

Provider Name: SAMPLE 3, CLUSTER 2	*Unique Participant ID: _____
Region/Site Name:	Registration/Assessment Date: _____
*Termination Date: _____ *Reason: _____	
Service Categories(Titles IIIB, IIIC and IIID):	
<input type="checkbox"/> *Assisted Transportation <input type="checkbox"/> *Congregate Meals (N) <input type="checkbox"/> *Nutrition Counseling (N)	
Notes: Requires N-Nutritional Assessments on Page 2	

SECTION 1 (Client)
 (*) Required for All Registered Programs

Personal Data (Please Print):					
First Name:					
Middle Initial:					
Last Name:					
* What is your gender? (Check only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
* What was your sex at birth? (Check only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated				
* How do you describe your sexual orientation or sexual identity (Check only one)	<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"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
*Birth Date:					
Last 4 Digits Social Security # <i>Optional</i>	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> </tr> </table>				
Home Phone #:	()				
Residential Address:					
Street:					
City:					
*Zip Code:					

Mailing Address:	
Same As Residential? <input type="checkbox"/> Yes – Skip to Next Section	
Street:	
City:	
* Zip Code:	
Emergency Contact:	Name: Relationship: Phone #: ()
*Ethnicity:	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State
*Federal Poverty Level (FPL)	<input type="checkbox"/> At or below FPL <input type="checkbox"/> Above FPL <input type="checkbox"/> Declined to State
*Lives Alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
*Rural?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
*Race: (Please Check ONE)	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race	
Asian:	
<input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	
Hawaiian/Other Pacific Islander:	
<input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to State	
Title III B Eligibility:	
Are you age 60 or over? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Transportation Service Needs:	
<input type="checkbox"/> Walks with no assistance (Non-Assisted) <input type="checkbox"/> Walks with assistance (Assisted) <input type="checkbox"/> Wheelchair ramp/lift	

SECTION 2 – Nutritional Assessment (Annual)
Required for (IIIC): Congregate Meals; IIIC, D Nutritional Counseling

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

Notes: