Month Registered	YEAR REG.	Update Date
J F M A M J J A S O N D	_____ _____	_____ _____

Confidential

LUNCH CLUB 60 PARTICIPANT REGISTRATION

Please Print all Information

PeerPlace ☐ Yes ☐ No

IIIC-1_____

SNAP_____

LAST NAME _____ MI. ____ FIRST NAME _____ DATE OF BIRTH ____/____/____ MALE _____ FEMALE _____

ADDRESS _____ CITY _____ STATE NY ZIP CODE _____ HOME PHONE _____ CELL PHONE _____

Demographics: Please Check Appropriate Box

1. Ethnic Background: African-American ☐ Latino/Hispanic ☐ White ☐ Asian Pacific ☐ Indian (American/Alaskan Native) ☐
2. Do you live alone? Yes ☐ No ☐ if No, who do you live with? Spouse ☐ Relatives ☐ Spouse and Other Relatives ☐ Non-Relative ☐
3. Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐
4. Are you physically challenged? Yes ☐ No ☐
5. Please list previous career/job, hobbies and interests:_____
6. Would you like to volunteer at your center? Yes ☐ No ☐ Maybe at a later date ☐
7. What forms of transportation do you use? Check all that apply. Public ☐ Your Car ☐ Med. Motors ☐ Ride w/a friend ☐ Center Van ☐ Walk ☐ Other ☐

EMERGENCY CONTACTS:

1. _____ First Name, Last Name _____ Address _____ Relationship _____ Home Phone _____ Work Phone _____ Cell Phone
2. _____ First Name, Last Name _____ Address _____ Relationship _____ Home Phone _____ Work Phone _____ Cell Phone

FINANCIAL INFORMATION:

	IIIC-1	SNAP
1. Yearly Individual Income:	Below $10,830 ☐ Over $10,830 ☐	Below $16,245 ☐ Over $16,245 ☐

2. Total Household Income: Less than $15,000 ☐ $15,000-$24,999 ☐ $25,000-$44,999 ☐ $45,000-$74,999 ☐ $75,000 or Greater ☐

MEDICAL INFORMATION:

1. _____ Physician Name _____ Physician Phone Number _____ Physician Address _____ Zip Code
2. Medical Condition(s) (Please List)_____
3. Allergies:_____
4. Prescriptions:_____
5. Do you follow a physician prescribed special diet? Yes ☐ No ☐ If yes, please tell us the diet type_____

(OVER)

Rvsd. 2/27/08 (ch)

This questionnaire is a requirement of the Older Americans Act (Federal) to be administered to the Lunch Club 60 regular participants

The Warning Signs of Poor Nutritional Health

Please check the statements ONLY IF it applies to you.

NUTRITIONAL TEST

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 a day	3
I eat few fruits or vegetabkes, 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 makes 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 last 6 months	2
I am not always physically able to shop, cook and/or feed myself	2
TOTAL	

Six or above indicates Nutritional High Risk. REFFERAL REQUIRED

Person Referral Acceptance: Yes No

Person's Initials: _____

Coordinator's Referral Date: _____ Updated

Professional Intervention Date: _____

By: _____

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TOTAL	

Six or above indicates Nutritional High Risk. REFFERAL REQUIRED

Person Referral Acceptance: Yes No

Person's Initials: _____

Coordinator's Referral Date: _____

Professional Intervention Date: _____

By: _____

CERTIFICATION OF AGE:

THIS IS TO CERTIFY THAT I AM 60 OR MORE YEARS OF AGE (OR THE SPOUSE OF A PERSON 60 OR OVER)

DATE: _____ **SIGNATURE:** _____