



**DEMOGRAPHICS:**  
(ANSWER ALL QUESTIONS)

**1. Gender:**

- Male                       Female
- Trans Male       Trans Female
- Genderqueer/Gender Non-binary
- Not Listed, Please Specify:

\_\_\_\_\_

Declined/Not Stated

**2. Sex at Birth:**

- Male
- Female
- Declined/Not Stated

**3. Sexual Orientation or Sexual Identity:**

- Straight/Heterosexual
- Bisexual
- Gay/Lesbian/Same-Gender Loving
- Questioning/Unsure
- Not Listed, Please Specify:

\_\_\_\_\_

Declined to Answer

**4. If Under 60 Years of age. Are you:**

- Disabled
- Lives in senior housing (Disabled)
- Lives with Client
- Meal Site Staff (paid)
- Meal Volunteer
- Other: \_\_\_\_\_
- Spouse of older individual 60 or over that is a Client

**3. Race (Select All that Apply)**

- American Indian/Alaskan Native
- Asian, please specify:
  - Chinese                       Japanese
  - Filipino                       Korean
  - Vietnamese                       Asian Indian
  - Laotian                       Cambodian
  - Other Asian \_\_\_\_\_

- Black/African American
- Guamanian
- Hawaiian/Pacific Islander
- Other Pacific Islander: \_\_\_\_\_
- Samoan
- White
- Declined to State

**4. Ethnicity:**

- Hispanic or Latino
- Non-Hispanic or Non-Latino
- Declined to State

**5. Lives in:**

- Rural area
- Urban area (more than 20,000)
- Declined to State

**6. Living Arrangement:**

- Lives Alone
- Lives with Others  
Number of Household Members \_\_\_\_\_
- Declined to State

**7. Poverty Level:**

- At or Below Federal Poverty Level
- Above Federal Poverty Level
- Declined to State

| <b>Reference Chart</b>                                      |               |
|---|---------------|
| <b>2022 Federal Poverty Level</b>                           |               |
| Changes each year   |               |
| Persons in family   | Annual income |
| 1   | \$13,590      |
| 2   | \$18,310      |
| <b>Each additional household member up to 8 add \$4,720</b> |               |

*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 may benefit.*

**Participant Signature:**

\_\_\_\_\_

**MUST BE COMPLETED BY**  
**Staff/Volunteer that Assisted**  
**with Application**

**Site Staff/Volunteer Name:**  
 \_\_\_\_\_

ID Check for age, **type:** \_\_\_\_\_

Double checked for completeness – all information filled in by client OR staff has marked “Declined to State”

Renewal Enrollment

New Enrollment

Termination. Date: \_\_\_\_\_  
 Reason \_\_\_\_\_

Date sent to office: \_\_\_\_\_

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Office Staff Name:** \_\_\_\_\_

Date entered: \_\_\_\_\_

Begin Date: \_\_\_\_\_

Client number: \_\_\_\_\_

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

| <b>DETERMINE YOUR NUTRITIONAL HEALTH</b><br>(Circle the number in the "YES" column for those that apply to you. Total the "YES" answers below. ) | <b>Circle if YES</b>     |
|--|--------------------------|
| • I have an illness or condition that made me change the kind and/or amount of food I eat.   | <b>2</b>                 |
| • I eat fewer than 2 meals per day.  | <b>3</b>                 |
| • I eat few fruits or vegetables or milk products.   | <b>2</b>                 |
| • I have 3 or more drinks of beer, liquor or wine almost every day.  | <b>2</b>                 |
| • I have tooth or mouth problems that make it hard for me to eat.  | <b>2</b>                 |
| • I don't always have enough money to buy the food I need.   | <b>4</b>                 |
| • I eat alone most of the time.  | <b>1</b>                 |
| • I take 3 or more different prescribed or over-the-counter drugs a day.   | <b>1</b>                 |
| • Without wanting to, I have lost or gained 10 pounds in the last 6 months.  | <b>2</b>                 |
| • I am not always physically able to shop, cook and/or feed myself.  | <b>2</b>                 |
| <b>TOTAL</b> <i>(Add up the circled amounts)</i>   |                          |
| <b>Declined to State</b>   | <input type="checkbox"/> |

### **Total Your Nutritional Score. If it's –**

**0 – 2      Good!** Recheck your nutritional score in 6 months.

**3 – 5      You are at moderate nutritional risk.** See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Recheck your nutritional score in 3 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. Ask for help to improve your nutritional health.