AGEOPTIONS

Connecting Older Adults with Community-based Resources and Options

ATTACHMENT D

AgeOptions Nutrition Referral for Home Delivered Meals. This form must be completed and forwarded to the appropriate Home Delivered Meal nutrition provider agency.

Currently receiving home delivered meals from another source: Yes No
Currently receiving over 8 hours of homemaker services: Yes No NA for this AAA
Days client to receive meals (circle all that apply): M T W R F All M-F Weekend Second meals
Type of meal (circle one): Hot Cold Frozen

Client Demographic Information

Name:	SS#:	Date:
Address:	DOB:	Phone Number:
Race: Caucasian__ African American__ Asian__ Hispanic__ Pacific Islander__ Alaska Native__ American Indian__ Other_____ Ethnicity: Hispanic or Latino Not Hispanic or Latino	Marital Status: M__ D__ S__ W__ Legally separated ___ Domestic partner ___	Gender: M___ F___ Other _____

Limited English Speaking: Yes No If yes, specify language spoken:	Below Poverty: Yes No Monthly Income:	Lives Alone: Yes No Type of Housing: Home Apt Subsidized Housing: Yes No

Major Health Problems (circle all that apply)

Ambulation: Full Partial Assisted Bedfast	Other major health concerns (describe):
Vision: Full Limited Glasses Blind	
Hearing: Full Hard of hearing Hearing Aid Deaf	Determination of Need (DON) score:

Nutrition Risk Screen (circle points under Yes or No)

	Y	N		Y	N
Have you made changes in the way you eat because of an illness or medical condition?	2	0	Do you eat alone most of the time?	1	0
Do you eat fewer than two meals a day?	3	0	Have you lost or gained ten pounds in the last six months without wanting to?	2	0
Do you eat few fruits and vegetables?	1	0			
Do you eat fewer than 2 servings of dairy products per day?	1	0	Are you unable to shop, cook, and feed yourself?	2	0
Do you not have enough money to buy the food you need?	4	0	Do you have three or more drinks per day?	2	0
Do you have trouble eating well due to problems with chewing/swallowing?	2	0	Do you take three or more prescribed or over-the counter drugs a day?	1	0
TOTALS			TOTALS		

Combined column totals: ___/21 possible points **Six or more points = high nutritional risk**

Impairment/Problem with Activity of Daily Living	**Y**	**N**	**Impairment/Problem with Instrumental Activities of Daily Living**	**Y**	**N**
Bathing (excluding washing back or hair)			Preparing meals		
Dressing			Managing medications		
Using the toilet			Managing money		
Transferring			Performing heavy housework		
Eating			Performing light housekeeping		
Walking in home			Shopping		
			Using transportation		
			Using the telephone		
Total			**Total**		

Additional nutrition information	
Who does the grocery shopping? How often?	Can client feed self? Yes No If no, who assists? What type of help: Cutting Puree Feeding
Is anyone available to prepare food? Yes No If yes, who? What days? Which meals?	Does client have any of these difficulties with (circle all that apply): Swallowing Indigestion Heartburn Vomiting Diarrhea Constipation
Usually how much of each meal does the client eat (circle one)? Under 25% 25% 50% 75% Over 75%	How is the client's appetite in general (circle one)? Poor Fair Good Excellent
Client's kitchen facilities (circle all that apply): Kitchen Kitchen privileges Stove Microwave Refrigerator Freezer with available space	Is client able to use these appliances unsupervised (circle all that apply): Stove Microwave Refrigerator Freezer
Client food source for the weekends:	Special Diet Needs: General Diabetic
Condition of the home: Good Poor If poor, specify:	Dietary restrictions: Food allergies:

Reason for Home Delivered Meals (circle all that apply):

- Homebound
- Permanently disabled
- Temporarily disabled
- Respite for caregiver
- Meal for spouse or disabled adult in home
- Other (specify) _____

Client will benefit from Home Delivered Meals because (circle all that apply):

- Meals will increase nutritional intake as client has a limited income
- Client has difficulty cooking, tires easily
- Client is recovering from surgery, illness, etc.
- Other (specify): _____

Duration of meals (circle one): Short term Long term Re-evaluate date:

Other Contacts Information	
Physician Name:	Physician Phone:
Emergency Contact Name:	Home phone: Cell phone:
Address:	
Emergency Contact Name:	Home phone: Cell phone:
Address:	

Authorization of Release of Information

I give permission to _____ to send a copy of this assessment form to the Home Delivered Meal Provider, _____, and to discuss my needs with their and AgeOptions Staff.

Client Signature:	Date:

I certify that this client meets AgeOptions eligibility criteria for Home Delivered Meals under the Older Americans Act.

Signature:	Phone:
Case Manager Name:	E-mail:
Managed Care Organization:	MCO Intake:

HDM start date:	Redetermination date:	Termination Date:

Driver instructions (circle all that apply):

Ring bell Knock loudly Beware of dog(s) Other: _____