☐ **New Client** ☐ **Reassessment** ☐ **Ineligible/Termination** **(Reason: _____)**

Nutrition Referral for Food Delivery (Meal Kit) Program

This form must be completed and forwarded to the appropriate Food Delivery Program provider agency.

Referral Source: ☐ Care Coordination Unit (CCU) _____ ☐ Managed Care Organization (MCO) _____

Cuisine Type: ☐ General ☐ Black/African American ☐ Korean ☐ Halal ☐ Latino/Hispanic ☐ Kosher (Available only in northern suburbs)

Special Notes:

Duration of Deliveries (check one): ☐ Short Term ☐ Long Term Re-evaluate Date: _____

Older Adult Demographic Information

Name:	Phone:	Cell phone:
Address: Zip Code:	DOB:	Gender (check one: ☐ Male ☐ Female ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	Limited English Speaking: ☐ Yes ☐ No If yes, primary language spoken: _____	Type of Housing: ☐ Home ☐ Apt (# :__) ☐ Other (specify) _____

Race (check all that apply):
☐ White ☐ American Indian or Alaskan Native
☐ Black or African American ☐ Asian or Asian American
☐ Native Hawaiian or Pacific Islander ☐ Middle Eastern, North Africa (MENA)

Below Poverty: ☐ Yes ☐ No	Monthly Income: _____	# of Individuals in household: _____

Authorized Representative Name: Phone:	Primary Physician Name: Phone:
Emergency Contact #1 Name: Relationship: Daytime/Cell Phone:	Emergency Contact #2 Name: Relationship: Daytime/Cell Phone:

Nutrition Risk Screen (circle points under Yes or No)	**Y**	**N**		**Y**	**N**
I have an illness or condition that has made me change the kind or amount of food I eat.	2	0	I eat alone most of the time.	1	0
I eat less than two meals a day.	3	0	I take three or more different prescribed or over- the-counter drugs a day.	1	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	Without wanting to, I have lost or gained ten pounds in the last six months.	2	0
I have tooth or mouth problems that make it hard for me to eat.	2	0	I am not always physically able to shop, cook and/or feed myself.	2	0
I don't always have enough money to buy the food I need.	4	0			
Totals			**Totals**		

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

☐ 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 Activities of Daily Living			**Impairment/Problem with Instrumental Activities of Daily Living**		
0 (No Assist) or 4 (Unknown) = No; 1-3 (Assist) = Yes	**PTS**	**Y/N**	**0 (No Assist) or 4 (Unknown) = No; 1-3 (Assist) = Yes**	**PTS**	**Y/N**
Eating			Laundry		
Bathing			Shopping		
Grooming			Light Housework		
Dressing			Heavy Housework		
Toileting			Telephone		
Walking/Mobility			Financial Management		
Transferring (in/out of bed/chair)			Transportation		

Effective 10/01/2023

			Meal Preparation		
			Medication		
Total Points			**Total Points**		
Total "Yes" = _____Total "No" = _____			**Total "Yes" = _____Total "No" =** _____		

Additional Nutrition Information ***(Participants that shop or have someone available to shop are ineligible)***

Who does the grocery shopping? How often?	Can Older Adult feed self? ☐ Yes ☐ No If no, who assists? _____ What type(s) of help: ☐ Cutting ☐ Feeding ☐ Opening Containers____

Is anyone available to prepare food? ☐ Yes ☐ No
If yes, who? _____ What days? _____ Which meals? _____

Currently receiving home delivered meals from another source (e.g. family, church, etc.)**:** ☐ Yes ☐ No

Older Adult's kitchen facilities/equipment (Check all that apply): ☐ Kitchen ☐ Kitchen privileges ☐ Freezer w/ available space ☐ Refrigerator ☐ Stove ☐ Microwave	Is Older Adult able to use these appliances unsupervised (Check all that apply): ☐ Stove ☐ Microwave ☐ Freezer ☐ Refrigerator

Dietary restrictions:_____

Food Allergies: ☐ Yes (specify)_____ ☐ No
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? ☐ **Yes** ☐ **No** **(**Examples: SNAP, SFMNP, TEFAP)

Reason/Eligibility for Food Deliveries: (Check all that apply)
☐ Homebound ☐ Permanently disabled ☐ Temporarily disabled ☐ Respite for caregiver
☐ Other (specify):

Older Adult will benefit from Food Deliveries because (check all that apply): ☐ Limited mobility
☐ Limited or no reliable transportation ☐ Recovering from surgery, illness, etc.
☐ Food will increase nutritional intake as Older Adult has a limited income ☐ Other (specify): _____

For Food Delivery Providers:

☐ Referred client to Community Care Program (CCP) for additional Home and Community Based Services
☐ The Food Delivery 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 Food Delivery Provider, _____, and to discuss my needs with the Provider, Care Coordination Unit (CCU), Managed Care Organization (MCO), and/or the AAA.

Older Adult Signature: ☐ * Verbal Consent Provided Date:

I certify this Older Adult meets AgeOptions (AAA) eligibility criteria for Food Deliveries.

Signature:	Phone:
Case Manager Name:	Email:
Organization:	Date:

Food Delivery Start Date: Reassessment Date: Termination Date:

Driver instructions: (check all that apply):
☐ Limited vision: Text, call, ring bell ☐ Limited hearing: Knock loudly or text
☐ Needs help inside ☐ Beware of dog ☐ Other: _____

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