HOME DELIVERED MEAL ASSESSMENT

Name (First, MI, Last):

Date of Assessment:

Residential Address (Fire No. & Street):

Date of Birth (month/day/year)**:**
/ /

City/State/Zip:

Gender:
❒ Male ❒ Female

Mailing Address (if different from resident/street address):

Telephone Number:

City/State/Zip:

Email Address:

Race:

❒ American Indian/Native Alaskan
❒ Asian
❒ Black/African American
❒ Hispanic
❒ Native Hawaiian/Pacific Islander
❒ White (non-Hispanic)
❒ Other_____

Ethnicity:

❒ Hispanic or Latino
❒ Not Hispanic or Latino

Living Arrangement:

Lives Alone
❒ Yes ❒ No

Marital Status:

❒ Single ❒ Married ❒ Widowed ❒ Divorced
❒ Life Partner ❒ Other_____

Income Status:

Is your income below the following Federal Income Guidelines?
❒ Yes ❒ No

# in Home	Month	Year
1	$1,012	$12,140
2	$1,372	$16,460
3	$1,732	$20,780
4	$2,092	$25,100

ACTIVITIES OF DAILY LIVING (ADLs) and INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

Check each ADL that you/the client have/has difficulty in completing or need help with:

	No	**Yes**
Getting in and out of the bath or shower or preparing the bath, washing and drying	____	____
Dressing and undressing	____	____
Completing toilet activities and personal care	____	____
Getting in and out of bed or a chair	____	____
Using utensils and eating without help	____	____
Walking up and down a flight of stairs or walking without assistance	____	____
TOTAL Number of Yes ADLS		____

Check each IADL that you/the client have/has difficulty in completing or need help with:

	No	**Yes**
Preparing own meals	____	____
Medication management	____	____
Handling bill paying, banking, etc	____	____
Doing heavy housework and outside chores	____	____
Doing light housework	____	____
Shopping for personal items and/or groceries	____	____
Traveling in a van, taxi, bus or car	____	____
Answering the telephone or calling out on the telephone	____	____
TOTAL Number of Yes IADLS		____

Privacy Statement: "The information you are being asked to provide is needed to determine if you are eligible to receive Older Americans Act Services and to comply with federal reporting requirements. This information will be stored in a secure electronic database and will not be used for any other purpose. Your information will not be shared with another agency without your permission. This information will not be sold to anyone. You have the right to review your electronic record and request changes to assure accuracy. You will not be denied most services if you refuse to provide this information. If you have questions regarding this, please ask the aging unit staff."

Nutrition Risk Screening Questions	No	Yes
I have an illness or condition that made me change the kind and/or amount of food I eat.	0	2
I eat fewer than 2 meals a day.	0	3
I eat few fruits or vegetables or milk products.	0	2
I have three or more drinks of beer, liquor or wine almost every day.	0	2
I have tooth or mouth problems that make it hard for me to eat.	0	2
I don't always have enough money to buy the food that I need.	0	4
I eat alone most of the time.	0	1
I take 3 or more different prescribed or over-the-counter drugs daily.	0	1
Without wanting to, I have lost or gained 10 pounds in the last six months.	0	2
I am not always able to physically shop, cook and/or feed myself.	0	2

Risk Level: ___ 0-2 Low ___ 3-5 Moderate ___ 6+ High TOTAL ____

Reason(s) meals are needed:

- ☐ Individual is frail and essentially homebound by reason of illness, disability, or isolation.
- ☐ Spouse or domestic partner of a person eligible for a HDM and his/her participation is in the best interest of the homebound older individual.
- ☐ Individual is an underage disabled individual who resides at home with an eligible older individual participating in the program.
- ☐ Individual is unable to leave his or her home under normal circumstances.
- ☐ Individual is unable to participate in the congregate meals program because of physical or emotional problems.
- ☐ Individual is unable, either physically or emotionally, to obtain food and prepare adequate meals.
- ☐ Other: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Email: _____

Program Contributions

- ☐ Participant would like a contribution letter mailed to his/her home.
- ☐ Participant will make contributions directly. Do NOT mail a contribution letter.
- ☐ Someone else who will be contributing on his/her behalf for meals. Send contribution letter to:

  Name: _____

  Address: _____

  Phone: _____ Email: _____

Date of Referral: _____ **Person/Agency Making Referral:** _____

Requested start date: _____

Reassessment due: _____

Allergies or Special Dietary Needs: _____

Meals approved for:

- ☐ **6 months**
- ☐ **1 year**
- ☐ **Other:** _____

Concerns to follow up on: _____

Person Conducting Assessment: _____ **Date:** _____