BCAAA Client Assessment Form – Nutrition Services

Entry Point		**Date**	
Resource Specialist		**Data Entry workflow**	
ADRC follow-up ☐	**DO NOT MAIL** ☐	**Event Profile**	

Client Information

First and Last Name			
Date of Birth		**Primary Language**	
Mailing Address		**Phone**	
City, Zip Code		**Email**	
Gender	☐Female ☐Male ☐Non-binary/third gender ☐Prefer not to say ☐Prefer to self-describe as:		
Healthcare Coverage	☐Medicaid ☐Medicare ☐Other insurance ☐None	**Are you working?**	☐No ☐Full-time ☐Part-time ☐Retired ☐Volunteering
Living Situation:	☐ Alone ☐ With others	**Number of people in household:**	
Grandparent, raising grandchild?	☐ Yes ☐ No	**Veteran, Spouse, and/or Survivor?**	

Identify as: Select all that apply	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Prefer to self-describe as:	**Income** Is your income less than the federal poverty level as indicated in the table below?	☐ Yes ☐ No Actual (if needed):

Household size	Monthly Income	Annual income
1	$1,073	$12,880
2	$1,452	$17,420
3+	Add $4,540 per person to annual income threshold	

Emergency Contact	Name:	Phone:	Relation:

Are you interested in hearing about other services?	☐ Yes ☐ No	**If yes, how may we contact you?**	☐Phone ☐Email ☐Mail
What services are you interested in?			
Are you interested in receiving nutrition counseling?	☐ Yes ☐ No		

Nutrition Checklist

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

0-2 = No Risk 3-5 = Moderate Risk 6 or more = High Risk

Total Score from "Yes" answers: _____

Disclosures and Waivers

If consent is NOT provided, DO NOT check the box

☐ **Contributions, complaints, and appeals rights -** I have been informed of the Boulder County Area Agency on Aging's policies regarding voluntary contributions, complaint procedures, and appeals rights (found on the Consumer Information Assessment FAQ).

☐ **Information Sharing -** I am aware that in order to receive requested services, it may be necessary to share information with other BCAAA programs or contracted service providers and I herewith give my consent to do so.

Client Signature:_____ **Date:**_____

☐CLIENT AGREED VIA PHONE	**Staff Name**	
	Staff Signature – *type full name*	
	Organization	
	Date	