

Date of Assessment: \_\_\_\_\_

ServTracker

Existing Client

Scanned

New Client List

## SourcePoint Meals on Wheels Program Café Registration

Please print information below

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ AKA: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex at birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ ZIP: \_\_\_\_\_ County: \_\_\_\_\_

**Marital Status:**

- Single
- Married
- Separated
- Widowed
- Divorced

**Gender Identity**

- Female
- Male
- Non-Binary
- Non-Disclose
- Other
- Transgender-Female
- Transgender-Male
- Unknown

**Race**

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

**Living Arrangement:**

- Alone
- Spouse/Partner
- Spouse & Child
- Child
- With Others
- Unknown

**Poverty:**

- Yes (Below level)
- No (Above Level)

*Levels:*

*Household of 1: \$15,060/year  
Household of 2: \$20,440/year*

**Served in the Armed Forces:**

- Yes
- No

**Rural**

Urban

**Disabled:**

- Yes
- No
- Unknown

**Ethnicity**

- Hispanic or Latino
- Not Hispanic or Latino
- Refuse to Answer

**Primary Language**

- English
- Spanish
- Spanish speaking, reads English
- Other: \_\_\_\_\_

**If Café 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 café'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

Continue to reverse for NRA.

## Nutritional Risk Assessment

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