State of Illinois
Illinois Department on Aging

Nutrition Referral for Home Delivered Meals

Emergency Need: ☐ Yes ☐ No

This form must be completed and forwarded to the appropriate Home Delivered Meal nutrition provider agency.

Currently receiving home delivered meals from another source: ☐ Yes ☐ No

Days Older Adult to receive meals (check all that apply): ☐ M ☐ T ☐ W ☐ R ☐ F ☐ All M-F ☐ Weekend ☐ 2nd Meals

Type of meal(s): ☐ Hot ☐ Cold ☐ Frozen

Special Notes: Addt'l Notes

Older Adult Demographic Information

Name: Authorized Rep:

Address: City:

State: Phone Number: Rep Phone Number:

Date of Birth: Gender: ☐ Male ☐ Female ☐ Other

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Legally Separated ☐ Domestic Partner

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race:
☐ White Non-Hispanic
☐ White Hispanic
☐ American Indian or Alaskan Native
☐ Asian
☐ African American
☐ Native Hawaiian or Pacific Islander
☐ Other Race
☐ Two or More Races

Limited English Speaking: ☐ Yes ☐ No

If yes, primary language spoken: _____

Below Poverty Line: ☐ Yes ☐ No

Monthly Income:

Type of Housing: ☐ Home ☐ Apartment

Subsidized Housing: ☐ Yes ☐ No

Lives Alone: ☐ Yes ☐ No

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

Six or more points = High nutritional risk **COMBINED TOTALS: 0 /21 possible**

Impairment/Problem with Activity of Daily Living 0 – no assist; 1 – min; 2 – mod; 3 – max; 4 – unknown	Pts	Y/N	Impairment/Problem with Instrumental Activities of Daily Living 0 – no assist; 1 – min; 2 – mod; 3 – max; 4 – unknown	Pts	Y/N
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		
Totals	0		**Totals**	0	
Total "Yes": 0 / Total "No": 0			**Total "Yes": 0 / Total "No": 0**		

Print Save Clear Form

Major Health Problems (check all that apply)

Ambulation	☐ Full	☐ Partial	☐ Assisted	☐ Bedfast
Vision:	☐ Full	☐ Limited	☐ Glasses	☐ Blind
Hearing:	☐ Full	☐ Hard of Hearing	☐ Hearing Aid	☐ Deaf

Other major health concerns (describe): **More**

Determination of Need (DON) score:

Additional Nutrition Information

Who does the grocery shopping?

How often:

Can Older Adult feed self? ☐ Yes ☐ No

If no, who assists? _____

What type of help: ☐ Cutting ☐ Puree ☐ Feeding

Is anyone available to prepare food? ☐ Yes ☐ No

If yes, who? _____ What days? _____ Which meals? _____

Does Older Adult have any of these difficulties with: (check all that apply)

☐ Swallowing ☐ Indigestion
☐ Heartburn ☐ Vomiting
☐ Diarrhea ☐ Constipation

Usually how much of each meal does the Older Adult eat? (check one)

☐ Under 25% ☐ 25% ☐ 50% ☐ 75% ☐ Over 75%

How is the Older Adult's appetite in general? (check one)

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Older Adult's kitchen facilities/equipment: (check all that apply)

☐ Kitchen ☐ Kitchen privileges
☐ Stove ☐ Microwave
☐ Refrigerator ☐ Freezer /available space

Is Older Adult able to use these appliances unsupervised? (check all that apply)

☐ Stove ☐ Microwave ☐ Refrigerator ☐ Freezer

Older Adult food source for the weekends

Special Diet Needs: ☐ General ☐ Diabetic

Condition of the home: ☐ Good ☐ Poor

If poor, specify: _____

Dietary restrictions:

Food allergies:

Reason 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)

☐ Meals will increase nutritional intake as Older Adult has limited income
☐ Older Adult has difficulty cooking, tires easily
☐ Older Adult is recovering from surgery, illness, etc.
☐ Other (specify) _____

Duration of meals: (check one) ☐ Short term ☐ Long term

Other Contacts Information

Physician Name:		Physician Phone:
Emergency Contact Name:	Home Phone:	Cell Phone:
Address:	City:	State:
Emergency Contact Name:	Home Phone:	Cell Phone:
Address:	City:	State:

AUTHORIZATION OF RELEASE OF INFORMATION

I give permission to _____, to send a copy of this assessment form to the Home Delivered Meal Provider, _____, and to discuss my needs with the Provider and/or the AAA.

Older Adult Signature:_____ Date:

I certify that this participant meets eligibility criteria for Home Delivered Meals under the Older Americans Act.

Case Manager Name:	Phone:
Organization:	Email:
Signature:	Date:

HDM start date:	Reassessment date:	Termination date:

Driver Instructions: (check all that apply) ☐ Ring bell ☐ Knock loudly ☐ Beware of dog(s) ☐ Other _____

Print **Save** **Clear Form**