Name:____

Please complete ALL questions. Staff is available to help.

Does the individual have a Medicaid Number?
☐ No
☐ Yes
☐ Pending

Does the individual have Medicare?
☐ No
☐ Yes

Does the individual have any other insurance?
☐ No
☐ Yes
☐ Don't Know

Is the individual homeless?
☐ No
☐ Yes

Type of PERMANENT residence in which the individual resides
☐ Assisted Living
☐ Apartment
☐ Domiciliary Care
☐ Group Home
☐ Nursing Home
☐ Own Home
☐ Personal Care Home
☐ Relative's Home
☐ Specialized Rehab/Rehab Facility
☐ State Institution
☐ Other – Please provide details in notes

Is the individual the spouse/widow or dependent child of a Veteran?
☐ No
☐ Yes
☐ Unable to Determine

Is the individual receiving Veteran's benefits?
☐ No
☐ Yes
☐ Unable to Determine

Does the individual require communication assistance?
☐ No
☐ Yes – Please provide assistance type in notes
☐ Unable to Determine

Does the individual use sign language as their PRIMARY language?
☐ No
☐ Yes – Please provide type of sign language in notes

What is the individual's PRIMARY language?

Is the individual's postal/mailing address exactly the same as the residential address?
☐ No
☐ Yes

What was the outcome when the individual was offered a voter registration form?
☐ PASC will submit completed voter registration
☐ Does not meet voter requirements
☐ Individual declined application
☐ Individual declined-already registered
☐ Individual will submit completed voter registration
☐ No Response

Notes

Does the individual generally have a good appetite?

☐ No – Please provide details in notes
☐ Yes

Does the individual use a dietary supplement?

☐ No
☐ Yes – Please provide details in notes

Does the individual have any food allergies?

☐ No
☐ Yes – Please provide details in notes

Does the individual have a special diet for medical reasons?

☐ No
☐ Yes – Please provide details in notes

Does the individual have a special diet for religious/cultural reasons?

☐ No
☐ Yes – Please provide details in notes

Has there been a change in lifelong eating habits because of health problems?

☐ No
☐ Yes – Please provide details in notes

Does the individual eat fewer than 2 meals per day?

☐ No
☐ Yes – Please provide details in notes

Does the individual eat fewer than 2 servings of dairy products (such as milk, yogurt, or cheese) every day?

☐ No
☐ Yes – Please provide details in notes

Does the individual eat fewer than 5 servings (1/2 cup each) of fruits or vegetables every day?

☐ No
☐ Yes – Please provide details in notes

Does the individual have 3 or more drinks of beer, liquor or wine almost every day?

☐ No
☐ Yes – Please provide details in notes

Does the individual have trouble eating due to problems with chewing/swallowing?

☐ No
☐ Yes – Please provide details in notes

Individual does not have enough money to buy food needed?

☐ No
☐ Yes – Please provide details in notes

Does the individual eat alone most of the time?

☐ No
☐ Yes – Please provide details in notes

Does the individual take 3 or more prescribed or over-the-counter drugs (OTC) per day?

☐ No
☐ Yes – Please provide details in notes

Has the individual lost or gained at least 10 pounds or more in the LAST 6 MONTHS?

☐ No
☐ Yes, gained 10 pounds or more
☐ Yes, lost 10 pounds or more
☐ Don't know

Is the individual not always physically able to shop, cook and/or feed themselves (or to get someone to do it for them)?

☐ No
☐ Yes – Please provide details in notes