

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

Please complete both sides.

**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

**Would the individual like to register to vote?**

- Individual is already registered
- Individual does not meet voter requirements
- Individual declined application
- PASC will submit completed voter registration
- 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