

- New
- Delete
- Change

**Santa Clara County
Senior Nutrition Program
SC 1367 Registration Form**

Q Entry Date: _____
Staff Initial: _____
Registration # _____

The funding received to provide these meals requires we ask information from individuals receiving these services. California Law prohibits the public disclosure of this information, so your personal information will be kept confidential.

Site Name: _____

Check one of the following:

<input type="checkbox"/> Older adult above 60 years old	<input type="checkbox"/> Spouse of an older adult under 60 years old
<input type="checkbox"/> A person with a disability under 60 years old who resides in senior housing (John 23rd, Stevenson House)	
<input type="checkbox"/> A person with disability under 60 years old cared by an older adult	<input type="checkbox"/> Volunteer under the age of 60 years old

PLEASE PRINT CLEARLY

Participant Information - Complete all fields

*First Name	MI	*Last Name	Date	Phone Number

***Address:**

Street: _____

City: _____ Zipcode: _____

*Date of Birth (M/D/Y)	*Race: (Check all that apply)			
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> American Indian/Alaska Native		
	<input type="checkbox"/> Black			
*Ethnicity: (Check one)	Asian:			
	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Chinese	<input type="checkbox"/> Japanese	<input type="checkbox"/> Korean
	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Other Asian
	<input type="checkbox"/> Declined to state	<input type="checkbox"/> Laotian		
*Marital Status: (Check one)	Hawaiian/Other Pacific Islander			
	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Samoan	<input type="checkbox"/> Other Pacific/Islander
	<input type="checkbox"/> Declined to state			

Social Security Number - last 4 digits (optional)

xxx-xx-_____

***Primary language (check one)**

<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Chinese	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Korean	<input type="checkbox"/> Tagalog
<input type="checkbox"/> Other: _____					

***Rural**

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to state
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***Do You Receive SSI or SSP?**

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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***Do You Live Alone?**

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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***Federal Poverty Level (FPL): (please check one)**

<input type="checkbox"/> Below 100% FPL	<input type="checkbox"/> Above 100% FPL	<input type="checkbox"/> Declined to state
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***What is your gender? (Check one)**

<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Transgender Female to Male	<input type="checkbox"/> Transgender Male to Female
<input type="checkbox"/> Genderqueer/Gender Non-binary	<input type="checkbox"/> Not listed, please specify:-----		<input type="checkbox"/> Declined to state

***What was your sex at birth? (Check one)**

<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Declined to state
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***How do you describe your sexual orientation or sexual identity? (Check one)**

<input type="checkbox"/> Straight/Heterosexual	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Gay/Lesbian/Same-Gender Loving	<input type="checkbox"/> Questioning/Unsure
<input type="checkbox"/> Declined to state			

*Veteran Status

Have you ever served in the United States military? Yes No Declined to state

Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military? Yes No Declined to state

If you identify as being military affiliated, check below if: "I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for 12 months."

Yes No

Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626

*Nutrition Risk Assessment

Circle the number in the "Yes" column for those that apply to you.

Total your nutritional score

I have an illness or condition that made me change the kind and/or amount of food I eat.

Yes

No

Declined to state

2

I eat fewer than 2 meals per day.

3

I eat few fruits, vegetables or milk products.

2

I have 3 or more drinks of beer, liquor or wine almost every day.

2

I have tooth or mouth problems that make it hard for me to eat.

2

I don't always have enough money to buy the food I need.

4

I eat alone most of the time.

1

I take 3 or more prescribed or over-the-counter drugs a day.

1

Without wanting to, I have lost or gained 10 pounds in the past six months.

2

I am not always physically able to shop, cook and/or feed myself.

2

0-5 Not at risk; 6 and above at risk

Total

Emergency Contact Information

Name:

Relationship:

Phone:

Address:

Doctor Name:

Phone:

*Food Security Questionnaire

In the last 12 months, have you worried whether your food would run out before you got money to buy more?

Often True Sometimes True Never True

In the last 12 months, the food that I bought just didn't last, and I didn't have money to get more

Often True Sometimes True Never True

In the last 12 months, were you ever hungry but didn't eat because there wasn't enough money for food?

Often True Sometimes True Never True

In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

Yes No