Project Open Hand

DAS-OCP CONSUMER INTAKE FORM 23/24

Nutrition – Congregate Meal Program

*Intake Date:_____ *Agency/Meal Site: Must choose option below

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:_____/_____/_____
Month Day Year

SF DAS GetCare Client ID:_____ Agency Internal ID_____ (if applicable) Gold Card ID:_____ (if issued)

Requires Assistance in an emergency: ☐Yes ☐No

Homeless? ☐Yes ☐No

Address Type: ☐Home ☐Alternative Home ☐Mailing ☐Other

*Address: _____

*City:_____ *State:_____ *Zip Code_____

*Phone: 1._____ ☐ Home ☐Cell/Mobile ☐Alternate Home

☐Other_____ ☐None

*Email: 1._____ ☐ Personal ☐Other_____ ☐None

Notes: _____

*To-Go Meal Criteria and Verification:

*Are you comfortable and able to eat in our communal dining room every time you participate in our nutrition program? ☐Yes ☐No

If "No", reverification is required every 3 months.

For Office Use Only (circle one): C1 / C1-Modified

***Required Information** / Blue text questions are *not* required, but may be helpful to collect for home delivery clients.

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

*1. Name: _____

Last Name First Name Middle Name/Initial

*Communication Restrictions? ☐ No ☐ Yes, check type:

☐ Medical Information ☐ Financial Information ☐ Medications ☐ Home Care Services

☐ Other ☐ Additional restrictions info: _____

*Type of Contact (select only one):

Close Contacts - ☐ Emergency ☐ Personal ☐ Other Close Contact: _____

Medical - ☐ Primary Physician ☐ Other Medical: _____

Miscellaneous - ☐ Other Miscellaneous: _____

*Primary Language: _____ *Relationship: _____

*Address: _____

*City: _____ *State: _____ *Zip Code: _____

*Phone: _____ ☐ Home ☐ Work ☐ Cell ☐ None ☐ Other: _____

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

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. *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- PacificIslander		

***Required Information** / Blue text questions are *not* required, but may be helpful to collect for home delivery clients.

4. *Ethnicity:

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

5. *Lives With:

☐Alone ☐Not Alone ☐Decline to State

6. *Urban/Rural:

☐Urban ☐Rural ☐Decline to State

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

☐Yes ☐No ☐Decline to State

Is income below 185% Federal Poverty Line (FPL)?

☐Yes ☐No ☐Decline to State

Approx. Household Income: _____

8. If <60 Reason for Service: ☐Lives w/client ☐Spouse ☐Disabled

☐Lives in Elder Housing (disabled) ☐Other ☐N/A (over 60)

9. *Primary (Main) Language:_____

10. Total Number of Family Members in Household Including Client:_____

11. English Fluency:

☐Fluent ☐Limited ☐Needs translation ☐Decline to State

12. *Veteran Status:

☐No ☐Yes, veteran #: _____

Spouse of Veteran?

☐No ☐Yes, veteran #: _____

13. Supervisory District: (1st – 11th)_____(SF supervisory district lookup on CA-GetCare)

14. *Receives Social Security:

☐None ☐Retirement ☐Disability

15. *Receives SSI:

☐Yes ☐No

16. *Medicaid/Medi-Cal:

☐Yes ☐Eligible ☐No ☐Decline ☐Unknown

☐Other _____

***Required Information** / Blue text questions are *not* required, but may be helpful to collect for home delivery clients.

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, 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.

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:_____

***Required Information** / Blue text questions are *not* required, but may be helpful to collect for home delivery clients.

Site Name:_____ Staff full name:_____ Date:_____

*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)

Project Open Hand

***Required Information** / Blue text questions are *not* required, but may be helpful to collect for home delivery clients.