Date Rec'd & Scanned

MCN – Elderly Nutrition Program

(Title VI Grant 4/2023 to 3/2026)

Congregate_____

Homebound_____

INTAKE FORM

Today's Date: _____ ENP Site: _____

First Name: _____ Nick Name: _____

Middle Name: _____ Last Name: _____

Date of Birth: _____ Sex: Male Female Other: _____

Race: American Indian Alaskan Native Native Hawaiian Other: _____

Tribe: _____ Blood Degree: _____ Roll No: _____

Contact Information

Street Address: _____

City: _____ State: _____

Zip Code: _____ Phone Number: _____

Email Address: _____

Emergency Contact Information

Marital Status – Circle one Married Single Divorced/Separated Widowed

If Non-Native list Spouse that is eligible: _____

List 2 Emergency Contacts Name and Phone Number

Name: _____ Phone No: _____

Name: _____ Phone No: _____

Primary Language - circle one

Tribal English Spanish Other: _____

Type of Housing - circle one

House Apartment Community Housing Homeless

Other: _____

Whom do you live with - circle all that apply

Spouse/Partner Family Friends Alone Other: _____

Number in Household: _____

Grandchildren in Household - circle one Yes No If yes, how many? _____

Do you have any food allergies? - circle one

Yes No If yes, please list: _____

Health Information - circle all that apply

Asthma Alzheimer's Arthritis Cancer Chronic Pain Dementia

Diabetes Falls Heart Disease High Cholesterol High Blood Pressure

Other: _____

Health Devices Walker/Cane Wheelchair Hearing Aid Glasses

Dentures Artificial Limb None

Medications: _____

_____

Transportation - circle all that apply

Own a vehicle Relies on Family/Friends Uses Tribal Transportation

Walks Rides a bicycle Other: _____

Needs and/or Concerns - please list any needs or concerns that you may have and if available we will give you contact information:

_____

_____

_____

_____