COUNTY of VENTURA
Human Services Agency
Area Agency on Aging

Senior Nutrition Program CONGREGATE Meals (C1) – Client Intake Form FY2025-2026

THIS INFORMATION IS STRICTLY CONFIDENTIAL.

TO RECEIVE CONGREGATE MEALS: Person must be aged 60 or older, spouse of congregate meal participant, disabled person residing where the congregate site is located, or disabled person who resides with and accompanies a congregate meal participant. There is no charge for meals; however, voluntary contributions are accepted. A person will not be denied services if that individual chooses not to contribute.

Provider Location:		Date:	
Preferred Language:		Birthdate (*Required*):	
Last Name:		First Name (*No Nicknames*):	

Eligibility: ☐ Age 60+ ☐ Spouse of Congregate Meal Participant ☐ Disabled Person residing where the congregate site is located ☐ Disabled Person who resides with an accompanies a congregate meal participant ☐ Volunteer

ADDRESS & CONTACT INFORMATION

Address:		City:		Zip:	
Phone:		Email:			
Local Emergency Contact Name/Phone number:			# of Persons in Household:		
Lives Alone?	☐ Yes ☐ No ☐ Decline to State ☐ Missing		Lives in Rural Area? *(91307, 93066, 93040)*	☐ Yes ☐ No ☐ Decline to State ☐ Missing	

	APPLICANT SIGNATURE:
I understand that the information I am providing on this form is for registration purposes. I understand it will be kept confidential and that the Area Agency on Aging and service providers may use it to help identify other services for which I may benefit.	

These are used to ensure that services are distributed equitably and do NOT affect eligibility.

DEMOGRAPHIC INFORMATION ☐ DECLINE TO STATE ☐ MISSING

What is your marital status?	☐ Divorced ☐ Domestic Partnership ☐ Married ☐ Never Married ☐ Separated ☐ Widowed ☐ Decline to State ☐ Missing				
What is your approximate annual income?	IF single	☐ $15,650 or less	At or below Federal Poverty Level	☐ $15,651 or more	Above Federal Poverty Level
	IF married	☐ $21,150 or less		☐ $21,151 or more	

Do you think of yourself as:	What sex were you assigned at birth?	Do you think of yourself as:
☐ Nonbinary Genderqueer ☐ Female ☐ Male ☐ Trans male ☐ Trans female ☐ Other; please specify: ☐ Decline to answer ☐ Missing	☐ Female ☐ Male ☐ Intersex ☐ Other; please specify: ☐ Decline to answer ☐ Missing	☐ Straight/Heterosexual ☐ Bisexual ☐ Don't know ☐ Lesbian or gay ☐ Queer, pansexual, questioning ☐ Something else; please specify: ☐ Decline to answer ☐ Missing

How do you identify your ethnicity?	How do you identify your race(s)? ☐ Decline to State ☐Missing			
☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Answer ☐ Missing	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Cambodian	☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hawaiian	☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian	☐ Samoa ☐ Other Asian ☐ Other Pacific Islander ☐ Vietnamese ☐ White

Have you ever served in the United States military?	☐ YES ☐ NO	Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?	☐ YES ☐ NO

Do you consent to this agency and the California Department of Aging transmitting your name, email address, and telephone number to the Department of Veterans Affairs, only for the purpose of receiving additional information on veterans benefits for which you may be eligible? Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.	☐ I decline my consent. ☐ I consent. I understand that this is valid for 12 months.

Determine Your Nutritional Health	Check All That Apply to Applicant:	
I don't always have enough money to buy the food I need.	☐	4 pts
I eat fewer than 2 meals per day.	☐	3 pts
I have an illness or condition that made me change the kind and/or amount of food I eat.	☐	2 pts
I eat few fruits or vegetables or milk products.	☐	2 pts
I have 3 or more drinks of beer, liquor, or wine almost every day.	☐	2 pts
I have tooth or mouth problems that make it hard for me to eat.	☐	2 pts
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	☐	2 pts
I am not always physically able to shop, cook and/or feed myself.	☐	2 pts
I eat alone most of the time.	☐	1 pt
I take 3 or more different prescribed or over-the-counter drugs a day.	☐	1 pt

Decline to state. *unable to score*	☐	Check if total score is equal to or greater than 6 and the client is at **high nutritional risk**.	☐	Total Score:	

DO NOT WRITE IN THIS BOX – OFFICIAL USE ONLY	
Q Database/Unique Participant ID Number:	☐ Senior Spouse ☐ Non-Senior ☐ Disabled
Reviewed by: ☐ Staff ☐ Volunteer	*Type of Meals:* ☐ Hot ☐ Frozen

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CONSENT TO REMOVE MEALS

Ventura County Human Services Agency, Area Agency on Aging in partnership with cities in Ventura County provides hot, nutritious lunches at congregate meal sites to seniors age 60 and over. Meals are available in most cities Monday through Friday. In the event you would like to take a meal home, or any portion of a meal home, you are accepting all responsibility for the food. Please sign below to release any and all liability.

The undersigned_____ desires to remove a frozen and/or
(Participant's Name)
take home the remainder of his/her lunch. In doing so, he/she accepts full responsibility for this food. In consideration for agreeing to surrender this food, the participant or his/her authorized agent agrees to release VCAAA, Senior Nutrition Program, the volunteers, directors, officers, agents and employees from any consequences. The participant acknowledges that he/she has been advised that hot food items held below 140°F for longer than 2 hours must be discarded, and frozen meals should remain frozen at all times and be placed in the refrigerator or freezer immediately.

_____ _____
Participant's Signature Date

_____ _____
Family Member/Guardian/Caregiver Signature Date