State of Illinois
Illinois Department on Aging

Nutrition Services Registration Form for Grab and Go Meals

Older Adult Demographic Information *(ALL INFORMATION IS REQUIRED)*			
First Name:	Last Name:		Date of Birth:
Address:			Phone:
City:	Zip Code:		Cell:
Authorized Representative:			
Name:	Phone:		Relationship:
Emergency Contact:			
Name:	Phone:		Relationship:
Race: (Check all that apply) ☐ White ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaskan Native ☐ Asian or Asian American	Gender: ☐ Male ☐ Female ☐ Other	Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Domestic Partner ☐ Legally Separated	Do you live alone? ☐ Yes ☐ No Total Individual Income: **$**
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino		Have you served in the U.S. Armed Forces? ☐ Yes ☐ No	
Limited English-Speaking: ☐ Yes ☐ No	If yes, primary language spoken:		

Nutrition Risk Screen	**Yes/No**	**Points**
I have an illness or condition that changes the kind or amount of food I eat.	☐ Yes ☐ No	
I eat less than two meals a day.	☐ Yes ☐ No	
I eat few fruits and vegetables, or milk products.	☐ Yes ☐ No	
I have three or more drinks of beer, liquor or wine almost every day.	☐ Yes ☐ No	
I have tooth or mouth problems that make it hard for me to eat.	☐ Yes ☐ No	
I don't always have enough money to buy the food I need.	☐ Yes ☐ No	
I eat alone most of the time.	☐ Yes ☐ No	
I take three or more different prescribed or over-the-counter drugs a day.	☐ Yes ☐ No	
Without wanting to, I have lost or gained ten pounds in the last six months.	☐ Yes ☐ No	
I am not always physically able to shop, cook and/or feed myself.	☐ Yes ☐ No	
	Total Points	**0**

Additional Nutrition Information	
Do you currently receive food assistance benefits? (Examples: SNAP, SFMNP, TEFAP)	☐ Yes ☐ No
Do you currently receive meal assistance from another source? (i.e.: family, church, etc.)	☐ Yes ☐ No
Do you have difficulty chewing/poor dental health?	☐ Yes ☐ No
Do you have difficulty swallowing?	☐ Yes ☐ No
Do you have special diet needs? (If yes, please specify below)	☐ Yes ☐ No
☐ Diabetic ☐ Low Sodium ☐ Vegetarian ☐ Other:	

Additional Nutrition Information (Continued)	
Do you have any food allergies? ☐ Yes ☐ No	**NOTE: It is your responsibility to review the weekly menu and bring any allergy concerns to the attention of the nutrition provider. When feasible, the provider will supply a special meal to meet the dietary needs of the client.**
If yes, please list all food allergies:	

Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

Check "Yes" for each of the activities if you have trouble completing the task or frequently need help to complete the task.

ADL	Yes / No	IADL	Yes / No
Eating	☐ Yes ☐ No	Laundry	☐ Yes ☐ No
Bathing	☐ Yes ☐ No	Shopping	☐ Yes ☐ No
Grooming	☐ Yes ☐ No	Light Housework	☐ Yes ☐ No
Dressing	☐ Yes ☐ No	Heavy Housework	☐ Yes ☐ No
Toileting	☐ Yes ☐ No	Telephone	☐ Yes ☐ No
Walking/Mobility	☐ Yes ☐ No	Financial Management	☐ Yes ☐ No
Transferring (in/out of bed/chair)	☐ Yes ☐ No	Transportation	☐ Yes ☐ No
		Meal Preparation	☐ Yes ☐ No
		Medication	☐ Yes ☐ No

I certify that all the information provided is accurate.	
Participant Signature:	Date:

TO BE COMPLETED BY STAFF:

Reason for Grab and Go Meals: *(Check all that apply)*
☐ Homebound ☐ Permanently disabled ☐ Temporarily disabled
☐ Respite for caregiver ☐ Meal for spouse or disabled adult in home ☐ Other:

Older Adult will benefit from Grab and Go Meals because: *(Check all that apply)*
☐ Difficulty Cooking ☐ Recovering from surgery ☐ Increase nutritional intake ☐ Other:

Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

Total Number of ADL "Yes":	Total Number of IADL "Yes":

☐ If recipient reported "yes" to difficulty with ADL/IADL, referral was completed to area service providers.

Nutrition Risk Screening

Total Nutritional Risk Score: ☐ Low ☐ Medium ☐ High

☐ The Risk Score was explained to client and brochure provided

☐ If at high risk, a recommendation to follow up with health care provider completed

I certify this Older Adult meets eligibility criteria for Grab and Go Meals under the Older Americans Act.

Signature:	Phone:
Staff Name:	Email:
Organization:	Date:

Authorization of Release of Information
I give permission to the provider and/or the Area Agency on Aging Staff to discuss my needs.

Client Signature:	**Date:**