Senior Nutrition Program HOME DELIVERED Meals (C2) – Client Intake Form FY2017-18

CONFIDENTIAL

PROVIDER LOCATION: ______________________________

TO RECEIVE HOME DELIVERED MEALS: Person must be aged 60 or older, homebound due to illness or disability, unable to prepare his/her own meals, unable to drive and unable to attend a congregate meal site if transportation were provided. There is no charge for meals, however, donations are accepted. A person will not be denied services if he/she chooses not to donate.

Date:		Phone:		Birth Date: *(Required)*	
Last Name:		First Name: *(No nicknames)*			

APPLICANT ELIGIBILITY	YES	NO	NOTE:
Is applicant homebound due to illness or disability?*			* If answer is NO, stop here, applicant is not eligible for home-delivered meals.
Is applicant 60 or older, and/or the spouse/full-time caregiver of an eligible senior?*			
Is applicant able to prepare meals?**			**If answer is YES, stop here; applicant is not eligible for home-delivered meals.
Does applicant drive?**			
Can applicant attend a congregate meal site if transportation is provided?**			

Street Address:

City:		ZIP:		RURAL: (91307, 93066, 93040)	☐ Yes ☐ No ☐ Declined to State

MARITAL STATUS: ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Declined to State

RACE - PLEASE CHOOSE (✓) ONE:

☐ American Indian or Alaska Native	☐ Guamanian	☐ Other Asian
☐ Asian Indian	☐ Hawaiian	☐ Other Pacific Islander
☐ Black or African American	☐ Japanese	☐ OTHER RACE – Includes Hispanic /Latino
☐ Cambodian	☐ Korean	☐ Samoan
☐ Chinese	☐ Laotian	☐ Vietnamese
☐ Filipino	☐ Multiple Race	☐ White ☐ Declined to State

Ethnicity:	☐ Not Hispanic/Latino ☐ Hispanic/Latino	Gender:	☐ Female ☐ Male ☐ Transgender Woman ☐ Declined to State ☐ Transgender Man
Veteran Status:	☐ Yes ☐ No	Client Lives:	☐ Alone ☐ Not Alone
Preferred Language:		Number of Persons Living in Household:	

APPLICANT'S INCOME LEVEL (approximate):		LOCAL EMERGENCY CONTACT:
IF MARRIED: ☐ At or below Federal Poverty Level *(at or below $16,240/year)* ☐ Above Federal Poverty Level *(at or above $16,241/year)* ☐ Declined to State	**IF SINGLE:** ☐ At or below Federal Poverty Level *(at (or below $12,060/year)* ☐ Above Federal Poverty Level *(at or above $12,061/year)* ☐ Declined to State	NAME: ____________ PHONE: ____________

ABOUT THE APPLICANT:	YES	NO	COMMENTS:
Any dietary restrictions? (If yes, explain)			
A working refrigerator?			
Freezer space to store five (5) frozen meals?			
A working oven/microwave?			
Physically and mentally able to reheat a meal?			
Interested in weekend meals, if available?			
Applicant is: ☐ Blind ☐ Deaf Applicant uses: ☐ Walker ☐ Wheelchair ☐ Cane			

NUTRITIONAL ASSESSMENT OF APPLICANT:		CHECK ALL THAT APPLY
I have an illness or condition that made me change the kind and/or amount of food I eat.	(2pts)	☐
I eat fewer than 2 meals per day.	(3pts)	☐
I eat few fruits or vegetables or milk products.	(2pts)	☐
I have 3 or more drinks of beer, liquor or wine almost every day.	(2pts)	☐
I have tooth or mouth problems that make it hard for me to eat.	(2pts)	☐
I don't always have enough money to buy the food I need.	(4pts)	☐
I eat alone most of the time.	(1pt)	☐
I take 3 or more different prescribed or over-the-counter drugs a day.	(1pt)	☐
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	(2pts)	☐
I am not always physically able to shop, cook and/or feed myself.	(2pts)	☐
(If equal to or greater than 6, the client is at high nutritional risk→)	**Total Score:**	
	Declined to State:	☐

CALIFORNIA ACTIVITIES & INSTRUMENTAL ACTIVITIES (IADLS) OF DAILY LIVING (ADLS)
➔ PLEASE CHECK (✓) ONE OF THE COLUMNS FOR EACH ACTIVITY 🡸

	TYPE OF ASSISTANCE NEEDED TO PERFORM TASK ➔	**1 - INDEPENDENT** Needs No Help	**2- VERBAL QUE** Needs verbal reminders	**3 – STAND BY** Needs some human help	**4 – HANDS ON** Needs lots of human help	**5 – DEPENDENT** Cannot perform task	**Declined to State**
ADLS	**Eating**						
	Dressing						
	Transferring						
	Bathing						
	Toileting						
	Walking						
IADLS	**Light Housework**						
	Shopping/Errands						
	Meal Prep/Cleanup						
	Transportation						
	Using Telephone						
	Managing Medications						
	Managing Money						
	Heavy Housework						

I certify that all statements on this form are true and correct → ____________________
Applicant's Signature

DO NOT WRITE IN THIS BOX – OFFICIAL USE ONLY	
Client Care Access (Q) Database Number:	☐ Senior ☐ Non-Senior
Care Plan:	Type of Meals: ☐ Hot ☐ Frozen