Name of Home-Delivered Meals Provider (SAMPLE 4, C-2)

This form is designed to be completed by an intake staff. Items marked with asterisk (*) are required.

Route:

Intake Date: ________

Active Date: ________ Inactive Date: ________

Active Date: ________ Inactive Date: ________

Active Date: ________ Inactive Date: ________

***Unique Participant ID:** | ***Termination Date:** | ***Reason:**

***Date of Birth**: / /

Last 4 Digits Social Security # *Optional* ☐☐☐☐

☐ New client
☐ Annual reassessment
☐ Change in information

First Name: | Last Name

Home Address: | City: | *Zip Code:

Home Phone: ( )

Alternate Phone: ( )

Emergency Contact Name:

Address:

Phone: ( ) Relationship:

***Living Arrangement**
# of household members ☐
☐ Declined to State

***What is your approximate household income?**
$______________ per ☐ month ☐ year
☐ Declined to State

***Rural Area?**
☐ Yes ☐ No
☐ Declined to State

*** What is your gender? (Check only one)**
☐ Male ☐ Female
☐ Transgender Female to Male
☐ Transgender Male to Female
☐ Genderqueer/Gender Non-binary
☐ Not Listed, please specify:
____
☐ Declined/not stated

*** What was your sex at birth? (Check only one)**
☐ Male ☐ Female
☐ Declined/not stated

*** How do you describe your sexual orientation or sexual identity (Check only one)**
☐ Straight/Heterosexual
☐ Bisexual
☐ Gay/Lesbian/Same-Gender Loving
☐ Questioning/Unsure
☐ Not Listed, please specify:
____
☐ Declined/not stated

***Ethnicity** (Check One)
Hispanic ☐ Yes ☐ No ☐ Decline to State

Language:
☐ English speaking ☐ Need interpreter ☐ Non-English/Language

***Race**: (Check One) ☐ White ☐ Black ☐ American Indian/Alaska Native
☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese
☐ Other Asian ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander
☐ Multiple Race ☐ Other Race ☐ Declined to State

***ADLs and IADLs (Activities of Daily Living and Instrumental Activities of Daily Living)**
Please rate your functional abilities for the following activities.

ADLs	Rated Value	IADLs	Rated Value	IADLs	Rated Value
Feeding		Meal Preparation		Light Housework	
Dressing		Shopping		Heavy Housework	
Bathing		Manage Medication		Notes:	
Transferring In/Out of Chair		Money Management			
Walking		Telephone			
Toileting		Transportation			

RATING SCALE

1 = Independent
2 = Verbal Assistance
3 = Some Human Help
4 = Lots of Human Help
5 = Dependent
6= Declined to State

Eligibility:	Prioritization:
☐ Are you homebound due to an illness, disability, or isolation? ☐ Are you a spouse of a person who is homebound? ☐ Are you an individual with a disability who resides with a homebound meal recipient?	

*Nutritional Assessment:	Circle if yes
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits or vegetables or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more different prescribed or over–the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the past 6 months?	2
I am not always physically able to shop, cook, and/or feed myself.	2
Total Score: (If equal to or greater than 6, the client is at high nutritional risk)	
	☐ **Declined to State**

	Yes	No	Comments
Do you have any dietary restrictions?			
Do you have a working refrigerator?			
Do you have a working microwave?			
Are you physically and mentally able to open the food containers?			
Are you physically and mentally able to reheat a meal?			
Are there pets?			
Have you recently been discharged from the hospital?			

Referral(s) Made:

- ☐ Nutritional education/counseling for at risk client
- ☐
- ☐
- ☐

Notes:

Staff Completing Assessment

Date