

□ New Client	☐ Reassessment	☐ Ineligible/Termination
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: Care Coordination Unit (CCU)					
☐ Managed Care Organization (MCO)					
☐ Area Agency on Aging ☐ Nutrition Provider					
Days Older Adult to Receive Meals (Check		Mon □ Tues □ Wed □ All M-F □ Weekend □ 2			
Type of meal(s): ☐ Hot ☐ Cold ☐	Frozen Specia	al Notes:			
Priority Level:					
Duration of Meals: (Check only one) ☐ Sh	nort Term	erm Re-evaluate Date	:		
Special Diet Needs: ☐ General ☐ Diab	etic	☐ Other (specify):			
Older Adult Demographic Information					
Name:		DOB:			
Address:	City:	State:	Zip:		
Phone: Cell Phone	e:	DI DI			
Authorized Representative:	F	Phone:			
Emergency Contact Name #1: Relationship:		ergency Contact Name #2 ationship:			
Daytime/Cell Phone:		rtime/Cell Phone:			
Ethnicity: ☐ Hispanic or Latino	What is your gende		Type of Housing:		
□ Not Hispanic or Latino	(Check only one)	□M □D	☐ Home		
Li Not Hispanic of Latino	☐ Male ☐ Femal	le 🗆 S 🗆 W	☐ Apt (#:)		
Race (Check all that apply):	☐ Other	☐ Domestic Partner	☐ Other (specify):		
☐ White		☐ Legally Separated			
☐ Black or African American ☐ Native Hawaiian or Pacific Islander	Are you a Veteran?	?			
☐ American Indian or Alaskan Native	☐ Yes ☐ No		Subsidized Housing:		
☐ Asian or Asian American			☐ Yes ☐ No		
Below Poverty ☐ Yes ☐ No More	nthly Income:	uals in Household:			
Limited English Speaking: ☐ Yes ☐ No	If yes, primary langu	uage spoken:			
Nutrition Risk Screen (select points unde	er Yes or No)		Yes/No		
I have an illness or condition that has made	me change the kind of	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, o	r wine almost every d	lay.			
I have tooth or mouth problems that make it	hard for me to eat.				
I don't always have enough money to buy th	e food I need.				
I eat alone most of the time.					
I take three or more different prescribed or o	ver-the-counter drugs	s a day.			
Without wanting to, I have lost or gained ten	pounds in the last six	x months.			
I am not always physically able to shop, coo	k, and/or feed myself				
		TOTAL	/21 possible points		
		Six or more poin	ts = High Nutritional Risk		
☐ Nutritional Risk was explained to client.☐ Client is considered at High Nutritional Risl	k. 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"= T	otal "No"=	•

Additional Nutrition Information				
Who does the grocery shopping?	Can Older Adult feed self? ☐ Yes ☐ No If no, who assists?			
How often?	What type of help: ☐ Cutting ☐ Feeding ☐ Opening Containers			
Is anyone available to prepare food? ☐ Yes ☐ No If yes What days? Which meals?	Does Older Adult have difficulty chewing/poor dental health?			
Older Adult's kitchen facilities/equipment (Check all that app	oly): Is Older Adult able to use these appliances unsupervised (Check all that apply):			
☐ Kitchen ☐ Kitchen privileges ☐ Freezer w/ available spa☐ Refrigerator ☐ Stove ☐ Microwave	ace ☐ Stove ☐ Microwave ☐ Freezer ☐ Refrigerator			
Older Adult food source for the weekends:	Dietary restrictions:			
Food Allergies: ☐ Yes ☐ 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? Yes No (Examples: SNAP, SFMNP, TEFAP)				
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):				
Older Adult will benefit from Home Delivered Meals because (Check all that apply):				
☐ Older Adult has difficulty cooking, tires easily ☐ Older Adult is recovering from surgery, illness, etc. ☐ Meals will increase nutritional intake as Older Adult has a limited income ☐ Other (specify):				
Currently receiving home delivered meals from another source (e.g. family, church, etc.): ☐ Yes ☐ No				
Major Health Problems (Check all that apply)				
Ambulation: ☐ Full ☐ Partial ☐ Assisted ☐ Bedfast	Determination of Need (DON) score: (If Known)			
Vision: ☐ Full ☐ Limited ☐ Glasses ☐ Blind	Other major health concerns (describe):			
Hearing: ☐ Full ☐ Hard of Hearing ☐ Hearing Aid ☐ Deaf				

Priority Level Screening Questio	ns (After client is determ	ined to be '	"eligible" fo	r HDMs)
1. (a): If you had groceries available use them to prepare hot meals?☐ Yes (Go to Question 2a) ↓	e, would you be able to	☐ Yes (G	o to Quest	
□ No (Go to Question 1b)→		□ NO (S1	OP - Ched	ck High Priority Level)
2. During the last month				
(a)how often was this statement to didn't have money to get more		bought just	didn't last,	and I/we
(b)how often was this statement t	true? I/we could not affo	rd to eat ba	lanced me	als?
(c)did you or other adults in your there wasn't enough money for		size of your	meals beca	ause
(d)did you or other adults in your enough money for food?	household ever skip me	als because	e there was	n't
(e)did you ever eat less than you for food?	felt you should because	there wasn	i't enough r	money
(f)were you ever hungry but didn'	t eat because you could	n't afford en	nough food	?
			Total poir	nts 2a-2f
3. Are you able to get groceries i	nto your home when yo *Refer to total point			
0-1 Point AND "l				Shopping Services or Food Delivery
Check	the appropriate Priority			nefit from additional nutrition services
		, 2010: 20/	<u> </u>	
Other Contacts Information				
Primary Physician Name:		Prima	ary Physicia	an Phone:
	For Home Delivere	ed Meal Pro	oviders:	
☐ Referred client to Community Care Program (CCP) for additional Home and Community Based Services. ☐ The HDM client was informed of the possibility that foods may contain or come into contact with food allergens.				
	Authorization of Rel	ease of In	formation	<u>n</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: * 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: ☐ Ring bell ☐ Knock loudly ☐ Beware of dog(s) ☐ 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:				