State of Illinois
Illinois Department on Aging

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Registration for Congregate Meals

Name of Site: _____ ☐ **New Client** ☐ **Renewal**

This form must be completed by the appropriate Congregate nutrition provider.

Older Adult Demographic Information					
Date:	Name:			DOB:	
Address:				Zip Code:	
Email:		Phone:		Cell Phone:	
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Race: ☐ White (Not Hispanic) ☐ Asian ☐ White (Hispanic) ☐ African American ☐ American Indian or Alaskan Native ☐ Other Race ☐ Native Hawaiian or Pacific Islander ☐ Two or More Races				Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Legally Separated ☐ Domestic Partner	Gender: ☐ M ☐ F Other:
Limited English Speaking: ☐ Yes ☐ No If yes, specify language:_____		Monthly Income:_____ Below Poverty: ☐ Yes ☐ No		☐ Lives Alone ☐ Lives with Others # of Individuals in Household: _____	

Major Health Problems (check all that apply)

☐ Ambulation ☐ Hearing ☐ Vision ☐ Other:_____

Nutrition Risk Screen (circle points under Yes or No, then combine column totals)

	Y	N		Y	N
I have an illness or condition that made me change the kind and/or amount of food I eat.	2	0	I don't always have enough money to buy the food I need.	4	0
I eat fewer than 2 meals per day.	3	0	I eat alone most of the time.	1	0
I eat few fruits and vegetables, or milk products.	2	0	I take 3 or more different prescribed or over-the-counter drugs a day.	1	0
I have 3 or more drinks of beer, liquor, or wine almost every day.	2	0	Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2	0
I have tooth or mouth problems that make it hard for me to eat.	2	0	I am not always physically able to shop, cook, and/or feed myself.	2	0
Totals			**Totals**		

Six or more points = High nutritional risk **Combined Column Totals: _____/21 possible points**

Additional Nutrition Information

Does client have difficulty swallowing: ☐ Yes ☐ No	**Special Diet Needs:** ☐ General ☐ Diabetic ☐ Other: _____
Client food source for the weekends:	**Dietary restrictions:**

UCLA 3-Item Loneliness Scale (check one response for each of the three questions)

1. How often do you feel that you lack companionship?	☐ Hardly Ever	☐ Some of the Time	☐ Often
2. How often do you feel left out?	☐ Hardly Ever	☐ Some of the Time	☐ Often
3. How often do you feel isolated from others?	☐ Hardly Ever	☐ Some of the Time	☐ Often

Other Contact Information

Emergency Contact Name #1:	Daytime/Cell Phone:
Emergency Contact Name #2:	Daytime/Cell Phone:

Authorization of Release of Information

I give permission to the provider and/or the Area Agency on Aging Staff to discuss my needs.

Client Signature:	**Date:**

Staff Person Initials:_____