☐ **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)

Weekly Meal Count: ☐ 14 Meals ☐ 21 Meals

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**

Hunger Vital Signs Questions *(Clients must answer these two questions)*

"Within the past year, I(we) worried whether our food would run out before I(we) got money to buy more."
☐ Often true ☐ Sometimes true ☐ Never true

"Within the past year, the food I(we) bought just didn't last and I(we) didn't have money to get more."
☐ Often true ☐ Sometimes true ☐ Never true

☐ Nutritional Risk was explained to client.
☐ Client is considered at High Nutritional Risk. A recommendation was made to follow-up with a healthcare provider.

Effective 01/01/2025

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		
			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)***

Does someone do grocery shopping for you? ☐ Yes ☐ No | Is anyone available to prepare food? ☐ Yes ☐ No

Do you get food from another source? ☐ Yes ☐ No (Examples: SNAP, SFMNP, TEFAP, your church, family, etc.)

Do you have and use (Check all that apply): ☐ Kitchen ☐ Kitchen privileges ☐ Freezer w/available space
☐ Refrigerator ☐ Stove ☐ Microwave

FOOD ALLERGIES NOTE: If allergic to any food item, it is the client's responsibility to avoid using that food item in preparing meals from food delivered with Meal Kits.

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 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.