

Congregate Nutrition Assessment Form

Welcome! Please tell us a bit about yourself so we can offer services that best meet your needs. We ask for demographic information to meet requirements from our funders. All your personal information is confidential. Please see the attached FAQs for more information and guidance on filling out this form.

Contact & Demographic Information:

Last Name: _____ First Name: _____ M.I. _____

Date of Birth: _____ Age: _____

Gender: Male Female Other gender not listed: _____

Home Address Line 1: _____

Line 2 (Apt/Unit/Floor #): _____ City: _____

Zip: _____ County: _____ State: _____

Mailing Address Line 1: _____

Line 2 (Apt/Unit/Floor #): _____ City: _____

Zip: _____ County: _____ State: _____

Location Comments (additional directions for home or mailing address):

Home Phone: _____ Cell Phone: _____

Email: _____

Primary language: English Spanish Other: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race, select all that apply:

American Indian/Alaska Native Native Hawaiian or Pacific Islander

Asian or Asian American White

Black or African American Other not listed: _____

Do you live: Alone With Others

Number of people in your household (including you): _____

Is your income above or below the amount listed for your household size:

Above At/Below

Household Size	Monthly Income	Annual Income
1	\$1,133	\$13,590
2	\$1,526	\$18,310
3	\$1,919	\$23,030
4	\$2,313	\$27,750
For each additional person, add \$4,720 to annual income		

Emergency Contact:**Primary Emergency Contact:**

Name: _____

Phone: _____ Relationship: _____

Nutrition Screening:

Determine your nutritional health. If the statement is true for you, check the box in the “Yes” column and add the points in the “Yes Score” column to the total score.

Nutrition Risk Score Questions	Yes	No	Yes Score
Do you have an illness or condition that has made you change the kind and/or amount of food you eat?	<input type="checkbox"/>	<input type="checkbox"/>	2
Do you eat fewer than 2 meals per day?	<input type="checkbox"/>	<input type="checkbox"/>	3
Do you eat few fruits, vegetables, or milk products?	<input type="checkbox"/>	<input type="checkbox"/>	2
Do you have 3 or more drinks of beer, liquor, or wine almost every day?	<input type="checkbox"/>	<input type="checkbox"/>	2
Do you have tooth or mouth problems that make it hard for you to eat?	<input type="checkbox"/>	<input type="checkbox"/>	2
Are there times you do not have enough money to buy the food you need?	<input type="checkbox"/>	<input type="checkbox"/>	4
Do you eat alone most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	1
Do you take 3 or more different prescribed or over the counter drugs a day?	<input type="checkbox"/>	<input type="checkbox"/>	1
Without wanting to, have you lost or gained 10 pounds in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	2
Are there times you're physically unable to shop, cook, and/or feed yourself?	<input type="checkbox"/>	<input type="checkbox"/>	2
Total Nutrition Risk Score	<i>Total “Yes” Score:</i>		

Total Nutrition Risk Score: 0-2 = No Risk, 3-5 = Moderate Risk, 6 or more = High Risk

If you are at high nutrition risk – take action! Speak with a qualified health or social service professional about your nutritional health. Providers – if the client is at high nutrition risk, please make a case note and appropriate referral.

Interest in Other Services:

Health Insurance (select all that apply): Medicaid Medicare Other None

Are you interested in receiving nutrition counseling? Yes No

Would you like to hear about other services? Yes No

If yes, how can we contact you? Email Mail Phone

What services are you interested in? _____

Are you a grandparent, raising grandchildren? Yes No

Are you willing to volunteer? Yes No

Disclosures and Waivers

I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service provider and I herewith give my consent to do so.

Signature: _____ **Date:** _____

For Office Use Only –

(If filled out by assessor or via phone, please have assessor check here and sign below)

Filled Out By: _____ **Date:** _____

Congregate Nutrition Eligibility

- Individual Aged 60+
- Self-Declared Spouse of eligible individual
- Individual with disabilities living with eligible individual
- Individual with disabilities who resides in housing where meal site is located
- Long Term Care Facility resident 60+ or self-declared spouse of eligible individual (may have meal if not a substitute for meal provided by the facility)
- Meal Site Staff or Volunteer

Nutrition Counseling Eligibility:

- Individual Aged 60+
- Caregiver to an Individual Aged 60+

Client Information and FAQs Sheet

We are so glad you found us! Please keep this information for your records.

Provider and Area Agency on Aging Information:

Your local Area Agency on Aging: *Upper Arkansas Area Agency on Aging*

What is an Area Agency on Aging?

We're glad you asked! The Area Agency on Aging (AAA) is a regional agency that is designated by the state to administer federal, state, and local funding to meet the needs of older adults in their community. The AAA provides programs and services to older adults and caregivers directly and through contracts with community provider agencies. AAAs also serve as advocates for older adults.

Service Information:

The service you are requesting is funded through the Older Americans Act (OAA) and/or Older Coloradans Act (OCA) funding. This federal and state funding helps older adults, 60+, remain in their homes and communities of choice. Requests for services are processed as funds allow. We can provide you with referrals to other resources in your area, but we will not reach out to them without your permission.

What is the purpose of this form?

We ask you to fill-in this form for several reasons:

- To help us learn about you so we can offer services that best meet your needs
- To help us understand the needs of older adults in our community
- To help us show the need for funding our programs
- To help us meet reporting requirements from our funders

Taxpayer money funds these programs. We must prove that the funding only serves eligible clients and targets older adults and caregivers most in need of services. This paperwork helps us meet that level of accountability.

Income information is not used to determine your eligibility for services. Income and other demographic information (e.g. gender, race, ethnicity) are collected for anonymous demographic reporting purposes. None of your personal information, such as your name or date of birth is disclosed in reporting. You have the right to refuse to provide any of the information requested on the form.

What happens with my information?

We enter your information into a secure state database. As you receive services, we record the services you received in the database. This helps us prove how we spent the funding. The database is secured to the standards outlined in Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH). This means your data remains safe and confidential.

Will you sell my information?

No. We will never sell your information.

How do I provide feedback?

We love hearing how we can improve. Contact your service provider or your local Area Agency on Aging at **719-539-3341** or **tom.mcconaghy@uaacog.com**. Because we value your input, we may at times send you a survey to ask for your feedback.

How do I file a complaint, grievance, or appeal?

Complaint/Grievance/Appeal Procedure:

You have the right to file a complaint or grievance with the organization asking you to fill out this form. If you are not satisfied with the organization's decision, you can appeal the decision to your local Area Agency on Aging (AAA), and/or the State Unit on Aging (SUA). The complete Complaint/Grievance/Appeal Procedures are available upon request by contacting your local AAA and/or the SUA as follows:

<p>Upper Arkansas Area Agency on Aging 139 E 3rd St Salida, CO 81201 719-539-3341 Tom.mcconaghy@uaacog.com</p>	<p>Colorado Department of Human Services, State Unit on Aging 1575 Sherman Street, 10th Floor Denver, CO 80203 303.866.2800</p>
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Can I make a donation?

We accept donations and gifts to contribute towards the cost of services and to support our efforts. Every dollar we receive goes back into the programs and services. Donations are voluntary and are not required to receive services.

You can send to donations to **UAACOG, 139 E 3rd St, Salida, CO 81201**

What other resources are available?

Feel free to reach out to your Area Agency on Aging to get more information about the services available in your region. We love to help!

Services available in our region include: *Financial aid for dental and vision procedures, in home safety related repairs, meals on wheel, congregate meals, in home assistance, respite services, and legal services.*

You can also call the statewide Aging and Disability Resources for Colorado (ADRC) for information about resources in your area: 1-844-COL-ADRC / 1-844-265-2372

How can I help?

We couldn't meet the needs of older adults in our communities without the amazing help from volunteers and members of our Regional Advisory Councils. Reach out to either your provider or your AAA to see how you can help make a difference in the lives of older adults in our community.