DAS-OCP CONSUMER INTAKE FORM

Nutrition – Congregate Meal Program

Intake Date:____________________ Agency/Meal Site:_____________________________

Form completed by: ☐ Agency Representative ☐ Consumer

Consumer Identification

*Name: ____

Last Name First Name Middle Name/Initial

____

AKA Last Name AKA First Name

*Date of Birth:______/______/______ Email Address:______________________________

Month Day Year

CA.GetCare Client ID:______________Agency Internal ID___________Gold Card ID:____________

(if applicable) (if issued)

Address Type: ☐Unknown ☐Home ☐Mailing Homeless? ☐Yes/☐No

*Address: ____

*City:____*State:_______________*Zip Code:________

Phone: 1.________________________________ ☐ Home ☐Work ☐Cell ☐None

Phone: 2.________________________________ ☐ Home ☐Work ☐Cell ☐None

Notes:

Contact No. 1 (please indicate type): ☐Personal ☐Emergency ☐Medical

1. Name: ____

Last Name First Name Middle Name/Initial

Relationship:____________________________Email Address: ____________________________

Address:____

City:______________________________ State:_______ Zip Code: _____________

Phone: 1.________________________________ ☐ Home ☐Work ☐Cell ☐None

Phone: 2.________________________________ ☐ Home ☐Work ☐Cell ☐None

***Required Information**

Contact No. 2 (please indicate type): ☐Personal ☐Emergency ☐Medical

Name:____

Last Name First Name Middle Name/Initial

Relationship:____________________________Email Address: ______________________________

Address:____

City:___________________________________ State:______ Zip Code: _____________

Phone: 1.________________________________ ☐ Home ☐Work ☐Cell ☐None

Phone: 2.________________________________ ☐ Home ☐Work ☐Cell ☐None

Contact Notes:

Consumer Demographics

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

   ☐Male ☐Female ☐Trans Male ☐Trans Female

   ☐Genderqueer/Gender Non-binary ☐Not listed, please specify____________________

   ☐Decline to State

2. *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

3. *Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Decline to State

4. *Race: (You may mark more than one)

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

***Required Information**

5. *Primary (Main) Language: ______________________________

(Refer to Demographic Look-up Key for options)

6. English Fluency:

☐Needs translation ☐Limited ☐Fluent

7. Veteran Status:

☐Child ☐No ☐Spouse ☐Veteran

8. *Urban/Rural:

☐Urban ☐Rural ☐Declined to State

9. Supervisory District: (1st – 11th)____________(supervisory district lookup on ca.getcare)

10. *Lives With:

☐Alone ☐Not Alone ☐Declined to State

11. *Is your income level at or below 100% Federal Poverty Guidelines (FPL)?

☐Yes ☐No ☐Declined to State

If NO, please answer A & B: (refer to FPL table for annual guidelines)

A. Is your income level at or below 200% FPL? ☐Yes ☐No ☐Declined to State

B. Is your income level at or below 300% FPL? ☐Yes ☐No ☐Declined to State

12. *Receives SSI:

☐Yes ☐No

13. *Medicaid/Medi-cal:

☐Yes ☐Eligible ☐No ☐Decline ☐Unknown

***Required Information**

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.

*DETERMINE

Your Nutritional Health

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.

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.

I am interested in the following services:
☐ Nutrition Counseling ☐ Nutrition Workshop ☐ I am not interested

Developed by the Nutrition Screening Initiative, a project of the American Academy of Family Physicians, the American Dietetic Association, and the National Council on the Aging, Inc.

For Office Use Only: Provide High Nutrition Risk referral form to consumer

Provided: ☐ Nutrition Education- Materials ☐Additional Food Resources ☐Other:____________________

Site Name:__________________________Staff full name:__________________________Date:________

***Required Information**

*Food Security and Food Program Utilization

Date Completed: ______/______/______

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

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

3. In the last 12 months, have you or anyone in your household received food from a food program like a food pantry, free dining room, shelter meal, senior congregate meals, school meals, CalFresh, or WIC? ☐Yes ☐No **If "Yes", mark all that you participate in:**

   ☐Congregate Meals ☐Free Dining (e.g. Glide, St. Anthony) ☐Food Pantry

   ☐Home Delivered Meals ☐Home-Delivered Grocery

   ☐CalFresh/Food Stamps/SNAP/EBT ☐ WIC (Women, Infant & Children)

***Required Information**