Home Delivered Meal Assessment 2018-2019

Date of Home Visit:	**Assessor:**	**Site:**
Referred By: ☐Self ☐Other:	**Reason for Referral:**	☐**Initial Assessment** ☐**Reassessment**
Name:		**DOB:**
Gender: ☐Female ☐Male **Client Live Alone?** ☐Yes ☐No	**Client Race:** ☐American Indian/Native American ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐Non-Minority (White, non-Hispanic) ☐White – Hispanic ☐Other:	**Client Ethnicity:** ☐Hispanic or Latino ☐Not Hispanic or Latino
Low Income: ☐Yes ☐No ☐Single Person – Under $1,012/month or Under $12,060/year ☐Two Person – Under $1,372/month or Under $16,240/year ☐Three Person – Under $1,702/month or Under $20,420/year ☐Four Person – Under $2,050/month or Under $24,600/year		**Marital Status:** ☐Single ☐Married ☐Widowed ☐Divorced ☐Life Partnered ☐Other:
Address:	**Mailing Address if Different:**	**Phone:** Home: Cell: E-mail:

Nutrition Risk Assessment:

☐No ☐Yes – I have an illness or condition that made me change the kind and/or amount of food I eat
☐No ☐Yes – I eat fewer than 2 meals a day
☐No ☐Yes – I eat few vegetables or milk products
☐No ☐Yes – I have three or more drinks of beer, liquor or wine almost every day
☐No ☐Yes – I have tooth or mouth problems that make it hard for me to eat
☐No ☐Yes – I don't always have enough money to buy the food that I need
☐No ☐Yes – I eat alone most of the time
☐No ☐Yes – I take 3 or more different prescribed or over-the-counter drugs daily
☐No ☐Yes – Without wanting to, I have lost or gained 10 pounds in the last 6 months
☐No ☐Yes – I am not always able to physically shop, cook and/or feed myself

Activities of Daily Living:

☐No ☐Yes – I have difficulty getting in and out of the bath or shower or preparing a bath, washing and drying
☐No ☐Yes – I have difficulty dressing and undressing
☐No ☐Yes – I have difficulty completing toilet activities and personal care
☐No ☐Yes – I have difficulty getting in and out of a bed or chair
☐No ☐Yes – I have difficulty using utensils and eating without help
☐No ☐Yes – I have difficulty walking up and down a flight of stairs or walking without assistance

Instrumental Activities of Daily Living

☐No ☐Yes – I have difficulty preparing my own meals
☐No ☐Yes – I have difficulty with medication management
☐No ☐Yes – I have difficulty handling bill paying, banking, etc.
☐No ☐Yes – I have difficulty doing heavy housework and outside chores
☐No ☐Yes – I have difficulty doing light housework
☐No ☐Yes – I have difficulty shopping for personal items and/or groceries
☐No ☐Yes – I have difficulty traveling in a van, taxi, bus or car
☐No ☐Yes – I have difficulty answering the phone or calling out on the telephone

Homebound Reason: Please see decision tree

☐ - Individual is frail and essentially homebound
☐ - Partners service is in the best interest of the client
☐ - Non-Elderly disabled individual residing with an eligible participant
☐ - Inability to participate in Congregate Meals program (referral from Aging Program Supervisor)
☐ - Other health problem/reason

Emergency Contact:

#1 Name:	#2 Name:
#1 Relationship:	#2 Relationship:
#1 Phone:	#2 Phone:

Program Contributions:

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

Dietary Needs: *It is not a guarantee that the Nutrition Program can meet any or all dietary needs or restrictions.*
Allergies: ☐No ☐Yes:
Special Dietary Needs:

Managed Care Organization/IRIS Contact Information:
Care Manager Name:
Care Manager Phone:
Care Manager E-mail:

Emergency Preparedness:

☐Yes ☐No – Do you have at least 3 days of food at home?
☐Yes ☐No – During an extended power outage do you have family or friends you could stay with?
☐Yes ☐No – Do you have A/C in the summer and adequate heat in the winter?

Special Considerations:		**Pets:**
☐Vision Impairment	☐Hearing Impairment	☐ Cat(s)
☐Uses Oxygen	☐Wheelchair Bound	☐Dog(s)
☐Walker/Cane	☐Confusion/Disoriented	☐Other:
☐Lifeline		

Comments:

By signing this assessment, I understand that the Waupaca County Elderly Nutrition Program may contact the Emergency Contact individuals I listed in the event of an emergency. I give them permission to update my Emergency Contacts listed in the event I have experienced an emergency.

____________________________________ Date:________________________
(Signature of Participant/Legal Guardian)

Administrative Use Only:

☐Eligible
☐Ineligible Reason:

Services Offered:

☐Congregate Dining ☐Transportation ☐Options Counseling ☐Food Pantry ☐Other: