

OAA Congregate Meals

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I. General Information

I.A. Assessment Information (Date, type, etc.)

1. What is the date of the assessment?

____/____/____

2. Specify the type of assessment, or the reason for the assessor

- Initial assessment
 Reassessment

3. What is the date of the client's next assessment?

____/____/____

4. What is the name of the person conducting this assessment?

5. What is the name of the agency the assessor works for?

8. What is the Termination Date?

____/____/____

9. What are the reasons for Termination?

- Client Relocated
 Client Request
 Death
 Hospitalization
 Independence
 Nursing Home
 Other

4. Enter the age of the client in years.

5. What is the client's gender?

- Male
 Female

6. Enter the client's telephone number.

7.a. Enter the client's mailing street address or Post Office box.

7.b. Enter the client's mailing city or town.

7.c. Enter the client's mailing state.

7.d. Enter the client's mailing ZIP code.

8.a. Enter the client's residential street address or Post Office box.

8.b. Enter the client's residential city or town.

9. Describe how to get to the client's home.

I.C. Contact Information

1.a. Name of Friend or Relative (other than Spouse/Partner) to call

1.b. Relationship of Friend or Relative (other than Spouse/Partner)

1.c. Work Telephone Number of Friend or Relative (other than Spouse/Partner)

1.d. Home Telephone Number of Friend or Relative (other than Spouse/Partner)

2.a. What is the name of the client's primary care physician?

2.b. What is the work phone number for the client's primary care physician?

5.a. What is the name of the client's guardian?

5.b. Enter the work phone number of the client's guardian.

5.c. Enter the home phone number of the client's guardian.

II. Demographics

II.A. Demographics and Indicators (Incl. ethnicity, poverty, etc.)

1. What is the client's ethnicity?

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown

1.a. Enter the client's self-described ethnic background.

2. What is the client's race?

- American Indian/Native Alaskan
- Asian
- Black/African American
- Native Hawaiian/Other Pacific Islander
- Non-Minority (White, non-Hispanic)
- Other
- White-Hispanic

3. Specify the client's primary language.

- English
- French
- German
- Italian
- Spanish
- Other

4. Select the client's current marital status.

- Single
- Married
- Separated
- Widowed
- Divorced
- Unavailable

4.a. What is the name of the client's spouse/partner?

5. Indicate the type of residence that the client currently resides in

- House
- Private apartment
- Private apartment in senior housing
- Nursing home
- Unavailable

Other

6. Does the client own or rent his/her residence?

- Other
- Own
- Rent
- Unknown

7. Select the client's current living arrangement.

- Lives Alone
- With spouse/partner
- Lives with spouse and child
- With child/children
- Other

8. Does the client reside in a rural area?

- No
- Yes

9. Is the client's income level below the national poverty level?

- No
- Yes

10. Is the client socially isolated?

- No
- Yes

III. Nutrition Information

III.A. Nutrition

1. What is the client's idea of his/her appetite?

- Don't know
- Fair
- Good
- Poor

2. Is the client on any special diets for medical reasons?

- No
- Yes

3. Describe the client's special diet(s).

4. Does the client have trouble eating well due to other problems?

- No
- Yes

5. Describe the client's other problems that keep him/her from eating.

- Don't know
- No
- Yes

6. Does the client have trouble eating well due to problems with chewing?

- No
- Yes

7. Does the client eat alone most of the time?

- Don't know
- No
- Yes

8. Without wanting to, has the client lost or gained 10 pounds in the last 6 months?

- Don't know
- No
- Yes
- Yes, gained 10 pounds
- Yes, lost 10 pounds

9. Is the client not always physically able to shop, cook and/or feed himself/herself?

- Don't know
- No
- Yes

10. Does the client have 3 or more drinks of beer, liquor or wine alcohol per week?

- Don't know
- No
- Yes

11. Does the client take 3 or more different prescribed or over-the-counter medications?

- Don't know
- No
- Yes

III.A-1. Nutrition Screening Checklist

1. Has the client made any changes in lifelong eating habits because of illness or disability?

- Don't know
- No
- Yes

2. Does the client eat fewer than 2 meals per day?

- No
- Yes

3. Does the client eat fewer than five (5) servings (1/2 cup each) of fruits and vegetables per day?

- No
- Yes

4. Does the client eat fewer than two servings of dairy products (such as milk, cheese, or yogurt) per day?

- No
- Yes

5. Does the client sometimes not have enough money to buy food?