Confidential Form FY 18/19

C.C. Cafe Meal Participant

Place Label Here

☐ Rollover

☐ New

☐ Under 60

Required For All Participants

Participant ID # _____
Termination Date _____
Reason _____

(1) Name First:_____ MI:___Last:_____

(2) A.K.A. OR NICKNAME: First: _____ Last:_____

(3) City: _____ Zip Code: _____

(4) **Birth Date**: __ __-__ __-__ __ __ __
(M M / D D / Y Y Y Y)

Qualifying Under 60: Y / N
Related to: _____
Relationship: _____

(5) **Gender**: ___Male ___Female ___Transgender Female to Male ___Transgender Male to Female
___Genderqueer/Gender Non-binary ___Not Listed ___Declined/Not stated

(6) **Sex At Birth**: ___Male ___Female ___Declined/Not stated

(7) **Sexual Orientation or Sexual Identity:** ___Straight/Heterosexual ___Bisexual
___Gay/Lesbian/Same-Gender Loving ___Questioning/Unsure ___Not Listed ___Declined/Not stated

(8) **Race**: (Check One)

	White
	Black / African Amer.
	Am. Indian / Alaska Native
	Asian Indian
	Cambodian
	Central American
	Chinese
	Filipino

	Guamanian
	Hawaiian
	Japanese
	Korean
	Laotian
	Latino - Other
	Mexican American
	Middle Eastern

	Multiple Race
	Other Asian
	Other Pacific Islander
	Other Race
	Samoan
	South American
	Vietnamese
	Declined to State

(9) **Ethnicity**: Hispanic/Latino ___Yes ___ No ___ Declined to State

(10) **Marital Status**: ___ Married ___Widowed ___Single (Never Married) ___Separated
___Divorced ___ Domestic Partner ___ Declined to State

(11) **Veteran Status**: ___Veteran ___Veteran Dependent ___ No ___Declined to State

(12) **Rural Area?**: ___Yes ___No ___Declined to State

(13) **Living Arrangement**: # of household members ____ ___Declined to State

(14) **Is your monthly income less than $1,012/mo if single or less than $1,372/mo if married?**
___Yes ___No ___Declined to State

(15) **Is your monthly income level less than $2,587/mo?**
___Yes ___No ___Declined to State

(16) Café Location: **EL CERRITO** Start Date: __ __-__ __-__ __ __ __
(M M / D D / Y Y Y Y)

Please Complete Reverse Side (Over)

Nutritional Assessment:

	Circle: Y (yes) N (no)
I have an illness or condition that made me change the kind and/or amount of food I eat. (2)	Y N
I eat fewer than 2 meals per day. (3)	Y N
I eat few fruits or vegetables or milk products. (2)	Y N
I have 3 or more drinks of beer, liquor or wine almost every day. (2)	Y N
I have tooth or mouth problems that make it hard for me to eat. (2)	Y N
I don't always have enough money to buy the food I need. (4)	Y N
I eat alone most of the time. (1)	Y N
I take 3 or more different prescribed or over-the-counter drugs a day. (1)	Y N
Without wanting to, I have lost or gained 10 pounds in the last 6 months. (2)	Y N
I am not always physically able to shop, cook, and/or feed myself. (2)	Y N
	D Declined To State

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.

_____ _____

Signature of participant or person completing the form Date

CONFIDENTIAL PARTICIPANT INFORMATION	Café City:
Name: Last First Middle (Init.) (Print)	Date:
Address	Do You Need Transportation? (Circle) **Y** **N**
City Zip	
Phone # ( )	Ethnicity (Optional) Caucasian
Sex: M_____ F_____	Asian/P.I.
Age: Circle One 60-64 65-74 75-84 85+	Hispanic
Spouse Name: Age:	African Amer. Amer. Indian
	NP-43 Revised 7/06

EMERGENCY INFORMATION

IN CASE OF EMERGENCY PLEASE NOTIFY:

Name
Address
Phone # Relationship
Doctor or Hospital Preference
Medical Coverage Coverage#
Insurance #
Food Allergies:
Drug Allergies:
Chronic Conditions: ( )Heart ( )Diabetes ( )Pacemaker ( )Seizures ( )High Blood Pressure ( )Arthritis ( )Other

CAFÉ NAME_____

C. C. CAFÉ WAIVER FOR MARCH 2020

NO C.C. CAFÉ MEAL MAY BE TAKEN FROM THE C. C. CAFÉ UNTIL THIS FORM IS COMPLETED.

Remember that food spoils very easily. Hot foods must be kept hot, and cold foods must be kept cold.

The homebound hot/cold meal should be eaten immediately. Do not leave food unrefrigerated.

Participant's Name _____

I understand that by signing this waiver, I assume responsibility for the safety of any meals I take out of the senior center this month:

_____

(Signature) (Date)

Café Manager Signature: _____ Date: _____

C.C. CAFÉ

KEEP IT SAFE TO EAT

- Remember that food spoils very easily.
- Hot foods must be kept hot, and cold foods must be kept cold.

DO NOT LEAVE FOOD UNREFRIGERATED
WHEN IN DOUBT, THROW IT OUT!