Congregate Meal Program Registration Please complete this form to the best of your ability. Heavily outlined items are for office use only.						
Contact Date	AAA Region		igibility Category (Che Client Spouse Vo Disabled			
Section A. Basic Demographics						
Last Name: First			et Name:		Middle Initial:	
		Gender:	□ Female	□ Male	Date of Birth:	
Address:			☐ Unspecified Address #2:			
City:	State:		Zip Code:		County:	
Home Phone:	Mobile Phone:			Work Pho	rk Phone:	
Section B. Social History						
Race (Check all that apply): American In			or Alaska Native		Ethnicity (Check one):	
Asian or A				Hispanic or Latino		
	African A			Non-Hispanic		
Native Hawaiian or Pacific Islander White						
Household Size (Check One): I live alone. I live with others.						
Section C. Financial						
☐ <u>I live alone</u> and my monthly income is between (Check one)						
\$1,215/month or less \$1,216 - \$1,823/			\$1,824-\$2,430/m	onth M	Iore than \$2,430/month	
☐ <u>I live with my spouse</u> and our <u>monthly</u> income is between (Check one)						
\$1,643/month or less	\$1,644-\$2,465/	month	\$2,466-\$3,287/mor	nth M	ore than \$3,287/month	
Section D. Contacts						
Emergency Phone: En	nergency Conta	ct Name		Emei	rgency Contact Relationship	

Section E. Nutrition Risk Assessment						
Are there times when you don't have enough money to						
buy the food you need?						
Yes No						
Do you eat alone most of the time?						
Yes No						
Do you take 3 or more prescribed or over-the-counter						
drugs each day?						
Yes No						
Have you lost or gained 10 pounds in the last 6 months						
without wanting to?						
Yes No						
Are there times when you are not physically able to						
shop, cook or feed yourself?						
Yes No						
Section F. Use of Information						

I understand that the information I am providing on this form is for registration purposes. The information will be used by the U.S. Health and Human Services Administration for Community Living (ACL), the Minnesota Board on Aging (MBA) and the local Area Agency on Aging, to create statistical reports. ACL, MBA and/or its assignees may use this information to conduct a study and/or survey of this service. In addition, information provided here, may be used by other service providers to help identify other services from which I may benefit, such as follow up to the Nutrition Risk Assessment. This information will not be released to anyone other than the above mentioned parties in a way that will identify me as an individual unless I sign a separate consent for that purpose.

My signature (written or typed) indicates my agreement for this information to be used as indicated above.

Signature: Today's Date:

MBA 04/2023