RHODE ISLAND CONGREGATE MEALS PARTICIPANT INFORMATION FORM

CAFÉ SITE NAME:	
DATE:	
YOUR NAME:	
ADDRESS:	
CITY, STATE & ZIP CODE:	
PHONE #:	
MARITAL STATUS: (Circle 1)	MARRIED SINGLE WIDOWED SEPARATED DIVORCED

INFORMATION BELOW IS **REQUIRED** BY THE FEDERAL ADMINISTRATION ON COMMUNITY LIVING (ACL), THE AGENCY THAT PROVIDES FUNDS FOR THE CONGREGATE MEAL PROGRAM.

1. WHAT IS YOUR **DATE OF BIRTH** (OR) **YOUR AGE**?	**5.** DO YOU CONSIDER YOURSELF TO BE PART OF A **MINORITY GROUP**? (Circle One) YES NO
2.WHAT IS YOUR **GENDER?** (Circle One) FEMALE MALE OTHER	**6.** WHAT IS **YOUR ETHNICITY**? (Circle One) **ARE** YOU "HISPANIC OR LATINO" (OR) **"NOT** HISPANIC OR LATINO"
3. DO YOU **LIVE ALONE**? (Circle One) YES NO	**7**. DO YOU CONSIDER YOURSELF **LOW INCOME**? (Circle One) YES NO
4. WHAT IS **YOUR RACE**? (Circle all that apply) AMERICAN INDIAN or ALASKAN NATIVE ASIAN or ASIAN AMERICAN BLACK or AFRICAN AMERICAN NATIVE HAWAIIAN or PACIFIC ISLANDER WHITE	8. ARE YOU A: (Circle One If Appropriate) VETERAN - **OR -** SPOUSE OF A VETERAN

EMERGENCY INFORMATION (FOR USE BY THE CAFÉ' SITE)

YOUR EMERGENCY CONTACT'S NAME:	
THEIR RELATIONSHIP TO YOU:	**THEIR PHONE #**
HOW DID YOU HEAR ABOUT OUR CAFÉ'?	

TO BE FILLED OUT BY CAFÉ' MEALSITE WORKER.

NUTRITION SCORE:	**NUTRITION RISK**: (Circle One) YES NO	**ID CHECKED**: DRIVERS LICENSE OTHER
NAME OF WORKER WHO CHECKED THE FORM:		

CLIENT'S SIGNATURE:_____**DATE SIGNED**: _____

Privacy Statement Act: The Rhode Island Office of Healthy Aging 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 this form, I accept that my information will be used to qualify me for the Title III-C Congregate Nutrition Program.

(Rev.11/2021) *****PLEASE COMPLETE SURVEY ON THE BACK*****

RHODE ISLAND OFFICE OF HealthyAging

ACL Congregate Meal Program

NUTRITIONAL RISK SURVEY

Questions:	**Yes**	**No**
1. Has the client made any changes in lifelong eating habits because of health problems?		
2. Does the client eat fewer than 2 meals per day?		
3. Does the client eat fewer than five (5) servings (1/2 cup each) of fruits and vegetables every day?		
4. Does the client eat fewer than two (2) servings of dairy products (milk, cheese, yogurt, etc.) each day?		
5. Does the client sometimes not have enough money to buy food?		
6. Does the client have trouble eating due to problems with chewing or swallowing?		
7. Does the client eat alone most of the time?		
8. Without wanting to, has the client lost or gained 10lbs. in the last 6 months?		
9. Is the client not always physically able to shop, cook and/or feed themselves (or get someone to do it for them)?		
10. Does the client have 3 or more drinks of beer, liquor or wine almost every day?		
11. Does the client take 3 or more different prescribed or over-the-counter drugs per day?		
(Total the "YES" column. Totals of 6 or higher are considered a "Nutrition Risk") **TOTAL**		