RHODE ISLAND CONGREGATE MEALS PARTICIPANT INFORMATION FORM

***DATE OF INTAKE**: _____ ***MEAL SITE NAME**: _____

***NAME**: _____ ***GENDER:** Female ☐ Male ☐ Transgender ☐

***ADDRESS**: _____

***CITY:** _____ **STATE:** _____**ZIP:** _____

TELEPHONE #: _____ ***DATE OF BIRTH**: _____ ***AGE:** _____

***REQUIRED: LAST 4 DIGITS OF YOUR SOCIAL SECURITY #:** _____

MARITAL STATUS:
MARRIED ☐ SINGLE ☐

WIDOWED ☐ SEPARATED ☐

DIVORCED ☐

***LIVES ALONE:**
YES ☐ NO ☐

LIVING ARRANGEMENTS:
HOME OWNER ☐ RENTS ☐

PUBLIC SENIOR HOUSING ☐

LIVES WITH FAMILY MEMBER ☐

LIVES WITH NON-FAMILY MEMBER ☐

NUMBER IN HOUSEHOLD: ____

***RACE:**
WHITE ☐ BLACK or AFRICAN AMERICAN ☐

HISPANIC ☐ ASIAN ☐

ALASKAN NATIVE or AMERICAN INDIAN ☐

NATIVE HAWAIIAN OR PACIFIC ISLANDER ☐

***ETHNICITY:**
HISPANIC OR LATINO NOT HISPANIC OR LATINO

VETERAN ☐ **or SPOUSE OF VETERAN** ☐

***NUTRITION RATE** ____ ***NUTRITION RISK**?
YES ☐ NO ☐

IS INCOME BELOW CURRENT POVERTY LEVEL:
YES ☐ NO ☐

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ **PHONE:** _____

PRIMARY PHYSICIAN: _____**PHONE:** _____

COMPLETED BY: _____

HOW DID YOU HEAR ABOUT OUR MEALSITE? _____

Privacy Statement Act: The Rhode Island Department of Elderly Affairs and this site use the information provided in this form to provide proof of qualification for the Title III-C Congregate Nutrition Program as set forth by the U.S. Administration on Aging.
I understand that by signing and submitting this form, I accept that my information will be used to qualify me for the Title III-C Congregate Nutrition Program.

Signature: _____ **Date:** _____