Congregate Meal Program Registration

Please complete this form to the best of your ability.

Date	Eligibility Category (Check One) ☐ Age 60 and older ☐ Spouse ☐ Volunteer ☐ Disabled Under 60 ☐ Caregiver	Date of Birth / /	Age _____	Last 4 digits of Social Security Number

Last Name	First Name	Middle Initial	Gender (Check One) ☐ Female ☐ Male

Residential Address:	Mailing Address:

City:	State	Zip Code	County	Lives in Rural Area (Check One) ☐ Yes ☐ No

Home Phone: ( )	Emergency Phone: ( )	Emergency Contact Name	Emergency Contact Relationship

Ethnicity (Check One) ☐ Not Hispanic or Latino ☐ Hispanic or Latino	Race (Check One) ☐ White ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Other	Primary Language (Check One) ☐ English ☐ Other

Marital Status (Check One) ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced	Name of Spouse/Partner

Lives In (Check One) ☐ House ☐ Apartment ☐ Senior Housing ☐ Other	Housing (Check One) ☐ Own ☐ Rent ☐ Other	Lives (Check One) ☐ Alone ☐ With Spouse ☐ With Spouse/Child ☐ With Child/Children ☐ Other	Income Below Poverty (Check One) ☐ Yes ☐ No

Nutrition Screening Checklist

1. Have you made any changes in lifelong eating habits because of health problems? ☐ Don't know ☐ No ☐ Yes	2. Do you eat less than 2 meals a day? ☐ No ☐ Yes
3. Do you eat less than five (5) servings (1/2 cup each) of fruits or vegetables every day? ☐ No ☐ Yes	4. Do you eat fewer than two (2) servings of dairy products (such as milk, yogurt or cheese) every day? ☐ No ☐ Yes
5. Are there times when you don't have enough money to buy the food you need? ☐ Don't know ☐ No ☐ Yes	6. Do you have tooth or mouth problems that make it hard to eat? ☐ No ☐ Yes
7. Do you eat alone most of the time? ☐ Don't know ☐ No ☐ Yes	8 . Without wanting to have you lost or gained 10 pounds in the past 6 months? ☐ Don't know ☐ No ☐ Yes ☐ Yes, gained 10 pounds ☐ Yes, lost 10 pounds
9. Are there times when you are not physically able to shop, cook or feed yourself? ☐ Don't know ☐ No ☐ Yes	10. Do you have 3 or more drinks of beer, liquor or wine almost every day? ☐ Don't know ☐ No ☐ Yes
11. Do you take 3 or more different prescribed or over-the-counter drugs per day? ☐ Don't know ☐ No ☐ Yes	

Use of Information

I understand that the information I am providing on this form is for registration purposes. The information will be used by the ND Department of Human Services – Aging Services Division to create statistical reports and may be used by service providers to help identify other services from which I may benefit, such as follow up to the Nutrition Screening Checklist. This information will not be released to anyone other than the above mentioned parties in a way that will identify me as an individual unless I sign a separate consent for that purpose.

Name of Meal Site: _____