MILWAUKEE COUNTY
Department on Aging

MILWAUKEE COUNTY SENIOR DINING REGISTRATION

☐ NEW ☐ ANNUAL REVIEW **SITE:** ______________ **DATE:** __________

FIRST NAME:	**MI:**	**LAST NAME:**		**SUFFIX:** JR SR I II III
ADDRESS:		**CITY:**	**STATE:**	**ZIP:**
BIRTHDATE:	**PHONE:**	**EMAIL:**		

MARITAL STATUS:
- ☐ Single
- ☐ Married
- ☐ Partnered
- ☐ Legally Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Other_____________

GENDER:
- ☐ Female
- ☐ Male
- ☐ Other

RACE:
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White *(Non-Hispanic, Non-Minority)*
- ☐ White-Hispanic
- ☐ Other _______________

ETHNICITY:
- ☐ HISPANIC / LATINO
- ☐ NOT HISPANIC / LATINO

DO YOU LIVE ALONE?
☐ NO ☐ YES

MILITARY/VETERAN?
☐ NO ☐ YES

2019-2020 INCOME LEVEL: *(Your response will not impact your eligibility)*

For **one**-person household: is your income below **$1,040**/month (**$12,490** annually)? ☐ NO ☐ YES

For **two**-person household: is your income below **$1,409**/month (**$16,910** annually)? ☐ NO ☐ YES

NUTRITION SCREEN		YES
1	An illness or condition changes the kind and/or amount of food I eat.	2
2	I eat fewer than 2 meals a day.	3
3	I eat few fruits, vegetables or dairy products.	2
4	I have 3 or more drinks of beer, wine or liquor almost every day.	2
5	Tooth or Mouth problems make it hard to eat.	2
6	I don't always have enough money to buy the food I need.	4
7	I eat alone most of the time	1
8	I take 3 or more prescribed or over-the-counter drugs.	1
9	Without wanting to, I lost or gained 10 pounds in the last 6 months.	2
10	I'm not always able to shop, cook or feed myself.	2

UNDER 60? Which Makes you Eligible?
- ☐ Active Volunteer
- ☐ Spouse of Active Diner
- ☐ Disabled, Live in Dining Site
- ☐ Disabled, Live with Active Diner

HOW DID YOU HEAR ABOUT US?
- ☐ Friend/Family
- ☐ Health Provider
- ☐ Church
- ☐ Internet Search
- ☐ Menu in Paper
- ☐ Facebook
- ☐ Other_____________

NUTRITION RISK LEVEL:

0-2 LOW
3-5 MODERATE
6+ HIGH

TOTAL: _____

DATE MCDA RECEIVED: ________

SAMS ENTRY DATE: ________

MCDA STAFF: ________

EMERGENCY CONTACT: ____________________ **PHONE:** ______________ **RELATIONSHIP:** __________________

Privacy Statement: "The information you are being asked to provide is needed to determine if you are eligible to receive Older Americans Act Services and to comply with federal reporting requirements. This information will be stored in a secure electronic database and will not be used for any other purpose. Your information will not be shared with another agency without your permission. This information will not be sold to anyone. You have the right to review your electronic record and request changes to assure accuracy. You will not be denied most services if you refuse to provide this information. If you have questions regarding this, please ask the aging unit staff."