COUNTY of VENTURA
Human Services Agency
Area Agency on Aging

Senior Nutrition Program HOME-DELIVERED Meals (C2) – Client Intake Form FY2025-2026

THIS INFORMATION IS STRICTLY CONFIDENTIAL.

TO RECEIVE HOME DELIVERED MEALS: Applicant must be aged 60 or older, homebound due to illness or disability, unable to prepare meals, to drive, or to attend a congregate meal site if transportation were provided. There is no charge for meals; however, voluntary contributions are accepted. A person will **not** be denied services if that individual chooses not to contribute.			
Provider Location:		Date:	
Preferred Language:		Birthdate (*Required*):	
Last Name:		First Name (*No Nicknames*):	

APPLICANT ELIGIBILITY	YES	NO
(a) Is applicant frail and homebound by reason of illness, disability, or isolation?	☐	☐
(b) Are you a spouse of (a) who is frail, and homebound by reason of illness, disability, or isolation and it is in their best interest that you also receive a meal? Name of person (a) _____.	☐	☐
(c) Are you an individual with a disability who resides with (a) and it is in their best interest that you also receive a meal? Name of person (a) _____.	☐	☐

NOTE: *If the answer is YES to any of the questions above, applicant is eligible for home-delivered meals.*

ADDRESS & CONTACT INFORMATION					
Address:		City:		Zip:	
Phone:		Email:			
Local Emergency Contact Name/Phone number:		# of Persons in Household:			
Lives Alone?	☐ Yes ☐ No ☐ Decline to State ☐ Missing	Lives in Rural Area? *(91307, 93066, 93040)*	☐ Yes ☐ No ☐ Decline to State ☐ Missing		
		APPLICANT SIGNATURE:			
I understand that the information I am providing on this form is for registration purposes. I understand it will be kept confidential and that the Area Agency on Aging and service providers may use it to help identify other services for which I may benefit.					

These are used to ensure that services are distributed equitably and do NOT affect eligibility.

DEMOGRAPHIC INFORMATION ☐ DECLINE TO STATE ☐ MISSING					
What is your marital status?	☐ Divorced ☐ Domestic Partnership ☐ Married ☐ Never Married ☐ Separated ☐ Widowed ☐ Decline to State ☐ Missing				
What is your approximate annual income?	IF single	☐ $15,650 or less	At or below Federal Poverty Level	☐ $15,651 or more	Above Federal Poverty Level
	IF married	☐ $21,150 or less		☐ $21,151 or more	

Do you think of yourself as:	What sex were you assigned at birth?	Do you think of yourself as:
☐ Nonbinary Genderqueer ☐ Female ☐ Male ☐ Trans male ☐ Trans female ☐ Other; please specify: ☐ Decline to answer ☐ Missing	☐ Female ☐ Male ☐ Intersex ☐ Other; please specify: ☐ Decline to answer ☐ Missing	☐ Straight/Heterosexual ☐ Bisexual ☐ Don't know ☐ Lesbian or gay ☐ Queer, pansexual, questioning ☐ Something else; please specify: ☐ Decline to answer ☐ Missing

How do you identify your ethnicity?	How do you identify your race(s)? ☐ Decline to State ☐Missing			
☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Answer ☐ Missing	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Cambodian	☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hawaiian	☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian	☐ Samoa ☐ Other Asian ☐ Other Pacific Islander ☐ Vietnamese ☐ White

Have you ever served in the United States military?	☐ YES ☐ NO	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

Do you consent to this agency and the California Department of Aging transmitting your name, email address, and telephone number to the Department of Veterans Affairs, only for the purpose of receiving additional information on veterans benefits for which you may be eligible? 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.	☐ I decline my consent. ☐ I consent. I understand that this is valid for 12 months.

SERVICE PROVIDER ASSESSMENT

Please ask these questions at the **FIRST** home-delivered meal **Dropoff**.

Applicant is:	☐ Blind ☐ Deaf	Applicant uses:	☐ Walker ☐ Wheelchair ☐ Cane

Does the applicant have:	YES	NO
a working refrigerator?	☐	☐
freezer space to store five frozen meals?	☐	☐
a working oven or microwave?	☐	☐
any dietary restrictions? (If yes, explain below)	☐	☐
are you physically and mentally able to open the food containers	☐	☐
are there pets?	☐	☐

Comments:

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

Decline to state. *unable to score*	☐	Check if total score is equal to or greater than 6 and the client is at **high nutritional risk**.	☐	Total Score:	

Referral(s) Made:

☐ Nutritional education/counseling for at risk clients

☐ Other:

☐ Other:

Notes:

CALIFORNIA ACTIVITIES AND INSTRUMENTAL ACTIVITIES (IADLS) OF DAILY LIVING (ADLS)
For each activity, mark the level of assistance you (or the client) need.

Level of assistance needed to perform the task of:	1 INDEPENDENT *needs no help*	2 VERBAL CUE *needs verbal reminders*	3 STAND BY *needs some human help*	4 HANDS ON *needs lots of human help*	5 DEPENDENT *cannot perform task*	Decline to State
ADLS						
Eating	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐
Moving In or Out of Bed or Chair	☐	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐	☐

IADLS						
Light Housework	☐	☐	☐	☐	☐	☐
Shopping or Errands	☐		☐		☐	☐
Meal Prep and Cleanup	☐	☐	☐	☐	☐	☐
Transportation	☐	☐	☐		☐	☐
Using the Telephone	☐	☐	☐		☐	☐
Managing Medications	☐	☐	☐	☐	☐	☐
Managing Money	☐	☐	☐		☐	☐
Heavy Housework	☐	☐	☐	☐	☐	☐

DO NOT WRITE IN THIS BOX – OFFICIAL USE ONLY	
Q Database/Unique Participant ID Number:	☐ Senior Spouse ☐ Non-Senior ☐ Disabled
Reviewed by (Name): ☐ Staff ☐ Volunteer	*Type of Meals:* ☐ Hot ☐ Frozen