

**MARC CLIENT INTAKE FORM - CONGREGATE MEALS**

**Client Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Gender: M F DOB: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_\_\_ DCN: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Living Alone: \_\_\_ Y \_\_\_ N

County: \_\_\_ Cass \_\_\_ Clay \_\_\_ Jackson \_\_\_ Platte \_\_\_ Ray \_\_\_ Other: \_\_\_\_\_

**Marital Status:** \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Partnered  
 \_\_\_ Separated \_\_\_ Widowed (date of spouse's death): \_\_\_\_\_

Primary Language: \_\_\_ English  
 \_\_\_ Spanish \_\_\_ Other: \_\_\_\_\_

**Ethnicity:** \_\_\_ Hispanic/Latino \_\_\_ Not Hispanic/Latino

**Citizenship Status**

**Race (mark more than one if necessary):** \_\_\_ African-American \_\_\_ American Indian/Native Alaskan  
 \_\_\_ Asian \_\_\_ Native Hawaiian/Pacific Islander \_\_\_ White \_\_\_ Other: \_\_\_\_\_

\_\_\_ US Citizen  
 \_\_\_ Permanent Res.

**Eligibility:** \_\_\_ Age \_\_\_ Eligible Spouse \_\_\_ Volunteer  
 \_\_\_ 18-59 Disabled \_\_\_ 18-59 Cong. Fac. Res. \_\_\_ 18-59 DRAH & AOP

**Income:** \_\_\_ Subsidized/Low-Income Housing \_\_\_ Medicaid \_\_\_ SSI \_\_\_ Food Stamps  
 \_\_\_ Low Income \_\_\_ Other: \_\_\_\_\_

<b>Nutritional Status</b>	7/1/11-6/30/12		7/1/12-6/30/13		Comment
	Yes	Yes	Yes	Yes	
I have an illness or condition that made me change the kind/amount of food I eat.	2	2			
I eat fewer than 2 meals per day.	3	3			
I eat few fruits, vegetables, or milk products.	2	2			
I have 3 or more drinks of beer, liquor, or wine almost everyday.	2	2			
I have tooth or mouth problems that make it hard for me to eat.	2	2			
I don't always have enough money to buy the food I need.	4	4			
I eat alone most of the time.	1	1			
I take 3 or more different prescribed or over-the-counter drugs a day.	1	1			
Without wanting to, I have gained or lost 10 pounds in the past 6 months	2	2			Change:
I am not always physically able to shop, cook or feed myself.	2	2			Which:
Total score for each Yes response					Risk level: ___ Low (0-2) ___ Moderate (3-5) ___ High (6 or more)

**Primary Emergency Contact**

Name: \_\_\_\_\_ Aware they are emergency contact? Y N

Home Number: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell Number: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Service Provider: \_\_\_\_\_ Service Area: \_\_\_\_\_ Services: Congregate Meals Transportation

Client Signature \_\_\_\_\_ Date \_\_\_\_\_