

Senior Nutrition Program HOME-DELIVERED Meals (C2) – Client Intake Form FY2026-2027

THIS INFORMATION IS STRICTLY CONFIDENTIAL.

TO RECEIVE HOME DELIVERED MEALS: Applicant must be aged 60 or older, homebound due to illness or disability, unable to prepare meals, to drive, or to attend a congregate meal site if transportation were provided. There is no charge for meals; however, voluntary contributions are accepted. A person will not be denied services if that individual chooses not to contribute.						
Provider Location:		Date:				
Preferred Language:			Birthdate (Required):			
Last Name:		First Name (No Nicknames):				
APPLICANT ELIGIBILITY					YES	NO
(a) Is applicant frail and homebound by reason of illness, disability, or isolation?					<input type="checkbox"/>	<input type="checkbox"/>
(b) Are you a spouse of (a) who is frail, and homebound by reason of illness, disability, or isolation and it is in their best interest that you also receive a meal? Name of person (a) _____.					<input type="checkbox"/>	<input type="checkbox"/>
(c) Are you an individual with a disability who resides with (a) and it is in their best interest that you also receive a meal? Name of person (a) _____.					<input type="checkbox"/>	<input type="checkbox"/>
NOTE: If the answer is YES to any of the questions above, applicant is eligible for home-delivered meals.						
ADDRESS & CONTACT INFORMATION						
Address:		City:		Zip:		
Phone:		Email:				
Local Emergency Contact Name/Phone number:			# of Persons in Household:			
Lives Alone?		Lives in Rural Area?				
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State		(91307, 93066, 93040)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State		
					APPLICANT SIGNATURE:	
I understand that the information I am providing on this form is for registration purposes. I understand it will be kept confidential and that the Area Agency on Aging and service providers may use it to help identify other services for which I may benefit.						

These are used to ensure that services are distributed equitably and do NOT affect eligibility

DEMOGRAPHIC INFORMATION						<input type="checkbox"/> DECLINE TO STATE
What is your marital status?		<input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Decline to State				
What is your approximate annual income?		IF single	<input type="checkbox"/> \$15,960 or less	At or below Federal Poverty Level	<input type="checkbox"/> \$15,961 or more	Above Federal Poverty Level
		IF married	<input type="checkbox"/> \$21,640 or less		<input type="checkbox"/> \$21,641 or more	
What is your sex at birth?		What is your gender?		What is your sexual orientation/identity?		
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Declined/not stated		<input type="checkbox"/> Female <input type="checkbox"/> Male Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Declined/not stated <input type="checkbox"/> Not listed, please specify: _____		<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Declined/not stated <input type="checkbox"/> Not listed, please specify: _____		

RACE/ETHNICITY – CHECK ALL THAT APPLY (X):	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Laotian	<input type="checkbox"/> Other Pacific Islander
	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Middle Eastern or North African	<input type="checkbox"/> Other Race/Ethnicity
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Other	<input type="checkbox"/> Samoan	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> Declined/no stated
<input type="checkbox"/> Chinese	<input type="checkbox"/> Japanese			
<input type="checkbox"/> Filipino	<input type="checkbox"/> Korean			

Have you ever served in the United States military?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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Do you consent to this agency and the California Department of Aging transmitting your name, email address, and telephone number to the Department of Veterans Affairs, only for the purpose of receiving additional information on veterans benefits for which you may be eligible? 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.	<input type="checkbox"/> I decline my consent. <input type="checkbox"/> I consent. I understand that this is valid for 12 months.
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SERVICE PROVIDER ASSESSMENT
Please ask these questions at the **FIRST** home-delivered meal **Dropoff**.

Applicant is:	<input type="checkbox"/> Blind <input type="checkbox"/> Deaf	Applicant uses:	<input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Cane
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Does the applicant have:	YES	NO
a working refrigerator?	<input type="checkbox"/>	<input type="checkbox"/>
freezer space to store five frozen meals?	<input type="checkbox"/>	<input type="checkbox"/>
a working oven or microwave?	<input type="checkbox"/>	<input type="checkbox"/>
any dietary restrictions? (If yes, explain below)	<input type="checkbox"/>	<input type="checkbox"/>
are you physically and mentally able to open the food containers	<input type="checkbox"/>	<input type="checkbox"/>
are there pets?	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Your Nutritional Health	Check All That Apply to Applicant:	
I don't always have enough money to buy the food I need.	<input type="checkbox"/>	4 pts
I eat fewer than 2 meals per day.	<input type="checkbox"/>	3 pts
I have an illness or condition that made me change the kind and/or amount of food I eat.	<input type="checkbox"/>	2 pts
I eat few fruits or vegetables, or milk products.	<input type="checkbox"/>	2 pts
I have 3 or more drinks of beer, liquor, or wine almost every day.	<input type="checkbox"/>	2 pts
I have tooth or mouth problems that make it hard for me to eat.	<input type="checkbox"/>	2 pts
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	<input type="checkbox"/>	2 pts
I am not always physically able to shop, cook and/or feed myself.	<input type="checkbox"/>	2 pts
I eat alone most of the time.	<input type="checkbox"/>	1 pt
I take 3 or more different prescribed or over-the-counter drugs a day.		1 pt
Decline to state. unable to score <input type="checkbox"/>	Check if total score is equal to or greater than 6 and the client is at high nutritional risk .	<input type="checkbox"/> Total Score:

Referral(s) Made:

Nutritional education/counseling for at risk clients

Other: _____

Other: _____

Notes: _____

CALIFORNIA ACTIVITIES AND INSTRUMENTAL ACTIVITIES (IADLS) OF DAILY LIVING (ADLS)

For each activity, mark the level of assistance you (or the client) need.

Level of assistance needed to perform the task of:	1 INDEPENDENT <i>needs no help</i>	2 VERBAL CUE <i>needs verbal reminders</i>	3 STAND BY <i>needs some human help</i>	4 HANDS ON <i>needs lots of human help</i>	5 DEPENDENT <i>cannot perform task</i>	Decline to State
ADLS						
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring In/Out of Bed or Chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IADLS						
Light Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping or Errands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meal Prep and Cleanup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing Money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DO NOT WRITE IN THIS BOX – OFFICIAL USE ONLY	
Q Database/Unique Participant ID Number:	<input type="checkbox"/> Senior Spouse <input type="checkbox"/> Non-Senior <input type="checkbox"/> Disabled
Reviewed by (Name): <input type="checkbox"/> Staff <input type="checkbox"/> Volunteer	Type of Meals: <input type="checkbox"/> Hot <input type="checkbox"/> Frozen