

MISSOULA AGING SERVICES SUPPLEMENT PROGRAM INTAKE FORM

The information you provide by completing this form is kept confidential. Your participation helps the Supplement Program stay funded and operating, allowing us to offer Ensure products at a reduced cost to seniors in Missoula.

DATE:	LAST NAME:	FIRST NAME:
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Mailing Address City/ST/Zip:

Physical Address (if different):

Phone # (include area code):	Birthdate (MM/DD/YYYY):
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Race: White Native Am. Hispanic African Am. Hmong Asian Belarusian Other

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Please check the range that best represents your monthly household income:

For a household of one: \$931 or below \$932 – \$1862 \$1863 or above

For a household of two: \$1261 or below \$1262 – 1862 \$1863 or above

Contact Information (If different from above):

Contact Name (first/last):	Relationship:
Mailing address/City/ST/ZIP	Phone number (include Area Code)

Use this contact as the billing name and address: Yes No

Please check the appropriate response to questions below:	YES	No
I have an illness that affects the kind and/or amount of food I eat	<input type="checkbox"/>	<input type="checkbox"/>
I eat less than 2 meals per day	<input type="checkbox"/>	<input type="checkbox"/>
I eat less than 3 servings of fruits or vegetables a day	<input type="checkbox"/>	<input type="checkbox"/>
I eat or drink less than 3 servings of dairy products a day	<input type="checkbox"/>	<input type="checkbox"/>
I drink less than 5 cups (8 oz each) of fluid a day	<input type="checkbox"/>	<input type="checkbox"/>
I have 3 or more alcohol drinks almost every day	<input type="checkbox"/>	<input type="checkbox"/>
I have tooth or mouth problems that make it hard for me to eat	<input type="checkbox"/>	<input type="checkbox"/>
I don't always have enough money to buy the food I need	<input type="checkbox"/>	<input type="checkbox"/>
I eat alone most of the time, or have few opportunities to socialize.	<input type="checkbox"/>	<input type="checkbox"/>
I take 3 or more different prescribed or over-the-counter drugs a day	<input type="checkbox"/>	<input type="checkbox"/>
Without wanting to, I have lost or gained 10 pounds in the last 6 months	<input type="checkbox"/>	<input type="checkbox"/>
I am not always physically able to shop, cook and/or feed myself	<input type="checkbox"/>	<input type="checkbox"/>

DATA ENTRY COMPLETED (OFFICE USE ONLY): <input type="checkbox"/> MASTS <input type="checkbox"/> NUTR DB	DATE & INITIAL:
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