



COMMUNITY MEAL SITE REGISTRATION FORM

WELCOME! The personal information you give us on this form is kept strictly confidential.

Please complete and return to assure the continued funding of the program.

Today's Date: ☐ New ☐ Update/Reassessment ☐ Center 50+ ☐ South Salem

Your Name: _____
(Last) (First) (M) Client ID#

Street Address: _____
- -
Date of Birth

City, State, Zip: _____

US Veteran: ☐ Yes ☐ No

Phone#: _____

Gender: ☐ Female ☐ Male ☐ Other

Number in Household _____

Marital Status: ☐ Married ☐ Single

Total Monthly Income \$ _____

Primary Language: _____

REV:11/2023

MPFS staff initial: _____

2615 Portland Rd. NE, Salem, OR 97301

503-364-2856 / foodsharemealsonwheels.org

National Aging Program Information Systems (NAPIS) Registration Form



Welcome! We're glad you're here. Would you help us by telling us a bit about you? Our services are funded in part by the Older Americans Act, a federal program since 1965. Annually we report demographics of participants. All information is confidential - we do not report personal information - only age, gender, race, zip code, poverty, etc.

Section I – Tell us about you

Last: _____ First: _____ Middle initial: _____

Phone: _____ Date of birth: _____

Street address: _____

City: _____ ZIP: _____

Mailing address: _____

City: _____ ZIP: _____

Monthly household income

HH=1: ☐ \$1,012 or below ☐ \$1,013 or above

HH=2: ☐ \$1,372 or below ☐ \$1,373 or above

HH=3: ☐ \$1,732 or below ☐ \$1,733 or above

HH=4: ☐ \$2,092 or below ☐ \$2,093 or above

Section 2 – In case of an emergency - please contact (Optional information)

Contact name 1: _____ Phone: _____

☐ Child ☐ Spouse ☐ Partner / Significant Other ☐ Other family

☐ Neighbor ☐ Not related ☐ Friend ☐ Grandchild

Contact name 2: _____ Phone: _____

☐ Child ☐ Spouse ☐ Partner / Significant Other ☐ Other family

☐ Neighbor ☐ Not related ☐ Friend ☐ Grandchild

Complete Sections 3 - 6 if you participate in a nutrition or in-home service

Section 3 – Nutritional data (Please check all that apply)

- ☐ I have an illness/condition and had to change the kind and/or amount of food I eat.
- ☐ I eat fewer than 2 meals per day.
- ☐ I eat few fruits, vegetables or milk products.
- ☐ I have 3 or more drinks of beer, liquor, or wine almost every day.
- ☐ I have tooth or mouth problems that make it hard for me to eat.
- ☐ I don't always have enough money to buy the food I need.
- ☐ I eat alone most of the time.
- ☐ I take 3 or more prescribed or over-the-counter medications a day.

Section 4 – Activities of Daily Living and Instrumental Activities of Daily Living

- ☐ Without wanting to, I have lost or gained 10 pounds in the last six months.
- ☐ I am not always physically able to shop, cook and/or feed myself.

Please mark **I** - Independent **A** - Assistance needed **D** - Dependent on helper

___ Bathing*	___ Behavior*	___ Dressing*
___ Eating*	___ Elimination/Toileting*	___ Mobility/Walking*
___ Personal Hygiene/Grooming*	___ Transferring*	___ Food Preparation
___ Heavy Housework	___ Housekeeping	___ Managing Finances
___ Medication Management	___ Shopping	___ Taking Medication
___ Using Telephones	___ Using Transportation	

Note – () indicates an Activity of Daily Living (ADL) in section 4.*

DISCLOSURE STATEMENT:

"I'll be asking about your/their race, ethnicity, abilities, language needs and other characteristics. We ask everyone the same questions. This is to make sure everyone receives the highest quality of services. You can answer these questions any way you want. You can always choose not to answer a question. Your answers are confidential. They will not negatively impact your/their services or ability to receive benefits in any way."

Section 5 – REALD

- How do you identify your **race, ethnicity, tribal affiliation, country of origin, or ancestry**?
- Which of the following describes your **racial or ethnic identity**? Please check **ALL** that apply.

Hispanic or Latino/a/x		American Indian or Alaskan Native		Asian	
<input type="checkbox"/>	Central American	<input type="checkbox"/>	American Indian	<input type="checkbox"/>	Asian Indian
<input type="checkbox"/>	Mexican	<input type="checkbox"/>	Alaska Native	<input type="checkbox"/>	Cambodian
<input type="checkbox"/>	South American	<input type="checkbox"/>	Canadian Inuit, Metis, Or First Nation	<input type="checkbox"/>	Chinese
<input type="checkbox"/>	Other Hispanic or Latino/a/x	<input type="checkbox"/>	Indigenous Mexican, Central American, Or South American	<input type="checkbox"/>	Communities of Myanmar
				<input type="checkbox"/>	Filipino/a
Native Hawaiian and Pacific Islander		Black and African American		<input type="checkbox"/>	Hmong
<input type="checkbox"/>	CHamoru, (Chamorro)	<input type="checkbox"/>	African American	<input type="checkbox"/>	Japanese
<input type="checkbox"/>	Marshallese	<input type="checkbox"/>	Afro-Caribbean	<input type="checkbox"/>	Korean
<input type="checkbox"/>	Communities of Micronesia region	<input type="checkbox"/>	Ethiopian	<input type="checkbox"/>	Laotian
<input type="checkbox"/>	Native Hawaiian	<input type="checkbox"/>	Somali	<input type="checkbox"/>	South Asian
<input type="checkbox"/>	Samoan	<input type="checkbox"/>	Other African (Black)	<input type="checkbox"/>	Vietnamese
<input type="checkbox"/>	Other Pacific Islander	<input type="checkbox"/>	Other Black	<input type="checkbox"/>	Other Asian
White		Middle Eastern / North African		Other Categories	
<input type="checkbox"/>	Eastern European	<input type="checkbox"/>	Middle Eastern	<input type="checkbox"/>	Other Please list:
<input type="checkbox"/>	Slavic	<input type="checkbox"/>	North African		
<input type="checkbox"/>	Western European			<input type="checkbox"/>	Don't know
<input type="checkbox"/>	Other White			<input type="checkbox"/>	Don't want to answer

3. If you checked more than one category above, is there <u>one</u> you think of as your primary racial or ethnic identity?			
<input type="checkbox"/>	Yes. Please circle your primary racial or ethnic identity above.	<input type="checkbox"/>	N/A I only checked one category above.
<input type="checkbox"/>	I do not have just one primary racial or ethnic identity.	<input type="checkbox"/>	Don't know.
<input type="checkbox"/>	No, I identify as Biracial or Multiracial.	<input type="checkbox"/>	Don't want to answer.

4. Language

a. What language or languages do you **use at home**?

Skip to question 7 if you indicated English only

b. In what language do you want us to communicate in person, on the phone, or virtually with you?

c. In what language do you want us to write to you?

5. Interpreter

a. Do you need or want an interpreter for us to communicate with you?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Don't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Don't want to answer

b. If you need or want an interpreter, what type of interpreter is preferred?

<input type="checkbox"/>	Spoken language interpreter	<input type="checkbox"/>	Deaf Interpreter for Deafblind, additional barriers, or both
<input type="checkbox"/>	American Sign Language interpreter	<input type="checkbox"/>	Contact sign language (PSE) interpreter
<input type="checkbox"/>	Other (<i>please list</i>):		

Skip to question 7 if you do not use a language other than English or sign language

6. How well do you speak English?

<input type="checkbox"/>	Very well	<input type="checkbox"/>	Not at all
<input type="checkbox"/>	Well	<input type="checkbox"/>	Don't know
<input type="checkbox"/>	Not well	<input type="checkbox"/>	Don't want to answer

Your answers will help us identify health and service differences among people with and without functional difficulties. Your answers are confidential. (<i>*Please write in "don't know" if you don't know when a health change was identified, or "don't want to answer" if you don't want to answer the question.</i>)	Yes	*If Yes, at what age did this condition begin?	No	Don't know	Don't want to answer	Don't know what this question is asking.
7. Are you deaf or do you have serious difficulty hearing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you blind or do you have serious difficulty seeing, even when wearing glasses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have serious difficulty walking or climbing stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have difficulty dressing or bathing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have serious difficulty learning how to do things most people your age can learn?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Using your usual (<i>customary</i>) language, do you have serious difficulty communicating (<i>for example understanding or being understood by others</i>)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 6 – Sexual Orientation and Gender Identity (SOGI) (Check all that apply)

1. Please describe your gender in any way you prefer:

2. What is your gender (check all that apply)

<input type="checkbox"/>	Woman or Girl	<input type="checkbox"/>	Not listed / Please Specify:
<input type="checkbox"/>	Man or Boy	<input type="checkbox"/>	Don't know
<input type="checkbox"/>	Agender / No Gender	<input type="checkbox"/>	I don't know what this question is asking
<input type="checkbox"/>	Non-Binary	<input type="checkbox"/>	I don't want to answer
<input type="checkbox"/>	Questioning		

3. Are you transgender?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Don't know
<input type="checkbox"/>	No	<input type="checkbox"/>	I don't know what this question is asking
<input type="checkbox"/>	Not Listed / Please Specify:	<input type="checkbox"/>	I don't want to answer

4. Please describe your sexual orientation or sexual identity in any way you want

5. How do you describe your sexual orientation or gender identity? (Check all that apply)

<input type="checkbox"/>	Same-gender loving	<input type="checkbox"/>	Asexual
<input type="checkbox"/>	Same-sex loving	<input type="checkbox"/>	Queer
<input type="checkbox"/>	Lesbian	<input type="checkbox"/>	Questioning
<input type="checkbox"/>	Gay	<input type="checkbox"/>	Not Listed / Please Specify:
<input type="checkbox"/>	Bisexual	<input type="checkbox"/>	Don't know
<input type="checkbox"/>	Straight (<i>attracted mainly to, or only to other gender[s]</i>)	<input type="checkbox"/>	I don't know what this question is asking
<input type="checkbox"/>	Pansexual	<input type="checkbox"/>	I don't want to answer