Office Use	Rec'd:	Assessed:	Start:	Site:
	Milk: Yes No		SUDS:	

Congregate Application 2024

Welcome! Please tell us a bit about yourself so we can offer services that best meet your needs. We ask for demographic information to meet requirements from our funders. All your personal information is confidential.

Contact & Demographic Information:

First Name: _____ **Middle Initial:** _____ **Date of Birth:** _____

Last Name: _____ **Nickname:** _____ **Age:** _____

Home Address: _____ Unit# _____

City: _____ County: _____ ST: _____ Zip: _____

Mailing Address: _____ Unit#: _____

City: _____ County: _____ ST: _____ Zip: _____

Home Phone: _____ **Cell Phone**: _____

Gender: ☐ Male ☐ Female ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race, select all that apply:

☐ American Indian / Alaska Native
☐ Asian or Asian American
☐ Black or African American
☐ Middle Eastern or North African
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Race, if not listed: _____

Are you a veteran: ☐ Yes ☐ No

Do you live: ☐ Alone ☐ With Others

Number of people in your household (including you): _____

Is your income above or below the following federal poverty guidelines?

☐ Above ☐ At or Below

Household Size	Monthly Income	Annual Income
1	$1,304.00	$15,650.00
2	$1,763.00	$21,150.00
For each additional person add $5,500 annual income		

Communication & Service Needs:

Health Insurance (select all that apply):

☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Medicaid Waiver
☐Private ☐None ☐ Other, if not listed: _____

Are you Hearing Impaired? ☐ Yes ☐ No **Are you Sight Impaired?** ☐ Yes ☐ No

Primary Emergency Contact:

Name: _____

Phone: _____ **Relationship:** _____

NUTRITION SCREENING: Nutrition Risk Score Questions	Yes	No	Yes Score
Do you have an illness or condition that has made you change the kind and/or amount of food you eat?	☐	☐	2
Do you eat fewer than 2 meals per day?	☐	☐	3
Do you eat few fruits, vegetables, or milk products?	☐	☐	2
Do you have 3 or more drinks of beer, liquor, or wine almost every day?	☐	☐	2
Do you have tooth or mouth problems that make it hard for you to eat?	☐	☐	2
Are there times you do not have enough money to buy the food you need?	☐	☐	4
Do you eat alone most of the time?	☐	☐	1
Do you take 3 or more different prescribed or over the counter drugs a day?	☐	☐	1
Without wanting to, have you lost or gained 10 pounds in the last 6 months?	☐	☐	2
Are there times you're physically unable to shop, cook, and/or feed yourself?	☐	☐	2
Total Nutrition Risk Score	*Total "Yes" Score:*		

Total Nutrition Risk Score: 0-2 = No Risk, 3-5 = Moderate Risk, 6 or more = High Risk

Are you interested in receiving nutrition counseling? ☐ Yes ☐ No

	Often	Sometimes	Never
Within the past 12 months you worried that your food would run out before you got money to buy more.	☐	☐	☐
Within the past 12 months the food you had just didn't last and you didn't have money to get more.	☐	☐	☐

Signature: _____ **Date:** _____

(If filled out by assessor or via phone, please have assessor check here and sign below ☐

Filled Out By: _____ **Date:** _____

Are you interested in learning about nutrition and a healthy diet?

If yes, you're invited to enroll in Text2LiveHealthy, a nutrition education program delivered to you via text message. Scan this QR code with your phone's camera to enroll or text the word FRUIT to 97699.

Message & Data Rates May Apply. Text HELP for information. Text STOP to97699 to opt out. No purchase necessary. For Privacy Policy and Terms and Conditions, visit: https://coloradosph.cuanschutz.edu/text2livehealthy

Disclosures and Waivers

I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service providers and I give my consent to do so.