

HOME DELIVERED MEAL REGISTRATION

Name (First, MI, Last):		Date of Registration:																
Residential Address (Fire No. & Street):		Date of Birth (month/day/year): / /																
City/State/Zip:		Phone Number (with area code):																
Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Self-Describe (specify): _____ -----	Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other: _____ -----	Household: <input type="checkbox"/> I live alone. <input type="checkbox"/> I live with others. ----- Income Status: Is your income at or below the following guidelines? <input type="checkbox"/> Yes <input type="checkbox"/> No <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"># in Home</th> <th style="text-align: left;">Month</th> <th style="text-align: left;">Year</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>\$1,215</td> <td>\$14,580</td> </tr> <tr> <td>2</td> <td>\$1,643</td> <td>\$19,720</td> </tr> <tr> <td>3</td> <td>\$2,072</td> <td>\$24,860</td> </tr> <tr> <td>4</td> <td>\$2,500</td> <td>\$30,000</td> </tr> </tbody> </table>		# in Home	Month	Year	1	\$1,215	\$14,580	2	\$1,643	\$19,720	3	\$2,072	\$24,860	4	\$2,500	\$30,000
# in Home	Month	Year																
1	\$1,215	\$14,580																
2	\$1,643	\$19,720																
3	\$2,072	\$24,860																
4	\$2,500	\$30,000																
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Hmong <input type="checkbox"/> Other: _____	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino																	

Activities of Daily Living (ADLs) Check Yes for each ADL that you/the client <i>need substantial assistance</i> to complete (including verbal reminding, physical cuing, or supervision). Check No for each ADL you <i>can</i> complete without substantial assistance.	No Help Needed	Yes, Needs Help
Bathing: Gets in and out of the bath or shower, uses faucets, washes, and dries oneself safely.		
Dressing: Dresses and undresses safely.		
Toileting: Uses toilet and cleans oneself.		
Transferring: Moves in and out of bed or chair.		
Feeding: Gets food or drink from plate, bowl, or cup into mouth and uses utensils.		
Continence: Exercises complete self-control.		

TOTAL Number of Yes ADLs _____

Instrumental Activities of Daily Living (IADLs) Check Yes for each IADL that you/the client <i>need substantial assistance</i> to complete (including verbal reminding, physical cuing, or supervision). Check No for each IADL you <i>can</i> complete without substantial assistance.	No Help Needed	Yes, Needs Help
Food Preparation: Plans, prepares, and serves adequate meals independently.		
Shopping: Takes care of all shopping needs independently.		
Medication Management: Takes medication in correct dosages at correct time.		
Ability to Manage Finances: Handles financial matters and/or day-to-day purchases.		
Housekeeping: Participates in housekeeping tasks.		
Laundry: Launders some items independently.		
Mode of Transportation: Travels unassisted via personal vehicle, public transportation, or taxi.		
Ability to Use Telephone: Dials and/or answers the telephone.		

TOTAL Number of Yes IADLs _____

PLEASE SEE OTHER SIDE

Nutrition Risk	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 per day.	0	3
I eat few fruits or vegetables or milk products.	0	2
I have 3 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 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 a day.	0	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	0	2
I am not always physically able to shop, cook, and or feed myself.	0	2

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

TOTAL _____

For each of the following statements, please tell me which one is “often true,” “sometimes true” or “never true” for the past 12 months.	Often True	Sometimes True	Never True
1. We (I) worried whether our food would run out before we (I) got money to buy more.	<input type="checkbox"/> Yes*	<input type="checkbox"/> Yes*	<input type="checkbox"/> Yes
2. The food that we (I) bought just didn't last and we (I) didn't have money to get more.	<input type="checkbox"/> Yes*	<input type="checkbox"/> Yes*	<input type="checkbox"/> Yes

<p>1. Have you recently lost weight without trying?</p> <p><input type="checkbox"/> No (0) <input type="checkbox"/> Unsure (2) <input type="checkbox"/> Yes</p> <p>If yes, how much weight have you lost?</p> <p><input type="checkbox"/> 2-13 pounds (1) <input type="checkbox"/> 14-23 pounds (2) <input type="checkbox"/> 24-33 pounds (3) <input type="checkbox"/> 34 pounds or more (4) <input type="checkbox"/> Unsure (2)</p> <p>2. Have you been eating poorly because of a decreased appetite?</p> <p><input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1)</p>

Weight loss score: ___ Appetite Score: ___ MST Score (Total): ___

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.”

PLEASE SEE SECOND SHEET

Reason(s) home-delivered meals are needed (check all that apply):

- 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 participation is in the best interest of the homebound older individual.
- Adult under age 60 with a disability and resides at home with an eligible older individual participating in the program.
- Individual is unable to leave home under normal circumstances.
- Individual is unable to participate in the congregate meals program because of physical or emotional problems.
- No spouse, domestic partner, or other adult living in same household who is both willing and able to prepare meals.
- 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 home.
- Participant will make contributions directly. Do NOT mail a contribution letter.
- Someone else who will be contributing on behalf for meals. Send contribution letter to:

Name: _____

Address: _____

Phone: _____ Email: _____

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

Requested start date: _____

Meals approved for:

Reassessment due: _____

6 months

Allergies or Special Dietary Needs: _____

1 year

Other: _____

Concerns to follow up on: _____

Person Conducting Assessment: _____ Date: _____