(06/05/2018)

HOME DELIVERED MEALS ASSESSMENT

Date_____

Name_____ Address_____ Phone_____

Physician_____ Phone_____

Major medical problems_____

Emergency contact_____ Phone_____

Date of Birth_____ or Age_____ Gender (circle): M F

Lives alone…Yes No Limited English…Yes No Low-income…Yes No Race: _____

INDICATORS OF NEED
(Circle reason for eligibility)

Homebound / Isolated
Temporary illness
Mental impairment
Physical limitation
Medical Issue
Other_____

OTHER INDICATORS

Able to cook	Yes	No
Able to feed self	Yes	No
Able to grocery shop	Yes	No
Uses community resources	Yes	No
Enough money to buy food	Yes	No
Has family assistance	Yes	No
Confused / Variable	Yes	No

CHECK DETERMINATION

Approved
If approved, is it temporary…Yes No
If temporary, enter planned date for re-determination below, next to "Assessed by:"_____
NOT Approved
STOP here if **NOT** approved

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Dietary restrictions:_____

If dietary restrictions, is medical authorization needed: Yes No

How are other meals prepared? (CCP/family)_____

What indicators are there for more than 1 hot meal per week:

DONATION METHOD
Cash____ Check____ Food Stamps____
Freq: Daily____ Wkly____ Monthly_____
By: Mail___ Pickup___ Other_____
Suggested donation explained: Yes No

Is it in the best interest of client for the spouse/disabled dependent to receive home delivered meals, also: Yes No

Does client know of someone who will deliver meal if meal provider can't? Yes No If yes, who? _____

Meals needed _____days a week. (# hot_____, # frozen_____)

Add need for other referrals in comments below.

OTHER INFORMATION (check their kitchen)

Stove / oven work?	Yes	No
Refrigerator works?	Yes	No
Has freezer space?	Yes	No
Can reheat cold / frozen meals?	Yes	No
If yes, circle: stove oven microwave		
Can open containers?	Yes	No
Can store food properly?	Yes	No
Can dispose empty containers?	Yes	No

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Comments and directions to home:_____

Assessed by:_____ Next assessment date_____

Agency:_____

Date meal delivery to begin/requested:_____

(06/05/2018)

NUTRITIONAL HEALTH

Participant's Name_____ Date_____

Address_____ City_____ County_____

The following is required **ANNUALLY FOR ALL** *Family Café Meal* and *HDM* participants and all **NEW** *In-Home Respite* and *All Day Club* participants.

Send this completed form to the Egyptian Area Agency on Aging.

Read the statements below. Circle the number under the column for answer that applies. Total the nutritional risk score at the bottom.

Nutritional Health Statement - Circle "Yes," "No," or check "No Answer."	**Yes**	**No**
1. I have an illness or condition that made me change the kind and/or amount of food I eat.	2	0
2. I eat fewer than 2 meals a day.	3	0
3. I eat few fruits & vegetables or milk products.	2	0
4. I have 3 or more drinks of beer, liquor, or wine almost every day.	2	0
5. I have tooth or mouth problems that make it hard for me to eat.	2	0
6. I don't always have enough money to buy the food I need.	4	0
7. I eat alone most of the time.	1	0
8. I take 3 or more different prescribed or over-the-counter drugs a day.	1	0
9. Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2	0
10. I am not always physically able to shop, cook, and/or feed myself.	2	0
TOTAL (0-21)		

Total Nutritional Score	Meaning of the score
0 - 2	**Good!** Recheck your nutritional score annually.
3 - 5	**Moderate nutritional risk –** See what can be done to improve eating habits and lifestyle. We recommend rechecking your nutritional score in 3-6 months.
6+	**High nutritional risk –** Show a copy of this form the next time you see your doctor, dietician, or other qualified health professional. Talk with them about any health problems you may have. Ask them for help to improve your nutritional health score.

Remember that warning signs suggest risk, but do not represent diagnosis of any condition.