



ENOA Diner's Choice Intake Information

Gender (Circle one) Female Male

Date: _____

*Name: _____ *Date of Birth: _____

*Address _____

*Town _____ *Zip _____ *Phone Number _____

*Race:	*Ethnicity:	*Medicare: ___ Yes ___ No
_____ American Indian/Alaska Native	_____ Hispanic or Latino	*Medicaid: ___ Yes ___ No
_____ Asian	_____ Not Hispanic or Latino	
_____ Black/African American	_____ No response	
_____ Hispanic or Latino		
_____ Native Hawaiian/Pacific Island	*Monthly Income (Circle one)	
_____ White	Single person above \$ <u>1563.00</u> Yes No	
	Married couple above \$ <u>1755.00</u> Yes No	

*Participant status for meals:	*Lives with:
_____ 60+ Person	_____ Alone
_____ Less than 60 spouse of 60+ person	_____ In a group setting
_____ Less than 60 disabled person residing with 60+ Person	_____ With other family/friends
	_____ With spouse
*Marital Status: (Circle one) Single Married Divorced Widow/Widower	
*Emergency Contact: (Please include name & phone number) _____	

***ALL "BOLD AREAS" ARE MANDATORY AND MUST BE COMPLETED**

***Please circle Yes or No to the following questions:**

- Has an illness or medical condition made you change the way you eat? Yes No
- Do you eat fewer than 2 meals a day? Yes No
- Do you eat less than one serving of milk or fruits and vegetables a day? Yes No
- Do you drink 3 or more glasses of beer, liquor, or wine every day? Yes No
- Do you have problems with your teeth or mouth that make it hard to eat? Yes No
- Do you have enough money to buy the food you need? Yes No
- Do you eat alone most of the time? Yes No
- Do you take 3 or more different prescription or over the counter drugs daily? Yes No
- Have you gained or lost more than 10 pounds in the last 6 months without wanting to? Yes No
- Are you able to do your own grocery shopping and cooking? Yes No

Release of Information: I consent to the release of information in this document so I can receive services. I understand the information in this document will be released to the Eastern Nebraska Office on Aging, and service providers as listed to enable the delivery of services and program monitoring.

Customer/Guardian Signature _____ Date _____