



Reason:

Nutrition Referral/Assessment for Home Delivered Meals

This form must be completed and forwarded to the appropriate Home Delivered Meal nutrition provider agency.

Referral Source: <input type="checkbox"/> Care Coordination Unit (CCU) _____			
<input type="checkbox"/> Managed Care Organization (MCO) _____			
<input type="checkbox"/> Area Agency on Aging		<input type="checkbox"/> Nutrition Provider	
Days Older Adult to Receive Meals (Check all that apply): <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Friday			
<input type="checkbox"/> All M-F <input type="checkbox"/> Weekend <input type="checkbox"/> 2nd meals			
Type of meal(s): <input type="checkbox"/> Hot <input type="checkbox"/> Cold <input type="checkbox"/> Frozen		Special Notes:	
Priority Level:			
Duration of Meals: (Check only one) <input type="checkbox"/> Short Term <input type="checkbox"/> Long Term Re-evaluate Date: _____			
Special Diet Needs: <input type="checkbox"/> General <input type="checkbox"/> Diabetic <input type="checkbox"/> Low sodium <input type="checkbox"/> Other (specify): _____			
Older Adult Demographic Information			
Name: _____		DOB: _____	
Address: _____		City: _____	State: _____
Phone: _____	Cell Phone: _____	State: _____	Zip: _____
Authorized Representative: _____		Phone: _____	
Emergency Contact Name #1:		Emergency Contact Name #2:	
Relationship: _____		Relationship: _____	
Daytime/Cell Phone: _____		Daytime/Cell Phone: _____	
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	What is your gender? (Check only one) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Marital Status: <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Legally Separated	Type of Housing: <input type="checkbox"/> Home <input type="checkbox"/> Apt (# : _____) <input type="checkbox"/> Other (specify): _____
Race (Check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian or Asian American	Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No		Subsidized Housing: <input type="checkbox"/> Yes <input type="checkbox"/> No
Below Poverty <input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Income: _____	# of Individuals in Household: _____	
Limited English Speaking: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, primary language spoken: _____			

Nutrition Risk Screen (select points under Yes or No)	Yes/No
I have an illness or condition that has made me change the kind or amount of food I eat.	
I eat less than two meals a day.	
I eat few fruits and vegetables, or milk products.	
I have three or more drinks of beer, liquor, or wine almost every day.	
I have tooth or mouth problems that make it hard for me to eat.	
I don't always have enough money to buy the food I need.	
I eat alone most of the time.	
I take three or more different prescribed or over-the-counter drugs a day.	
Without wanting to, I have lost or gained ten pounds in the last six months.	
I am not always physically able to shop, cook, and/or feed myself.	
TOTAL	/21 possible points
Six or more points = High Nutritional Risk	
<input type="checkbox"/> Nutritional Risk was explained to client.	
<input type="checkbox"/> Client is considered at High Nutritional Risk. A recommendation was made to follow-up with a healthcare provider.	

Impairment/Problem with Activity of Daily Living 0 No Assist = No; 1-3 Assist = Yes; 4 Unknown = No			Impairment/Problem with Instrumental Activities of Daily Living 0 No Assist = No; 1-3 Assist = Yes; 4 Unknown = No		
	PTS	Yes/No		PTS	Yes/No
Eating			Laundry		
Bathing			Shopping		
Grooming			Light Housework		
Dressing			Heavy Housework		
Toileting			Telephone		
Walking/Mobility			Financial Management		
Transferring (in/out of bed/chair)			Transportation		
			Meal Preparation		
			Medication		
Total Points			Total Points		
Total "Yes"=		Total "No"=	Total "Yes"=		Total "No"=

Additional Nutrition Information	
Who does the grocery shopping? How often?	Can Older Adult feed self? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, who assists? What type of help: <input type="checkbox"/> Cutting <input type="checkbox"/> Feeding <input type="checkbox"/> Opening Containers
Is anyone available to prepare food? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? What days? Which meals?	Does Older Adult have difficulty chewing/poor dental health? <input type="checkbox"/> Yes <input type="checkbox"/> No
Older Adult's kitchen facilities/equipment (Check all that apply): <input type="checkbox"/> Kitchen <input type="checkbox"/> Kitchen privileges <input type="checkbox"/> Freezer w/ available space <input type="checkbox"/> Refrigerator <input type="checkbox"/> Stove <input type="checkbox"/> Microwave	Is Older Adult able to use these appliances unsupervised (Check all that apply): <input type="checkbox"/> Stove <input type="checkbox"/> Microwave <input type="checkbox"/> Freezer <input type="checkbox"/> Refrigerator
Older Adult food source for the weekends:	Dietary restrictions:
Food Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: NOTE: It is the client's responsibility to review the weekly menu and bring any allergy concerns to the attention of the nutrition provider. When feasible, the provider will supply a special meal to meet the dietary needs of the client.	
Are you currently receiving food assistance benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No (Examples: SNAP, SFMNP, TEFAP)	
Reason/Eligibility for Home Delivered Meals: (Check all that apply) <input type="checkbox"/> Homebound <input type="checkbox"/> Permanently Disabled <input type="checkbox"/> Temporarily Disabled <input type="checkbox"/> Respite for Caregiver <input type="checkbox"/> Meal for Spouse or Disabled Adult in Home <input type="checkbox"/> Other (specify):	
Older Adult will benefit from Home Delivered Meals because (Check all that apply): <input type="checkbox"/> Older Adult has difficulty cooking, tires easily <input type="checkbox"/> Older Adult is recovering from surgery, illness, etc. <input type="checkbox"/> Meals will increase nutritional intake as Older Adult has a limited income <input type="checkbox"/> Other (specify):	
Currently receiving home delivered meals from another source (e.g. family, church, etc.): <input type="checkbox"/> Yes <input type="checkbox"/> No	
Major Health Problems (Check all that apply)	
Ambulation: <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Assisted <input type="checkbox"/> Bedfast	Determination of Need (DON) score: (If Known) Other major health concerns (describe):
Vision: <input type="checkbox"/> Full <input type="checkbox"/> Limited <input type="checkbox"/> Glasses <input type="checkbox"/> Blind	
Hearing: <input type="checkbox"/> Full <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Deaf	

Priority Level Screening Questions (After client is determined to be "eligible" for HDMs)	
1. (a): If you had groceries available, would you be able to use them to prepare hot meals? <input type="checkbox"/> Yes (Go to Question 2a) ↓ <input type="checkbox"/> No (Go to Question 1b)→	1. (b): Do you have reliable help with meal preparation? <input type="checkbox"/> Yes (Go to Question 2) <input type="checkbox"/> No (STOP – Check High Priority Level)
2. During the last month...	
(a)...how often was this statement true? The food that I/we bought just didn't last, and I/we didn't have money to get more?	
(b)...how often was this statement true? I/we could not afford to eat balanced meals?	
(c)...did you or other adults in your household ever cut the size of your meals because there wasn't enough money for food?	
(d)...did you or other adults in your household ever skip meals because there wasn't enough money for food?	
(e)...did you ever eat less than you felt you should because there wasn't enough money for food?	
(f)...were you ever hungry but didn't eat because you couldn't afford enough food?	
Total points 2a-2f	
3. Are you able to get groceries into your home when you need them? <i>*Refer to total points when selecting.</i>	
0-1 Point AND "No" = Low Priority (May benefit from Grocery Shopping Services or Food Delivery.) 2-6 Points = Intermediate Priority (May benefit from additional nutrition services.)	
Check the appropriate Priority Level Box at the top of Page 1	

Other Contacts Information		
Primary Physician Name:	Primary Physician Phone:	
For Home Delivered Meal Providers:		
<input type="checkbox"/> Referred client to Community Care Program (CCP) for additional Home and Community Based Services. <input type="checkbox"/> The HDM client was informed of the possibility that foods may contain or come into contact with food allergens.		
<u>Authorization of Release of Information</u>		
I give permission to _____ to send a copy of this assessment form to the Home Delivered Meal (HDM) Provider, _____, and to discuss my needs with the HDM Provider, Care Coordination Unit (CCU), Managed Care Organization (MCO), and/or the AAA.		
Older Adult Signature:	<input type="checkbox"/> * Verbal Consent Provided Date:	
I certify this Older Adult meets eligibility criteria for Home Delivered Meals under the Older Americans Act.		
Signature:	Date:	
Case Manager Name:	Phone:	
Organization:	Email:	
HDM Start Date:	Reassessment Date:	Termination Date:
Driver Instructions: <input type="checkbox"/> Ring bell <input type="checkbox"/> Knock loudly <input type="checkbox"/> Beware of dog(s) <input type="checkbox"/> Other: (Check all that apply)		

*Verbal consent can be provided in the event of a pandemic, civil unrest, or other circumstance that prevents a client from providing their written consent/signature.

Completed by (For Referring Agencies Only):	
Name of Referring Agency:	Phone #:
Address:	