



Reason: \_\_\_\_\_

## Nutrition Referral/Assessment for Home Delivered Meals

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

<b>Referral Source:</b> <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	
<b>Days Older Adult to Receive Meals</b> (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			
<b>Type of Meal(s):</b> <input type="checkbox"/> Hot <input type="checkbox"/> Cold <input type="checkbox"/> Frozen		<b>Special Notes:</b>	
<b>Priority Level:</b> <input type="checkbox"/> High <input type="checkbox"/> Intermediate <input type="checkbox"/> Low			
<b>Duration of meals</b> (Check only one): <input type="checkbox"/> Short Term <input type="checkbox"/> Long Term   Re-evaluate Date: _____			
<b>Special Diet Needs:</b> <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: _____	
Authorized Representative: _____		Phone: _____	
<b>Emergency Contact Name #1:</b> _____		<b>Emergency Contact Name #2:</b> _____	
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 (circle 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.	2	0
I eat less than two meals a day.	3	0
I eat few fruits and vegetables, or milk products.	2	0
I have three or more drinks of beer, liquor, or wine almost every day.	2	0
I have tooth or mouth problems that make it hard for me to eat.	2	0
I don't always have enough money to buy the food I need.	4	0
I eat alone most of the time.	1	0
I take three or more different prescribed or over-the-counter drugs a day.	1	0
Without wanting to, I have lost or gained ten pounds in the last six months.	2	0
I am not always physically able to shop, cook, and/or feed myself.	2	0
<b>TOTAL</b>		

**Six or more points = High Nutritional Risk**

Nutritional Risk was explained to client.

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		
<b>Total Points</b>			<b>Total Points</b>		
<b>Total "Yes"= _____ Total "No"= _____</b>			<b>Total "Yes"= _____ Total "No"= _____</b>		

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:
<b>Food Allergies:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: _____	
<b>NOTE:</b> 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.	
<b>Are you currently receiving food assistance benefits?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (Examples: SNAP, SFMNP, TEFAP)	
<b>Reason/Eligibility for Home Delivered Meals:</b> (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): _____	
<b>Older Adult will benefit from Home Delivered Meals because</b> (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): _____	
<b>Currently receiving home delivered meals from another source</b> (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	<b>Determination of Need (DON) score:</b> (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)	
<b>1. (a):</b> If you had groceries available, would you be able to use them to prepare hot meals? <input type="checkbox"/> <b>Yes</b> (Go to Question 2a) ↓ <input type="checkbox"/> <b>No</b> (Go to Question 1b)→	<b>1. (b):</b> Do you have reliable help with meal preparation? <input type="checkbox"/> <b>Yes</b> (Go to Question 2) <input type="checkbox"/> <b>No (STOP – Check High Priority Level)</b>
<b>2. During the last month...</b>	<b>Circle Answer</b>
<b>(a)</b> ...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>Often=1 pt; Sometimes=1 pt; Never=0 pts</b>
<b>(b)</b> ...how often was this statement true? I/we could not afford to eat balanced meals?	<b>Often=1 pt; Sometimes=1 pt; Never=0 pts</b>
<b>(c)</b> ...did you or other adults in your household ever cut the size of your meals because there wasn't enough money for food?	<b>Yes=1 pt; No=0 pts</b>
<b>(d)</b> ...did you or other adults in your household ever skip meals because there wasn't enough money for food?	<b>Yes=1 pt; No=0 pts</b>
<b>(e)</b> ...did you ever eat less than you felt you should because there wasn't enough money for food?	<b>Yes=1 pt; No=0 pts</b>
<b>(f)</b> ...were you ever hungry but didn't eat because you couldn't afford enough food?	<b>Yes=1 pt; No=0 pts</b>
<b>Total points 2a-2f: _____</b>	
<b>3. Are you able to get groceries into your home when you need them?</b>	<input type="checkbox"/> Yes or No AND 0-1 point – Low <input type="checkbox"/> Yes or No AND 2-6 points – Intermediate <i>*Refer to total points when selecting.</i>
<b>0-1 Point AND "No" = Low Priority</b> (May benefit from Grocery Shopping Services or Food Delivery.) <b>2-6 Points = Intermediate Priority</b> (May benefit from additional nutrition services.)	
<b>Check the appropriate Priority Level Box at the top of Page 1</b>	

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.	
Authorization of Release of Information	
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: _____	