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**Missoula Aging Services Community Lunch Intake** New

Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Site:\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Annual Update

***Completion of this form does not equate to eligibility.*** *The data collected on this form supplies funding for aging programs in Montana communities. Information will be kept confidential, and you will receive services regardless of your answers.*

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_/\_\_\_/\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male Female

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *I prefer contact by phone* ☐

**Emergency Contact:** *by email*☐

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| **Race: (May choose more than one)**   * American Indian/Alaska Native * Asian/Asian American * Black/African Amer. * Native Hawaiian / Pacific Islander * White * Other \_\_\_\_\_\_\_\_\_\_\_\_   **Veteran:**   * Yes * No | **Ethnicity:**   * Hispanic or Latino * Not Hispanic or Latino   **Marital Status:**   * Married * Divorced/   Separated   * Single * Widowed | **I am under 60 but believe I may be eligible for lunch because (check all that apply):**   * My spouse is over age 60. * I am the primary caregiver   for a person over age 60.   * I am disabled and living   with a person over age 60.  **Number of congregate meals you feel you can use in a month:**  20\_\_\_ 16\_\_\_ 12 \_\_\_ 8\_\_\_ 4\_\_\_ | **Income Level:**   * At or below poverty * Above poverty   *Thank you for participating. Participants will be asked to make voluntary contributions towards the cost of the meal. Please check with your site for the suggested amount.* |

|  |  |
| --- | --- |
| **Activities of Daily Living**  *I sometimes need help with the following*:  ☐ Eating ☐ Dressing ☐ Transferring  ☐ Bathing ☐ Walking ☐ Toileting ☐ None | **Instrumental Activities of Daily Living**  *I sometimes need help with the following:*  ☐ Meal prep ☐ Phone use ☐ Money Management ☐ Shopping  ☐ Transportation ☐ Medication Management ☐ Housework ☐ None |

**Nutrition Risk Assessment**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| I have an illness/condition that affects the kind and/or amount of food I eat |  |  |
| I eat less than 2 meals per day |  |  |
| I eat less than 3 fruits and vegetables a day |  |  |
| I consume few dairy products (such as milk, yogurt, cheese) a day |  |  |
| I drink less than 5 cups of fluids (such as water, juice, tea) a day |  |  |
| I have 3 or more drinks of beer, wine, or liquor almost every day |  |  |
| I have teeth or mouth problems that make it hard for me to eat |  |  |
| I don’t always have enough money to buy the food I need |  |  |
| I eat alone most of the time |  |  |
| I take 3 or more different prescribed or over-the-counter drugs a day |  |  |
| Without wanting to, I have lost or gained 10 pounds in the last 6 months |  |  |
| I am not always physically able to shop, cook and/or feed myself |  |  |

*Please complete back side*

(Office Use Only) Data Entry Completed: Capstone ServTracker/CXM

