Home-Delivered Meals Provider:_____

This form is designed to be completed by an intake staff.

Items marked with an asterisk (*) are required.

Route:

Intake Date:_____
Active Date:_____
Inactive Date:_____

***Date Registered:**

***Termination Date:** ***Reason:**

Last Name: | First Name: | MI:

Home Phone: ( )

Alternate Phone: ( )

Emergency Contact Name:

Address:

Phone: ( ) Relationship:

***Gender:** ☐ Male ☐ Female ☐ Declined to State

***Date of Birth:** (MM/ DD/ YYYY)

Last 4 Digits Social Security # *optional*:

Home Address: | City: | State:

County: | ***Zip Code:**

***Relationship (Marital) Status:**

☐ Single ☐ Married ☐ Domestic Partner ☐ Separated

☐ Divorced ☐ Widowed ☐ Declined to State

***Ethnicity:**

☐ Unknown ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to State

***In Poverty?:**

☐ No ☐ Yes ☐ Don't Know ☐ Declined to State

Approximate household income: $_____ per ☐ month ☐ year

(Refer to Poverty Guidelines for Older Americans Act and Older Californians Act Programs to determine Poverty Status)

***Living Arrangement (Lives Alone?):**

☐ No ☐ Yes ☐ Don't Know ☐ Declined to State

# of household members: _____

***Rural Area (Is Rural?):**

☐ No ☐ Yes ☐ Don't Know ☐ Declined to State

***Employment Status:**

☐ Full Time ☐ Part Time ☐ Retired

☐ Unemployed ☐ Declined to State

***Ethnic Race:**

☐ 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:

☐ 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?

Prioritization:

***Nutritional Assessment:**	Circle if yes	Comments
Have you made any changes in lifelong eating habits because of health problems?	2	☐
Do you eat fewer than 2 meals per day?	3	☐
Do you eat fewer than 5 servings (1/2 cup each) of fruits or vegetables every day?	1	☐
Do you eat less than 2 servings of dairy products (such as milk, yogurt, or cheese) every day?	1	☐
Do you have __biting, __chewing, or __swallowing problems that make it difficult to eat?	2	☐
Do you sometimes not have enough money to buy food?	4	☐
Do you eat alone most of the time?	1	☐
Do you take 3 or more different prescribed or over-the-counter drugs per day (aspirin, herbs, laxatives, etc.)?	1	☐
Without wanting to, have you lost or gained 10 pounds in the past 6 months?	2	☐
Are you not always physically able to __shop, __cook, and/or __feed yourself (or to get someone to do it for you)?	2	☐
Do you have 3 or more drinks of beer, liquor or wine almost every day?	2	☐
☐ Declined to State **Total Score Today:** (0-2: low risk; 3-5 moderate risk: 6 or more high risk)		

	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?	☐	☐	

Referral(s) Made:

☐ Nutritional education/counseling for at risk client

☐

☐

☐

Notes:

Staff Completing Assessment

Date