Date of Assessment: ________________

- ☐ **ServTracker**
- ☐ **SAMS**
- ☐ **Scanned**
- ☐ **New Client List**

SourcePoint Meals on Wheels Program
Cafe Registration

Last Name: ____________________ First Name: ____________________ MI: _____ AKA: ______________

DOB: ______________ Age: __________ Gender: __________ Phone: ___________________________

Address: ____
Street Apt/Unit City Zip

Emergency Contact: ____
Name Phone Number

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Widowed
- ☐ Divorced
- ☐ Unknown

Living Arrangement:
- ☐ Alone
- ☐ Spouse/Partner
- ☐ Spouse & Child
- ☐ Child
- ☐ With Others
- ☐ Unknown

How Many Living in Home:
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4 or more

Disabled:
- ☐ Yes
- ☐ No
- ☐ Unknown

Poverty:
- ☐ Yes (Below level)
- ☐ No (Above Level)

Levels:
Household of 1: $12,490
Household of 2: $16,910

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Refuse to Answer

Rural:
- ☒ Urban

Race:
- ☐ American Indian (Native American) / Native Alaskan
- ☐ Asian
- ☐ Black / African American
- ☐ Hispanic
- ☐ White
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other
- ☐ Refused to Answer

Primary Language:
- ☐ English
- ☐ Spanish
- ☐ Spanish speaking, reads English
- ☐ Other: ____________________

If cafe guest is under 60 years of age, please answer questions below:

1. Guest's spouse is 60 or over and is accompanying guest	☐ Yes	☐ No
2. Guest is a person with disabilities who resides in the cafe's location	☐ Yes	☐ No
3. Guest is a SourcePoint Nutrition Program volunteer	☐ Yes	☐ No
4. Guest is a person with disabilities who resides in the home of someone 60 or over and is accompanying the guest	☐ Yes	☐ No

Answer "Yes" or "No" by marking the number within the appropriate column. Add marked numbers to determine nutritional health score.	Yes	No
1. Have you made any changes in lifelong eating habits because of health problems?	☐ 2	☐ 0
2. Do you eat fewer than two (2) meals a day?	☐ 3	☐ 0
3. Do you eat fewer than five (5) servings (1/2 cup each) of fruits & vegetables every day?	☐ 1	☐ 0
4. Do you eat fewer than two (2) servings of dairy products (such as milk, yogurt, cheese) every day?	☐ 1	☐ 0
5. Do you sometimes not have enough money to buy food?	☐ 4	☐ 0
6. Do you have trouble eating well due to problems with chewing/swallowing?	☐ 2	☐ 0
7. Do you eat alone most of the time?	☐ 1	☐ 0
8. Without wanting to, have you lost or gained ten (10) pounds in the past six (6) months?	☐ 2	☐ 0
9. Are you not always physically able to shop, cook and/or feed yourself (or get someone to do it for you?)	☐ 2	☐ 0
10. Do you have three (3) or more drinks of beer, liquor, or wine almost every day?	☐ 2	☐ 0
11. Do you take three (3) or more prescription or over-the-counter drugs per day?	☐ 1	☐ 0
Nutritional Risk Total Score: ______ ✓ 0-2: Good, low risk ✓ 3-5: Moderate Risk ★ ★6 or more: High Risk		
★★**Results of 6 or more:** ☐ Client given information regarding home/community-based services		

DISCLOSURE STATEMENT

The attached Client Registration Form was developed to assist the Ohio Department of Aging to monitor the effectiveness of senior programs offered to the citizens of Ohio. Any client information obtained from this form will be kept confidential and no personal identifying information about a client (e.g., name, address, telephone number, ID number, etc.) will be released to the public without the client's prior written consent, or unless otherwise required under federal law.

The data collected (age, sex, race, low income status) will be forwarded to the Area Agency on Aging and the Ohio Department of Aging, and summarized and reported to the Administration on Aging (AOA) in order to keep both state and federal legislators informed on the effectiveness of senior programs (as required by the Older Americans Act). While all clients receiving services under the Older Americans Act are asked to complete this form in full, no client may be denied services for refusing to complete portions of the information requested.

____ ________________

Applicant's Signature Date

I have discussed\read\explained the Disclosure Statement with the client.

____ ________________

Provider's Signature Date