



CONFIDENTIAL

PROVIDER LOCATION: \_\_\_\_\_

TO RECEIVE HOME DELIVERED MEALS: Person must be aged 60 or older, homebound due to illness or disability, unable to prepare meals, unable to drive, and unable to attend a congregate meal site if transportation were provided. There is no charge for meals; however, donations are accepted. A person will not be denied services if that individual chooses not to donate.

Date:	Phone:	Birth Date: (Required)
Last Name:	First Name: (No nicknames)	
<b>APPLICANT ELIGIBILITY</b>		<b>NOTE:</b>
Is applicant homebound due to illness or disability?	YES <input type="checkbox"/>	NO <input type="checkbox"/> } If answer is NO, stop here; applicant is not eligible for home-delivered meals.
Is applicant 60 or older, and/or the spouse of an eligible senior?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is applicant able to prepare meals?	YES <input type="checkbox"/>	} If answer is YES, stop here; applicant is not eligible for home-delivered meals.
Does applicant drive?	YES <input type="checkbox"/>	
Can applicant attend a congregate meal site if transportation is provided?	YES <input type="checkbox"/>	
Street Address:	City:	ZIP:
Local Emergency Contact (Name/Phone)		Rural: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State <small>(91307, 93066, 93040)</small>
Contact Name:	Phone:	
<b>RACE – PLEASE CHOOSE (X) ONE:</b>		<b>Ethnicity:</b>
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Laotian
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Multiple Race
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Other Asian
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Pacific Islander
<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Other Race
<input type="checkbox"/> Samoan	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> White
<input type="checkbox"/> Decline to State	<input type="checkbox"/> Decline to State	<input type="checkbox"/> Decline to State
<b>Marital Status:</b> <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Decline to State		
<b>Veteran Status:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Preferred Language:</b>
<b>Client Lives:</b> <input type="checkbox"/> Alone <input type="checkbox"/> Not Alone <input type="checkbox"/> Decline to State	<b>Number of Persons Living in Household:</b>	
<b>Applicant's Income Level (approximate):</b>		
<b>IF MARRIED:</b>	<b>IF SINGLE:</b>	
<input type="checkbox"/> At or below Federal Poverty Level (\$16,910/year or less)	<input type="checkbox"/> At or below Federal Poverty Level (\$12,490/year or less)	
<input type="checkbox"/> Above Federal Poverty Level (\$16,911/year or more)	<input type="checkbox"/> Above Federal Poverty Level (\$12,491/year or more)	
<input type="checkbox"/> Decline to State	<input type="checkbox"/> Decline to State	
<b>The Gay Bisexual and Transgender Disparities Reduction Act of 2016 (AB 959)</b>		
The State of CA requires that we ask you some demographic questions followed by three questions under the new CA State AB 959 Law, the Gay, Bisexual and Transgender Disparities Reduction Act of 2016. VCAA values your privacy and you have the option to decline to state.		
<b>What was your sex at birth?</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Decline to State	
<b>What is your Gender?</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Decline to State <input type="checkbox"/> Not listed, please specify: _____	
<b>How do you describe your sexual orientation or sexual identity?</b>	<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"/> Decline to State <input type="checkbox"/> Not listed, please specify: _____	
<b>ABOUT THE APPLICANT:</b>	<b>YES</b>	<b>NO</b>
Any dietary restrictions? (If yes, explain)	<input type="checkbox"/>	<input type="checkbox"/>
A working refrigerator?	<input type="checkbox"/>	<input type="checkbox"/>
Freezer space to store five (5) frozen meals?	<input type="checkbox"/>	<input type="checkbox"/>
A working oven/microwave?	<input type="checkbox"/>	<input type="checkbox"/>
Physically and mentally able to reheat a meal?	<input type="checkbox"/>	<input type="checkbox"/>
Interested in weekend meals, if available?	<input type="checkbox"/>	<input type="checkbox"/>
Applicant is: <input type="checkbox"/> Blind <input type="checkbox"/> Deaf	Applicant uses: <input type="checkbox"/> Walker <input type="checkbox"/> Cane	<input type="checkbox"/> Wheelchair <input type="checkbox"/>
<b>COMMENTS:</b>		



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Nutritional Assessment of Applicant:		Check All That Apply:
I have an illness or condition that made me change the kind and/or amount of food I eat.	(2pts)	<input type="checkbox"/>
I eat fewer than 2 meals per day.	(3pts)	<input type="checkbox"/>
I eat few fruits or vegetables or milk products.	(2pts)	<input type="checkbox"/>
I have 3 or more drinks of beer, liquor or wine almost every day.	(2pts)	<input type="checkbox"/>
I have tooth or mouth problems that make it hard for me to eat.	(2pts)	<input type="checkbox"/>
I don't always have enough money to buy the food I need.	(4pts)	<input type="checkbox"/>
I eat alone most of the time.	(1pt)	<input type="checkbox"/>
I take 3 or more different prescribed or over-the-counter drugs a day.	(1pt)	<input type="checkbox"/>
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	(2pts)	<input type="checkbox"/>
I am not always physically able to shop, cook and/or feed myself.	(2pts)	<input type="checkbox"/>
Decline to State:		<input type="checkbox"/>
<b>(If equal to or greater than 6, the client is at high nutritional risk→)</b>		<b>Total Score:</b>

**CALIFORNIA ACTIVITIES & INSTRUMENTAL ACTIVITIES (IADLS) OF DAILY LIVING (ADLS)**  
Please Check (✓) One of the Columns for Each Activity

TYPE OF ASSISTANCE CARE RECEIVER NEEDS TO PERFORM TASK →		1 INDEPENDENT Needs No Help	2 VERBAL QUE 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
<b>A D L S</b>	Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>I A D L S</b>	Light Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Shopping/Errands	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Meal Prep/Cleanup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Using Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Managing Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Managing Money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Heavy Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

I certify that all statements on this form are true and correct. \_\_\_\_\_  
Applicant's Signature

**DO NOT WRITE IN THIS BOX – OFFICIAL USE ONLY**

Client Q Database/Unique Participant ID Number:	<input type="checkbox"/> Senior <input type="checkbox"/> Spouse <input type="checkbox"/> Non-Senior Disabled
Reviewed by: <input type="checkbox"/> Staff <input type="checkbox"/> Volunteer	Type of Meals: <input type="checkbox"/> Hot <input type="checkbox"/> Frozen