

Information is used for grant reporting and statistical purposes only and all information is confidential.

Last Name (Please Print)	First Name	Nickname	Date of Birth
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Street Address	City	Zip	Township
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Home Phone: _____ **Cell Phone:** _____

Email: _____

Please Circle: **Male** **Female** **Other: Please specify** _____

Marital Status: **Married** **Divorced** **Single** **Widowed**
 Legally Separated **Domestic Partner**

Are you a Veteran? (Please circle) **Yes** **No**

Assistive Device (circle if used): **Cane** **Standard Walker** **Walker with Seat** **Wheelchair**
 Motorized Scooter **Service Animal** **Oxygen** **Other:** _____

Emergency Contact: _____	Relationship: _____
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Home Phone: _____	Cell Phone: _____	Work Phone: _____
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Ethnicity: Check One

Hispanic ☐ **Non-Hispanic** ☐

Race: Check All that Apply

White ☐

Black or African American ☐

American Indian or Alaska Native ☐

Asian ☐

Native Hawaiian or Other Pacific Islander ☐

Other ☐

Please Circle Yes or No

- | | | |
|--|------------|-----------|
| 1. I live alone. | Yes | No |
| 2. I live alone and my monthly income is more than \$1,255. | Yes | No |
| 3. I do NOT live alone and my monthly income is more than \$1,703. | Yes | No |
| 4. Are you limited in understanding and speaking English? | Yes | No |

If "Yes" what is your primary language:

PLEASE COMPLETE BOTH SIDES AND SIGN





Data Page (continued)

Oct. 2024-Sept. 2025

PLEASE COMPLETE BOTH SIDES

Please Circle:

I have an illness or condition that has made me change the kind or amount of food I eat.	Yes	No
I eat less than 2 meals per day.	Yes	No
I eat few fruits and vegetables, or milk products.	Yes	No
I have three or more drinks of beer, liquor or wine almost every day.	Yes	No
I have tooth or mouth problems that make it hard for me to eat.	Yes	No
I don't always have enough money to buy the food I need.	Yes	No
I eat alone most of the time.	Yes	No
I take three or more different prescribed or over-the-counter drugs a day.	Yes	No
Without wanting to, I have lost or gained ten pounds in the last six months.	Yes	No
I am not always physically able to shop, cook, and/or feed myself.	Yes	No
Do you currently receive food assistance benefits? (Examples: SNAP, SFMNO, TEFAP)	Yes	No
Do you currently receive meal assistance from another source (i.e. food pantry, family)?	Yes	No
Do you have difficulty chewing/poor dental health?	Yes	No
Do you have difficulty swallowing?	Yes	No
Do you have special diet needs? (If yes, please specify below)	Yes	No
Diabetic Low Sodium Vegetarian Other: _____		

Circle "Yes" for each of the activities if you have trouble completing the task or frequently need help to complete the task.

Eating	Yes	No	Laundry	Yes	No
Bathing	Yes	No	Shopping	Yes	No
Grooming	Yes	No	Light Housework	Yes	No
Dressing	Yes	No	Heavy Housework	Yes	No
Toileting	Yes	No	Telephone	Yes	No
Walking/Mobility	Yes	No	Financial Management	Yes	No
Transferring (in/out of bed/chair)	Yes	No	Transportation	Yes	No
			Meal Preparation	Yes	No
			Medication	Yes	No

I certify that all information provided is accurate.

Authorization of Release of Information: *I give permission to the provider and/or the Area Agency on Aging Staff to discuss my needs.*

Signature

Date



AgeOptions does not discriminate in admission of programs or treatment of employment in programs or activities in compliance with the Illinois Human Rights Act ; the U.S. Civil Rights Act; Section 504 of the rehabilitation Act; the Age Discrimination act; the Age Discrimination in Employment Act; and the U.S. and Illinois Constitution. If you feel that you have been discriminated against, you have the right to file a complaint with the Illinois Department on Aging. For information; call 1-800-252-8966 (Voice and TDD)or contact the AgeOptions Civil Rights Coordinator at (708) 383-0258.