Instructions for Completing
The Nutritional Referral/Assessment for Home Delivered Meals Form

General Instructions

New Client, **Reassessment,** **Ineligible/Termination (Reason)**	Check appropriate box. (If ineligible or being terminated, be sure to indicate reason.)
Referral Source	Check appropriate box and if a CCU or MCO, include the name of the organization making the referral in the space provided.
Days Older Adult to receive meals (Choose all that apply): M T W TH F All M-F Weekend 2nd Meals	**NOTE:** Some options may not be available in the service area. **The MCO or the CCU must check the AAA website in the Planning and Service Area (PSA) where the nutrition provider is located to determine what meal options are available**. Most nutrition service providers downstate only have the resources to provide one meal per day and generally provide a mid-day meal. 2nd meals would be preference for supper meals. Choose the days the Older Adult needs meals (choose any options that apply).
Type of Meal(s): Hot Cold Frozen	Mark the types of meals the Older Adult would need and/or be able to prepare. **(Check the AAA's website in the PSA for available options for Home Delivered Meals.)**
Special Notes:	Provide information specific to the Older Adult's restrictions, needs, etc.
Priority Level Drop Down box (Top of Page 1) **Choose "HIGH" on fillable PDF or Hand write on print version**	**Use the Priority Level Screening Questions on Page 3** • **If "NO" to both 1(a) and 1(b)** ○ **Provide meals as soon as possible, in no later than 2 Business days.** Source: The Expanded Food Security Screener – Home-Delivered Meals Prioritization Tool developed by the College of Agriculture & Natural Resources Department of Nutrition and Food Science at the University of Maryland.

Choose "INTERMEDIATE" on fillable PDF or Hand write on print version	**<u>Use the Priority Level Screening Questions on Page 3</u>**
	
	• **If score of 2-6 points** for questions **2(a) through 2(f) AND** answers **"YES" or "NO"** to **Question #3**
	  o Prioritize above those at "Low" priority
	  o **Provide HDMs within 5 Business Days or sooner (**if there is NOT a waitlist and resources are available)
	  ▪ **Make person aware of:**
	  ▪ **Grocery Shopping Services**
	  ▪ **Food Delivery**
	  ▪ **Additional nutrition services along with HDMs:**
	  ▪ The Supplemental Nutrition Assistance Program (SNAP)
	  ▪ The Emergency Food Assistance Program (TEFAP)
	  ▪ Commodity Supplemental Food Program (CSFP), and others
	
	Source: The Expanded Food Security Screener – Home-Delivered Meals Prioritization Tool developed by the College of Agriculture & Natural Resources Department of Nutrition and Food Science at the University of Maryland.

Choose "LOW" on fillable PDF or Hand write on print version.	**<u>Use the Priority Level Screening Questions on Page 3</u>**
	
	• **If score of 0-1 point** for questions **2(a) through 2(f) AND** answers **"YES" or "NO"** to **Question #3**
	  o Prioritize last
	  o **Provide HDMs within 10 Business Days or sooner** if there is NOT a waitlist and resources are available.
	• **If Answers "NO"** to **Question #3 then Make person aware of:**
	  o **Grocery Shopping Services**
	  o **Food Delivery**
	
	Source: The Expanded Food Security Screener – Home-Delivered Meals Prioritization Tool developed by the College of Agriculture & Natural Resources Department of Nutrition and Food Science at the University of Maryland.

Duration of Meals: Short Term Long Term Re-evaluate date:	Select the duration the Older Adult will be receiving meals. Check only one box. Indicate the time the Older Adult anticipates the need for home delivered meals. • Short term (e.g. Recovery time after a surgery, caregiver unavailable, hospitalization, etc.). • Long term (longer time of need for meals).

Special Diet Needs: General Diabetic Low Sodium Other (specify)_____	Does the Older Adult need a "General," "Diabetic," or Low Sodium diet? If there is another diet the Older Adult needs, please indicate and check the "Other" option.
Older Adult Demographic Information	
Name:	Enter the Older Adult's full name.
Address: **State:** **City:** **Zip Code:**	Enter the Older Adult's residence including the zip code.
DOB:	Enter the Older Adult's date of birth.
Phone Number: **Cell Phone:**	Enter the phone numbers of the Older Adult.
Authorized Representative: **Phone:**	Enter the name of the authorized representative, if applicable and their phone number.
Emergency Contact Name #1 and #2 **Relationship** **Daytime/Cell Phone**	Enter the name of the older adult's emergency contact(s) and their relationship to the older adult. Enter the daytime/cell phone number for the emergency contact(s).
Ethnicity: ***Hispanic or Latino*** – A person of Cuban, Mexican, Puerto Rican, South of Central American, or other Spanish culture or origin, regardless of race. ***Not Hispanic or Latino***	Choose one of the Ethnicity options. **(NOTE: The IDoA is required to report data from the responses in this section to the federal agency).**
Race: ***White*** – A person having origins in any of the peoples of Europe, the Middle East, or North Africa. ***Black or African American*** – A person having origins in any of the black racial groups in Africa. ***Native Hawaiian or Pacific Islander*** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific islands. ***American Indian or Alaskan Native*** – A person having origins in any of the original peoples of North America (including Central America), and who maintains tribal affiliation or community attachments. ***Asian or Asian American*** – A person having origins in any of the original peoples of the Far East,	Check all races that apply. **(NOTE: The IDoA is required to report data from the answers in this section to the federal agency).**

Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	
Gender: Male Female Other	Check only one box to indicate the Older Adult's gender.
Are you a Veteran? Yes No	Check Yes or No.
Marital Status: M, D, S, W Domestic Partner Legally Separated	Check the box to indicate the Older Adult's marital status (Married, Divorced, Separated, Widowed, Domestic Partner, or Legally Separated).
Type of Housing: Home Apt # _____ Other (specify)	What type of housing does the older adult live in (home or apartment)? If it is another type of housing besides a Home or Apartment, check Other and specify the type.
Subsidized Housing: Yes No	Does the Older Adult live in subsidized housing? Check Yes or No.
Below Poverty: Yes No	Does the Older Adult have income that is below Federal poverty level (Y or N)? Refer to the most recent HHS Federal Poverty Guidelines sheet provided annually.
Monthly Income:	Enter the Older Adult's monthly income.
# of Individuals in the Household _____	Enter the number of individuals that live in the older adult's home including the older adult.
Limited English Speaking: Yes No If yes, specify primary language spoken:	Does the Older Adult have limited English speaking capabilities and if so, what is his/her primary language?
Nutrition Risk Screen	
Nutrition Risk Screen – 10 questions (select points under Yes or No) FEDERALLY REQUIRED INFORMATION	This section contains questions to determine if the Older Adult has high nutritional risk. Each question is assigned a point value if the Older Adult's answer is "yes" to a question. Total the points chosen in the "Y" column. If the total is six or more points, the Older Adult is considered to have high nutritional risk. The fillable PDF version will total the points automatically based on the selected responses to each question. ***Responses do not determine eligibility for HDM.*** **(NOTE: The IDoA is required to report data from the answers in this section to the federal agency).** **Source: DETERMINE Your Nutritional Health Checklist developed by the Nutrition Screening Initiative**

	<u>What do the scores mean:</u> 0-2: GOOD NUTRITION STATUS Should have their nutritional score rechecked in 6 months or annually. 3-5: MODERATE NUTRITIONAL RISK Lifestyle changes may be necessary. Should have their nutritional score rechecked in 3 to 6 months. 6-21: HIGH NUTRITIONAL RISK Client should follow-up with a healthcare provider, dietitian, or social service professional to improve their nutritional health. **Note: The screening suggests risk but does not represent a diagnosis of any condition.**
Nutritional Risk was explained to client	Check the box "Nutritional Risk was explained to the client" to indicate that the client's nutrition risk score was provided to them and explained which category they fall in.
Client is considered at High Nutritional Risk. A recommendation was made to follow-up with a healthcare provider.	Check the box "Client is considered at High Nutritional Risk, a recommendation was made to follow-up with a healthcare provider" if the client's nutrition score is 6 or above. If a client was screened at high nutritional risk upon initial assessment, they should be asked upon re-assessment if they followed up with a healthcare provider about their high nutritional risk. **If this box is checked, then the CCU, MCO, or Home Delivered Meal provider shall, if feasible, make a recommendation or referral to additional services to help improve the clients nutritional risk** (e.g. Supplemental Nutrition Assistance Program (SNAP), a CCU if the Nutrition Provider was the agency completing the form, a Registered Dietitian, or MCO). **The Home Delivered Meal Nutrition Provider should provide all Home Delivered Meal Participants upon starting the program, the IDoA *Nutritional Risk and Your Health* Brochure (**IL-402-1262) **regardless of Nutrition Risk status to inform/remind the client about their nutrition status.**

Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)	
Impairment/Problem with Activity of Daily Living (ADL) **Impairment/Problem with Instrumental Activities of Daily Living (IADL)** **FEDERALLY REQUIRED** **INFORMATION**	This section contains questions to determine an Older Adult's assistance level for activities of daily living and instrumental activities of daily living. If a Determination of Need (DON) assessment has already been completed by the CCU, you may use the Part A, Level of Impairment, score for these items. If a DON has not been completed by a CCU, the Older Adult should be asked about his/her need for assistance for each ADL/IADL. Each item will be assigned one of the following answers and the corresponding point value should be entered on the form. The fillable PDF will automatically calculate the total and number of Yes and No responses. • Independent – Enter 0 or No Independent (no assistance required): A score of zero for any function indicates that the Older Adult performs or can perform all essential components of the activity, with or without an existing assistive device. • Minimal Assist – Enter 1 or Yes Minimal Assistance: A score of one for any function indicates that the Older Adult performs or can perform most essential components of the activity with or without an existing assistive device, but some impairment of function remains such that the Older Adult requires some supervision or physical assistance to accomplish some or all components of the activity. • Moderate Assist – Enter 2 or Yes Moderate Assistance: A score of two for any function indicates that the Older Adult cannot perform most of the essential components of the activity, even with an existing assistive device, and requires a great deal of assistance or supervision to accomplish the activity. • Extensive Assist – Enter 3 or Yes Extensive Assistance: A score of three for any function indicates that the Older Adult cannot perform the activity and requires someone to perform the task, although the Older Adult may be able to assist in small ways, or require constant supervision. • Unknown – Enter 4 or No Unknown: (unable to determine need for assistance, needs assistance but refuses or does not provide an answer).

Additional Nutrition Information	
Who does the grocery shopping? **How often?**	Name(s) of individual who does the grocery shopping for the Older Adult. Indicate frequency of shopping (ie. weekly, monthly, etc.).
Can Older Adult feed self? Yes No **If no, who assists?** **What type of help:** Cutting Feeding Opening Containers	Ask the Older Adult if he/she can feed him/herself. If the answer is "No" list who provides assistance and the type(s) of help needed from the options listed.
Is anyone available to prepare food? Yes/No **If yes, who?** **What days?** **Which meals?**	Ask the Older Adult if there is anyone in the household to prepare food and if "Yes" list who provides the assistance, the frequency, and the meals (breakfast, lunch, dinner) when assistance is available.
Does Older Adult have difficulty-chewing/poor dental health? **Yes** **No**	Does the Older Adult have difficulty chewing or have poor dental health?
Older Adult's kitchen facilities and equipment: **(Check all that apply)** Kitchen Kitchen privileges Stove Microwave Refrigerator Freezer w/available space	Does the Older Adult have the types of kitchen facilities and equipment listed available?
Is Older Adult able to use these appliances unsupervised (Check all that apply): Stove Freezer Microwave Refrigerator	Ask the Older Adult which appliances from the list he/she can use unsupervised.
Older Adult food source for the weekends:	How does the Older Adult obtain meals on weekends?
Dietary Restrictions:	List any dietary restrictions given by the Older Adult.
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	If the participant has a food allergy, Check "Yes" and indicate which food(s) they are allergic to. If they do not have any food allergies, check "No." All clients will be provided with the "Food Allergy/Special Diet Notification Handout" by the HDM Nutrition Provider when they receive their first delivery of HDMs. When feasible, the provider will supply a special meal to

provider will supply a special meal to meet the dietary needs of the client.	meet the dietary needs of the client. Examples may include but are not limited to: swapping out cow's milk for a calcium-fortified soy or nut-based milk alternative for a Dairy Allergy; swapping out wheat bread for a slice of potato bread for a wheat allergy; providing an "allergy-friendly" shelf-stable or frozen meal that does not contain the client's food allergens. **Please note:** In most cases it may not be safe to serve the program's regular meals to a person with a physician documented life-threatening allergy due the risk of unknown ingredients and cross-contamination.
Are you currently receiving food assistance benefits? **Yes** **No**	Examples may include Supplemental Nutrition Assistance Program (SNAP) also referred to as "Food Stamps" program, The Emergency Food Assistance Program (TEFAP), Senior Farmers Market Nutrition Program (SFMNP), which runs from July to the end of October, the Commodity Supplemental Food Program (CSFP), or others. If the person indicates "NO" and they also scored "High Nutritional Risk," they would benefit from one or more of these additional nutrition programs.
Reason/Eligibility for Home Delivered Meals: (Check all that apply) • Homebound • Permanently disabled • Temporarily disabled • Respite for caregiver • Meal for spouse or disabled adult in home • Other (specify)	The case manager or assessor should indicate all reason(s) the Older Adult needs Home Delivered Meals. If "other" is chosen, the case manager or assessor should provide further detail.
Older Adult will benefit from Home Delivered Meals because: (Check all that apply) • Meals will increase nutritional intake as Older Adult has a limited income • Older Adult has difficulty cooking, tires easily • Older Adult is recovering from surgery, illness, etc. • Other (specify)	The case manager or assessor should indicate all benefits to the Older Adult from receiving home delivered meals. If "other" is chosen, the case manager or assessor should provide further detail.
Currently receiving home delivered meals from another source: Yes No	Answer "Yes" if older adult receives Home Delivered Meals (HDMs) from any other source such as church, family, etc.

Major Health Problems (Check all that apply)	
Ambulation: Full Partial Assisted Bedfast	Ask the Older Adult about his/her ambulation capability.
Vision: Full Limited Glasses Blind	Ask the Older Adult about his/her vision capability.
Hearing: Full Hard of Hearing Hearing Aid Deaf	Ask the Older Adult about his/her hearing capability.
Determination of Need (DON) score (If known):	Enter the Older Adult's total DON score (If Known).
Other major health concerns (describe):	Describe any other major health concerns.
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? **Responses: Yes (Go to Question 2)** **No (Go to Question 1 (b))** **1)** b) Do you have reliable help with meal preparation? **Responses: Yes (Go to Question 2)** **No (STOP – Check High Priority Level)** **2)** a) During the last month…how often was this statement true? The food that we bought just didn't last, and we didn't have money to get more. **Responses: Often, Sometimes, Never** **2)** b) During the last month …how often was this statement true? We couldn't afford to eat balanced meals. **Responses: Often, Sometimes, Never** **2)** c) During the last month …did you or other adults in your household ever cut the size of your meals because there wasn't enough money for food? **Responses: Yes, No** **2)** d) During the last month …did you or other adults in your household ever skip meals because there wasn't enough money for food? **Responses: Yes, No** **2)** e) During the last month …did you ever eat less than you felt you should because there wasn't enough money for food? **Responses: Yes, No** **2)** f) During the last month …were you ever hungry but didn't eat because you couldn't afford enough food? **Responses: Yes, No** **3)** Are you able to get groceries into your home when you need them? **Responses:** **Yes** (Select the point range below)	**Check only one box for each question/sub question.** **Add the points from questions 2(a) – 2(f).** **Note: if using the fillable PDF version, it will automatically total the points selected for questions 2(a) – 2(f).** **Point range is from 0-6** **Select the Point Range/Priority Level based on the total points from 2(a) – 2(f) and the response (Yes or No) for Question #3 to determine the Priority Level and additional services that the client may benefit from.**

0-1 Point = Low Priority **2-6 Points = Intermediate Priority** (May benefit from additional nutrition services) **No (**Select the point range below) **0-1 Point = Low Priority** (May benefit from Grocery Shopping Services or Food Delivery) **2-6 Points = Intermediate Priority** (May benefit from additional nutrition services)	
Other Contacts Information	
Primary Physician Name: Primary Physician Phone:	Name and phone number of the doctor the Older Adult would like to have listed on the form.
For Home Delivered Meal Providers	
Referred client to Community Care Program (CCP) for additional Home and Community Based Services	Check this box if you are the HDM Nutrition Provider completing this form and have identified that the client would benefit from additional services from the Community Care Program (CCP).
The HDM client was informed of the possibility that foods may contain or come into contact with food allergens.	**The HDM meal provider must check this box regardless of the client's response of Yes of No to having food allergies.** By checking the box, it signifies that the HDM Nutrition Provider gave the client the Food Allergy/Special Diets Notification with their first delivery of meals.
Authorization of Release of Information	
I give permission to__, to send a copy of this assessment form to the Home DeliveredMeal (HDM) Provider,_____, and to discuss my needs with the HDM Provider, Care Coordination Unit (CCU), Managed Care Organization (MCO), and/or AAA.	Provide the name of the case manager or assessor who will send a copy of the referral form to the meal provider and the name of the Home Delivered Meal provider. This person is also granted authorization to discuss the Older Adult's home delivered meal needs with the provider, CCU, MCO, and Area Agency on Aging (AAA).
Older Adult Signature:	The Older Adult signs the referral form or provides verbal consent if completed by telephone. Adobe Acrobat Instructions for the Older Adult's signature (if available): • Click on "Fill & Sign" under the Tools tab. • Click on the ink pen "Sign" at the top of the form. • Click on "Add Signature". • Choose "Draw". • Use the curser to sign the document or if touchpad, use finger or stylus, etc. Click "Apply" and click to place the signature. In the event that Adobe Acrobat signature option in unavailable, the form should be printed out for the older adult to sign.
Verbal Consent Provided **Date:**	Check this box if verbal consent was provided by telephone instead of the older adult signing the form in person. Enter the date that the older adult signed the form or provided verbal consent (can be done by using the drop-down calendar).
I certify this Older Adult meets eligibility criteria for Home Delivered Meals under the Older Americans Act.	
Case Manager Name:	Provide the name and phone number of the case manager or

	assessor who completed the referral form.
Organization:	Provide the name of the Managed Care Organization (MCO).
Phone Number:	Provide the phone number of the MCO or CCU completing the form.
Email:	Provide the email address of the Organization completing the form.
Signature:	Enter the case manager's digital or electronic signature or the assessor's signature if the nutrition provider is completing the form. (NOTE: The case manager may need to create an electronic signature in Adobe.)
Date:	Enter the date (can be done by using the drop-down calendar).
HDM Start Date:	Provide the date the Older Adult may begin receiving HDMs. (can be done by using the drop-down calendar.)
Reassessment Date:	Provide the date when the Older Adult should be reassessed for his/her need for HDMs. (can be done by using the drop-down calendar). **NOTE: The reassessment is required to be completed annually unless otherwise indicated during or after the referral form is completed.**
Termination Date:	Provide the date temporary HDMs can be stopped for the Older Adult. For example: if meals are to provide respite for a caregiver; during recovery following hospitalization or illness where the client is expected to recover and no longer be homebound, etc. (can be done by using the drop-down calendar).
Driver Instructions: (circle all that apply) Ring bell Knock loudly Beware of dog(s) Other: ___	Indicate any instructions for the driver to follow when delivering meals. If "other" is chosen, the case manager should provide further detail such as no handrails, steep steps, etc.
Completed by (For Referring Agencies Only)	
Name of Referring Agency Address Phone Number	Indicate the name, address, and phone number of the referring agency.
Print/Save/Clear Form	The case manager should "Print" or "Save" the form prior to choosing to "Clear Form".