ Alternate Home ☐ Other_____

7. Email: _____ ☐ Personal ☐ Other_____

*Required question. If a consumer declines, select or write in "decline to state"

FY:

8. Requires Assistance in an emergency: ☐ Yes ☐ No 9. Homeless? ☐ Yes ☐ No

Demographics

10. *What is your gender? (Check one that best describes your current gender identity)

☐ Male ☐ Female ☐ Trans Female to Male ☐ Trans Male to Female

☐ Genderqueer/Gender Non-binary ☐ Not listed, please specify:_____

☐ Decline to State

11. *How do you describe your sexual orientation? (Check one that best describes your sexual orientation)

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

☐ Questioning/Unsure ☐ Not listed, please specify_____ ☐ Decline to State

12. *Race: (You can mark more than one)

☐ American Indian or Alaska Native	☐ Chinese	☐ Korean	☐ Samoan
☐ Asian-Indian	☐ Filipino	☐ Laotian	☐ Vietnamese
☐ Black or African American	☐ Guamanian	☐ Latino/Latina	☐ White
☐ Cambodian	☐ Hawaiian	☐ Other- Asian	☐ Decline to State
	☐ Japanese	☐ Other- Pacific Islander	☐ Other – Not Listed

13. *Ethnicity:

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to State

14. *Living Arrangement:

☐ Lives Alone ☐ Does Not Live Alone ☐ Decline to State

15. *Lives in Urban/Rural environment:

☐ Urban ☐ Rural ☐ Decline to State

16. *Income Information measured in Federal Poverty Level (FPL):

☐ At or below 100% FPL ☐ Above 100% to at or below 185% FPL

☐ Above 185% to at or below 200% FPL ☐ Above 200% to at or below 300% FPL

☐ Above 300% FPL ☐ Decline to State

Approximate Monthly Household Income: $_____

17. *Primary (Main) Language: _____

18. English Fluency: ☐ Fluent ☐ Limited ☐ Needs Translation ☐ Decline to State

19a. *Have you ever served in the United States military? ☐ No ☐ Yes ☐ Decline to state

*Required question. If a consumer declines, select or write in “decline to state”

19b. *Are you a spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military? ☐ No ☐ Yes ☐ Decline to state

19c. If yes to question 19a or 19b, please check Yes or No to "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." ☐ 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.

Other Characteristics

20. Supervisory District: (1st – 11th)_____ (SF supervisory district lookup on SF DAS GetCare)

21. Receives Social Security: ☐ None ☐ Retirement ☐ Disability

22. *Receives SSI: ☐ Yes ☐ No

23. *Medicaid/Medi-Cal: ☐ Yes ☐ Eligible ☐ No ☐ Decline ☐ Unknown

Contacts:

24. **Contact No. 1** (please indicate type): ☐ Individual ☐ Organization

Name:_____
Last Name First Name Middle Name/Initial

a. Communication Restrictions? ☐ No ☐ Yes, check type:

☐ Medical Information ☐ Financial Information

☐ Medications ☐ Home Care Services ☐ Other

☐ Additional restriction information: _____

☐ All the Above

b. Type of Contact (select only one) ☐ Emergency ☐ Personal ☐ Other: _____

c. Primary Language: _____ d. Relationship: _____

e. Address Type: ☐Home ☐Office ☐Other ☐Alternative Home ☐Mailing ☐Main ☐Temporary

Address: _____

City: _____ State:_____ Zip Code: _____

Phone:_____ ☐ Home ☐ Work ☐ Cell ☐Other: _____

Email Address: _____☐ Personal ☐ Office ☐ Other: _____

*Required question. If a consumer declines, select or write in "decline to state"

25. **Contact No. 2** (please indicate type): ☐ Individual ☐ Organization

Name:_____
Last Name First Name Middle Name/Initial

a. Communication Restrictions? ☐ No ☐ Yes, check type:
☐ Medical Information ☐ Financial Information
☐ Medications ☐ Home Care Services ☐ Other
☐ Additional restrictions information: _____
☐ All the Above

b. Type of Contact (select only one): ☐ Emergency ☐ Personal ☐ Other: _____

c. Primary Language: _____ d. Relationship: _____

e. Address Type: ☐Home ☐Office ☐Other ☐Alternative Home ☐Mailing ☐Main ☐Temporary

Address: _____

City: _____ State:_____ Zip Code: _____

Phone:_____ ☐ Home ☐ Work ☐ Cell ☐ Other: _____

Email Address: _____ ☐ Personal ☐ Office ☐ Other: _____

*Required question. If a consumer declines, select or write in "decline to state"

The warning signs of poor nutritional health are often overlooked. Use this Checklist to find out if you or someone you know is at nutritional risk.

Read the questions 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 nutrition score.

*DETERMINE

Your Nutritional Health

Client Name_____ GetCare ID_____ Date Completed: ____/____/____

	Yes	No	Decline to State
1. *I have an illness or condition that made me change the kind and/or amount of food I eat.	2 ☐	0 ☐	0 ☐
2. *I eat fewer than 2 meals per day.	3 ☐	0 ☐	0 ☐
3. *I eat few fruits or vegetables or milk products. *"Few" means less than 5 servings of fruits/vegetables or less than 2 servings of milk/dairy products.*	2 ☐	0 ☐	0 ☐
4. *I have 3 or more drinks of beer, liquor or wine almost every day.	2 ☐	0 ☐	0 ☐
5. *I have tooth or mouth problems that make it hard for me to eat.	2 ☐	0 ☐	0 ☐
6. *I don't always have enough money to buy the food I need.	4 ☐	0 ☐	0 ☐
7. *I eat alone most of the time.	1 ☐	0 ☐	0 ☐
8. *I take 3 or more different prescribed or over-the-counter drugs a day.	1 ☐	0 ☐	0 ☐
9. *Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2 ☐	0 ☐	0 ☐
10. *I am not always physically able to shop, cook and/or feed myself.	2 ☐	0 ☐	0 ☐
Total Your Nutrition Score			

If your total nutritional score is:

0-2	**Good!** Recheck your nutritional score in 6 to 12 months
3-5	**You are at moderate nutritional risk.** See what can be done to improve your eating habits and lifestyle. Your DAS nutrition program, community/senior center or health department can help. Recheck your nutritional score in 6 months.
6 or more	**You are at high nutritional risk.** Bring this checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have and ask for help on how to improve your nutritional health.

*****Required question. If a consumer declines, select or write in "decline to state"

*Food Security and Food Program Utilization

Date Completed: _____/_____/_____
Month Date Year

Please read the statements below and check the box appropriate for you/your household.

1. *"We worried whether our food would run out before we got money to buy more." Was that often true, sometimes true, or never true for your household in the last 12 months:

   ☐ Often True ☐ Sometimes True ☐ Never true ☐ Decline to State

2. *"The food that we bought just didn't last and we didn't have money to get more." Was that often true, sometimes true, or never true for your household in the last 12 months:

   ☐ Often True ☐ Sometimes True ☐ Never true ☐ Decline to State

3. In the last 12 months, have you participated in CalFresh (also known as SNAP/Food Stamps/EBT)?

   ☐ Yes ☐ No ☐ Decline to State

Intake policy for program enrollment: (1) Consumer data will be entered in a database system, SF GetCare, and will not be sold and will only be used for service coordination and reporting requirements (2) Consumer has the right to decline requested information on an intake form (3) services may not be denied based on a consumer's decision to not provide the information requested

*Required question. If a consumer declines, select or write in "decline to state"