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**Congregate Client Application/Assessment**

Reassessment Date: \_\_\_\_ /\_\_\_\_/\_\_\_\_\_\_\_

Legal First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS Number: \_\_\_\_\_\_\_\_\_\_(last 4 digits)

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_Age: \_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Persons in Household: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Monthly Income (you may decline)

Amount $ \_\_\_\_\_\_\_\_\_\_\_\_\_

 Under $1044/mo. \_\_\_\_\_\_

 Above $1044/mo. \_\_\_\_\_\_

 **Declined** ( )

Veteran: ( ) Yes ( ) No

Male ( ) Female ( )

Disabled: Yes ( ) No ( )

( ) Single ( ) Married ( ) Widowed

 ( ) Divorced

Race: White ( ) Hispanic ( ) African American ( )

Native American/Alaskan ( ) Non-Hispanic ( )

Asian/Pacific Islander ( ) Refused ( )

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_

Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

Alt Phone: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

**NUTRITIONAL ASSESMENT**

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| **Nutritional Risk Criteria –** (Self-declared): Circle the answer given for each category, total the points, then check whether the client is at good, moderate, or high nutritional risk. |
| Have you made any changes in lifelong eating habits because of health problem? | Yes | No |
| Do you eat fewer than 2 meals per day? | Yes | No |
| Do you eat fewer than 5 servings (1/2 cup each) of fruits and vegetables every day? | Yes | No |
| Do you eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day? | Yes | No |
| Do you sometime not have enough money to buy food? | Yes | No |
| Do you have trouble eating well due to problems with chewing/swallowing? | Yes | No |
| Do you eat alone most of the time? | Yes | No |
| Without wanting to, have you lost or gained 10 pounds in the past 6 months? | Yes | No |
| Are you not always physically able to shop, cook and/or feed yourself? | Yes | No |
| Do you have 3 or more drinks of beer, liquor or wine almost every day? | Yes | No |
| Do you take 3 or more different prescribed or over-the-counter drugs per day? | Yes | No |
| 0-2GOOD | 3-5MODERATE | 6 OR MOREHIGH | TOTAL |  |  |

**DISCLOSURE STATEMENT FOR CONGREGATE MEAL CLIENTS**

The Client Registration Form was developed to assist the Ohio Department of Aging to monitor the effectiveness of Senior Programs offered to the citizens of Ohio. Any client information obtained from this form will be kept confidential and no personal identifying information about a client (e.g. name, address, telephone number, ID No., etc.) will be released to the public without the clients prior written consent, or unless otherwise required under federal law. The data collected (age, race, low income status, ADLs and IADLs) will be forwarded to the Area Agency on Aging and the Ohio Department of Aging and summarized and reported to the Administration on Aging (AOA) in order to keep both state and federal legislators informed on the effectiveness of senior programs (as required by the 1992 Older Americans Act reauthorization). While all clients receiving services under the Older Americans Act are asked to complete the client registration form in full, no client may be denied services for refusing to provide any of the information requested, including social security number. **If you have any questions, ask the staff member to explain why this release is necessary. Your personal information will be kept confidential** and exchanged only in regard to your care. Your signature on this Congregate Meal roster gives HAPCAP permission to release and receive information related to your care.

CLIENT SIGNATURE/DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have discussed and explained the Disclosure Statement with the client.

SITE MANAGER SIGNATURE/DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I will receive meals at following site:

Athens ( ) Glouster ( ) Logan ( )