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)

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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PLEASE ANSWER ALL QUESTIONS

Date Form Filled Out: ____/____/____

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)