Confidential Form **FY 21/22**

Café Costa Meal Participant

Place Label Here

☐ Rollover

☐ New

☐ Under 60

Required For All Participants

Participant ID # _____
Termination Date _____
Reason _____

(1) Name First:_____ MI:___Last:_____

(2) A.K.A. OR NICKNAME: First: _____ Last:_____

(3) City: _____ Zip Code: _____

(4) **Birth Date:** __ __-- __ __-__ __ __ __
(M M / D D / Y Y Y Y)

Qualifying Under 60: Y / N
Related to: _____
Relationship: _____

(5) **Sex At Birth**: ☐ Male ☐ Female ☐ Declined/Not stated

(6) **Gender**: ☐ Male ☐ Female
☐ Transgender Female to Male ☐ Transgender Male to Female
☐ Genderqueer/Gender Non-binary ☐ Not Listed ☐ Declined/Not stated

(7) **Sexual Orientation or Sexual Identity:** ☐ Straight/Heterosexual ☐ Bisexual
☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed ☐ Declined/Not stated

(8) **Race**: (Check One)

☐ Am. Indian / Alaska Native	☐ Filipino	☐ Laotian
☐ Asian Indian	☐ Guamanian	☐ Mexican American
☐ Black / African Amer.	☐ Hawaiian	☐ Samoan
☐ Cambodian	☐ Japanese	☐ Vietnamese
☐ Chinese	☐ Korean	☐ White
		☐ Declined to State

(9) **Ethnicity**: Hispanic/Latino ☐ Yes ☐ No ☐ Declined to State

(10) **Living Arrangement**: # of household members ___ ☐ Declined to State

(11) **Rural Area?**: ☐ Yes ☐ No ☐ Declined to State

(12) **Is your monthly income less than $1,073/mo if single or less than $1,452/mo if married?**
☐ Yes ☐ No ☐ Declined to State

(13) **Is your monthly income level less than $2,587/mo?**
☐ Yes ☐ No ☐ Declined to State

(14) **Marital Status**: ☐ Married ☐ Widowed ☐ Single (Never Married) ☐ Separated
☐ Divorced ☐ Domestic Partner ☐ Declined to State

(15) **Veteran Status**: ☐ Veteran ☐ Veteran Dependent ☐ No ☐ Declined to State

(16) Café Location: SAN PABLO ___ Start Date: __ __-__ __-__ __ __ __
(M M / D D / Y Y Y Y)

Please Complete Reverse Side (Over)

Nutritional Assessment:

	Mark one: Y (yes) N (no)
I have an illness or condition that made me change the kind and/or amount of food I eat. (2)	Y ☐ N ☐
I eat fewer than 2 meals per day. (3)	Y ☐ N ☐
I eat few fruits or vegetables or milk products. (2)	Y ☐ N ☐
I have 3 or more drinks of beer, liquor or wine almost every day. (2)	Y ☐ N ☐
I have tooth or mouth problems that make it hard for me to eat. (2)	Y ☐ N ☐
I don't always have enough money to buy the food I need. (4)	Y ☐ N ☐
I eat alone most of the time. (1)	Y ☐ N ☐
I take 3 or more different prescribed or over-the-counter drugs a day. (1)	Y ☐ N ☐
Without wanting to, I have lost or gained 10 pounds in the past 6 months. (2)	Y ☐ N ☐
I am not always physically able to shop, cook, and/or feed myself. (2)	Y ☐ N ☐
	☐ D Declined To State

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.

_____ _____

Signature of participant or person completing the form Date