COMMUNITY SERVICES
Senior Services

☐ C-1 CONGREGATE MEALS
☐ TRANSPORTATION CLIENT REGISTRATION

CLIENT INFORMATION

NAME*			***DATE OF BIRTH***
LAST	FIRST	MI	

ADDRESS*	CITY	***ZIP***	PHONE*

MARITAL STATUS	REASON FOR NUTRITION PROGRAM	EMAIL*
☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED	☐ 60+ ☐ DISABLED ☐ SPOUSE ☐ NUTRITION VOLUNTEER	

HOUSEHOLD INCOME ☐ DECLINED TO STATE

FPL INCOME LESS THAN $12,880 (1 person) PER YEAR OR $17,420 (2 people) PER YEAR? ☐ YES ☐ NO

1 PERSON:	☐ $12,880 - $16,099	☐ $16,100 - $17,129	☐ $17,130 - $17,387	☐ $17,388 - $17,773	☐ $17,774+
2 PEOPLE:	☐ $17,420 - $21,774	☐ $21,775 - $23,168	☐ $23,169 - $23,516	☐ $23,517 - $24,039	☐ $24,040+

RACE/ETHNICITY

RACE (Select all that apply)**:**

- ☐ WHITE
- ☐ BLACK
- ☐ AMERICAN INDIAN/ ALASKA NATIVE
- ☐ DECLINED/NOT STATED

Asian:

- ☐ ASIAN INDIAN
- ☐ CHINESE
- ☐ JAPANESE
- ☐ LAOTIAN
- ☐ OTHER ASIAN
- ☐ CAMBODIAN
- ☐ FILIPINO
- ☐ KOREAN
- ☐ VIETNAMESE

Hawaiian/Pacific Islander:

- ☐ GUAMANIAN
- ☐ HAWAIIAN
- ☐ SAMOAN
- ☐ OTHER PACIFIC ISLANDER

ETHNICITY:

- ☐ NOT HISPANIC/LATINO
- ☐ HISPANIC/LATINO
- ☐ DECLINED/NOT STATED

DEMOGRAPHICS

WHAT IS YOUR GENDER? ☐ DECLINED/NOT STATED

- ☐ MALE ☐ TRANSGENDER; FEMALE TO MALE
- ☐ FEMALE ☐ TRANSGENDER; MALE TO FEMALE
- ☐ GENDERQUEER/GENDER NON-BINARY
- ☐ NOT LISTED; SPECIFY: ____________________

HOW DO YOU DESCRIBE YOUR SEXUAL ORIENTATION OR SEXUAL IDENTITY? ☐ DECLINED/NOT STATED

- ☐ STRAIGHT/HETEROSEXUAL
- ☐ BISEXUAL
- ☐ GAY/LESBIAN/SAME-GENDER LOVING
- ☐ QUESTIONING/UNSURE
- ☐ NOT LISTED; SPECIFY: ____________________

WHAT WAS YOUR SEX AT BIRTH?
☐ MALE ☐ FEMALE ☐ DECLINED/NOT STATED

RURAL:
☐ YES ☐ NO ☐ DECLINED/NOT STATED

LIVING ARRANGEMENT:
☐ ALONE ☐ WITH OTHERS ☐ DECLINED/NOT STATED

NUMBER IN HOUSEHOLD:
____________________ ☐ DECLINED/NOT STATED

FEMALE HEAD OF HOUSEHOLD:
☐ YES ☐ NO

I CERTIFY THE ABOVE INFORMATION IS CORRECT.

____________________ SIGNATURE*

____________________ REGISTRATION DATE

C-1 CLIENT REGISTRATION

EMERGENCY CONTACT

NAME*			RELATIONSHIP
ADDRESS*			PHONE*
CITY	STATE	ZIP	ALTERNATE PHONE*
PRIMARY PHYSICIAN*	HEALTH INSURANCE*		OFFICE PHONE*

I AUTHORIZE CITY OF IRVINE STAFF TO CONTACT ABOVE PERSON IN THE EVENT OF AN EMERGENCY. ☐ YES ☐ NO

SIGNATURE*

NUTRITIONAL RISK ☐ DECLINED TO STATE			POINTS
1. I have an illness or condition that made me change the kind and/or amount of food I eat.	☐ YES	☐ NO	2
2. I eat fewer than 2 meals per day.	☐ YES	☐ NO	3
3. I eat few fruits or vegetables, or milk products	☐ YES	☐ NO	2
4. I have 3 or more drinks of beer, liquor or wine almost every day.	☐ YES	☐ NO	2
5. I have tooth or mouth problems that make it hard for me to eat.	☐ YES	☐ NO	2
6. I do not always have enough money to buy the food I need.	☐ YES	☐ NO	4
7. I eat alone most of the time.	☐ YES	☐ NO	1
8. I take 3 or more different prescribed or over-the-counter drugs a day.	☐ YES	☐ NO	1
9. Without wanting to, I have lost or gained 10 pounds in the last 6 months.	☐ YES	☐ NO	2
10. I am not always physically able to shop, cook and/or feed myself.	☐ YES	☐ NO	2
11. Do you have less than 5 cups (8 oz. per cup) of fluids per day?* *Question is not part of the Nutrition Risk scoring.	☐ YES	☐ NO	
HIGH NUTRITIONAL RISK? *(High nutritional risk is a score of 6 or more points)* ☐ YES ☐ NO			**TOTAL**

FOR OFFICE USE ONLY

TERMINATION DATE: ______________________

PARTICIPANT ID#: ______________________ TERMINATION REASON: ______________________