



# SPECTRUM LUNCH REGISTRATION FORM 2020-2021

Meal Site \_\_\_\_\_ Date of Registration \_\_\_\_\_

## Please Print Participant Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Birth Date (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

Eligibility for this program requires that you are 60 years or older\*

\*Guests younger than 60 must pay the \$10.00 non-senior meal rate

Exceptions:  Resident at Senior 55+ Housing Meal Site  Spouse  Meal Site Volunteer

Address \_\_\_\_\_ Apt # \_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Mobile/Cell Phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_

Mobile Carrier  Verizon  T-Mobile  Sprint  AT&T  Other: \_\_\_\_\_

Email \_\_\_\_\_

Spectrum would like to communicate with you regarding our programs and events

opt out of receiving emails  opt out of receiving text messages

## Emergency Contact

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_

**Thank you for taking the time to complete the required information below. Please answer the questions on all 3 pages. This data is requested by our funding sources (who provide 58% of the meal cost). All answers are kept strictly confidential.**

Are you the Head of Household?  Yes  No

Do You Live Alone?  Yes  No, number in household: \_\_\_\_\_

Are you a U.S. Veteran?  Yes  No

**CONTINUED ON PAGE 2**

**Preferred spoken language:**

- English       Mandarin       Cantonese       Vietnamese       Japanese  
 Spanish       Dari/Farsi       Tagalog       Other \_\_\_\_\_

**Preferred written language:**

- English       Simplified Chinese       Traditional Chinese       Spanish

**What is your gender? (Check only one)**

- Male       Transgender female to male       Genderqueer/Gender Non-binary  
 Female       Transgender male to female       Not listed/Please specify: \_\_\_\_\_  
 Declined/not stated

**What was your sex at birth? (Check only one)**

- Male       Female       Declined/not stated

**How do you describe your sexual orientation or sexual identity? (Check only one)**

- Straight/heterosexual       Bisexual       Gay/Lesbian/Same sex Loving  
 Not listed/please specify: \_\_\_\_\_       Declined/not stated

**Ethnicity:**  Hispanic or Latino     Not Hispanic or Latino     Unknown

**Race:**

- Caucasian (W)       American Indian/Alaska Native (AI)       Asian Indian (AS)  
 Japanese (JA)       African American/Black       Vietnamese (VI)  
 Chinese (CH)       Filipino (FI)       Hawaiian (HA)  
 Korean       Other Pacific Islander (OP)       Laotian (LA)  
 Other Asian       Guamanian (GU)       Other Race (OR)  
 Samoan (SA)       Cambodian (CA)       Decline to State (RM)

**Please indicate your household gross monthly income**

1 person	2 person	3 person	4 person
<input type="checkbox"/> \$0 - \$943	<input type="checkbox"/> \$0 - \$1,582		
<input type="checkbox"/> \$944 - \$2,288	<input type="checkbox"/> \$1,583 - \$2,613	<input type="checkbox"/> \$0 - \$2,938	<input type="checkbox"/> \$0 - \$3,263
<input type="checkbox"/> \$2,289 - \$3,808	<input type="checkbox"/> \$2,614 - \$4,350	<input type="checkbox"/> \$2,939 - \$4,896	<input type="checkbox"/> \$3,264 - \$5,438
<input type="checkbox"/> \$3,809 - \$4,570	<input type="checkbox"/> \$4,351 - \$5,220	<input type="checkbox"/> \$4,897 - \$5,875	<input type="checkbox"/> \$5,439 - \$6,525
<input type="checkbox"/> \$4,571 - \$6,092	<input type="checkbox"/> \$5,221 - \$6,963	<input type="checkbox"/> \$5,876 - \$7,833	<input type="checkbox"/> \$6,526 - \$8,700
<input type="checkbox"/> \$6,093 +	<input type="checkbox"/> \$6,964 +	<input type="checkbox"/> \$7,834 +	<input type="checkbox"/> \$8,701 +

- Decline to State

**CONTINUED ON PAGE 3**

## NUTRITION SCREENING INITIATIVE

Read the statements below.

Please **CIRCLE THE NUMBER** in the “YES” column for those that apply.

	YES
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat fewer than 5 servings (1/2 cup each) of fruits or vegetables, or milk products each day.	2
I have 3 or more drinks of beer, liquor, or wine almost every day.	2
I have trouble biting, chewing, or swallowing and/or I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and/or feed myself.	2
<b>Score TOTAL</b>	
Declined to State	

I have completed this form myself for my own registration

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have completed this registration on behalf of \_\_\_\_\_

Prepared by (print name) \_\_\_\_\_

Preparer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THANK YOU FOR  
COMPLETING THIS FORM**