**MCN – Elderly Nutrition Program**

Date Rec’d & Scanned

 **(Title VI Grant 4/2020 to 3/2023)**

Congregate\_\_\_\_\_

Homebound\_\_\_\_\_

 **INTAKE FORM**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ENP Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nick Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male Female Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: American Indian Alaskan Native Native Hawaiian Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tribe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood Degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Roll No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Information**

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Information**

Marital Status – Circle one Married Single Divorced/Separated Widowed

If Non-Native list Spouse that is eligible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List 2 Emergency Contacts Name and Phone Number

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Language** - circle one

Tribal English Spanish Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of Housing** - circle one

House Apartment Community Housing Homeless

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Whom do you live with** - circle all that apply

Spouse/Partner Family Friends Alone Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number in Household: \_\_\_\_\_\_\_\_\_\_

Grandchildren in Household - circle one Yes No If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any food allergies?** - circle one

Yes No If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Information** - circle all that apply

Asthma Alzheimer’s Arthritis Cancer Chronic Pain Dementia

Diabetes Falls Heart Disease High Cholesterol High Blood Pressure

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Devices** Walker/Cane Wheelchair Hearing Aid Glasses

Dentures Artificial Limb None

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Transportation** - circle all that apply

Own a vehicle Relies on Family/Friends Uses Tribal Transportation

Walks Rides a bicycle Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Needs and/or Concerns** - please list any needs or concerns that you may have and if available we will give you contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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