

**Nat-E – REQUIRED BY THE COUNTY FOR ALL MEAL PROGRAMS**

**PLEASE ANSWER ALL QUESTIONS**

Date Form Filled Out: \_\_\_/\_\_\_/\_\_\_

Full Name (First, MI, Last) \_\_\_\_\_ SSN (Last 4 #) \_\_\_\_\_

Individual's Nickname/Alias: \_\_\_\_\_

Individual's Date of Birth: \_\_\_/\_\_\_/\_\_\_ Gender Assigned at Birth: Male Female

Gender Identity: Male Female Non-Binary Transgender Male (F to M) Transgender Female (M to F)

Other \_\_\_\_\_

Ethnicity: Hispanic/Latino Not Hispanic/Latino Unknown Race: \_\_\_\_\_

What is Your Primary Language? English Russian Spanish Other \_\_\_\_\_

Sign Language (What Kind? \_\_\_\_\_)

Marital Status: Single Married Divorced Separated Widowed Other \_\_\_\_\_

Do you have a Medicaid Number? Yes No Pending Do you have Medicare? Yes No

Are you a veteran? Yes No Spouse of a Veteran? Yes No Receiving Veteran's Benefits? Yes No Don't Know

Are You a Registered Voter? Registered Not Eligible Needs Form Other \_\_\_\_\_

Homeless? Yes No ( If yes – do you have a place to sleep tonight / stay long-term? Yes No )

Type of Permanent Address: Asst. Living Apt. Domiciliary Care Group Home Nursing Home

Own Home Personal Care Home Relative's Home Rehab State Institution Other \_\_\_\_\_

Permanent Living Arrangement: Alone w/ Spouse only w/ children but not Spouse

w/ other Family Members Other \_\_\_\_\_

Is your home address the same as your mailing address? Yes No

Permanent Home Address (Street, Apt, City/Town, State, Zip)

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Residential Municipality: \_\_\_\_\_ Is the residence in a rural area? Yes No

Residential County: Philadelphia Montgomery Delaware Other \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Emergency Contact Name: \_\_\_\_\_

Emergency Relation: \_\_\_\_\_ Emergency Phone Number \_\_\_\_\_

**(Flip over for Nutrition Assessment)**

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**Dietary Issues**

**1. Do you generally have a good appetite?**

Yes No Note: \_\_\_\_\_

**2. Do you use a dietary supplement?**

Yes No Note: \_\_\_\_\_

**3. Do you have any food allergies?**

Yes No Note: \_\_\_\_\_

**4. Do you have a special diet for medical reasons?**

Yes No Note: \_\_\_\_\_

**5. Do you have a special diet for religious reasons?**

Yes No Note: \_\_\_\_\_

**6. Has there been a change in lifelong eating habits due to health issues?**

Yes No Note: \_\_\_\_\_

**7. Do you eat fewer than 2 meals per day?**

Yes No Note: \_\_\_\_\_

**8. Do you eat fewer than 2 servings a day of dairy products?**

Yes No Note: \_\_\_\_\_

**9. Do you eat fewer than 5 servings of fruits/veg every day?**

Yes No Note: \_\_\_\_\_

**10. Do you have 3 or more drinks of beer, liquor, wine almost daily?**

Yes No Note: \_\_\_\_\_

**11. Do you have trouble chewing / swallowing?**

Yes No Note: \_\_\_\_\_

**12. Do you have enough money to buy the food needed?**

Yes No Note: \_\_\_\_\_

**13. Do you eat alone most of the time?**

Yes No Note: \_\_\_\_\_

**14. Do you take 3 or more prescribed or OTC drugs per day?**

Yes No Note: \_\_\_\_\_

**15. Have you gained or lost 10 pounds or more in the last 6 months?**

Gained Lost Neither Note: \_\_\_\_\_

**16. Do you sometimes need help to physically shop, cook and/or feed yourself?**

Yes No Note: \_\_\_\_\_

**(Flip over for General Info)**