HOME-DELIVERED MEAL PROGRAM ASSESSMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGING SERVICES
SFN 480 (5-2023)

Clear Fields

Complete this form to the best of your ability.

Date of Assessment	First Name	Middle Initial	Last Name

Date of Birth	Gender
	☐ Female ☐ Male

Gender Identity
☐ Female ☐ Male ☐ Non-Binary ☐ Non-Disclosed ☐ Transgender-Female ☐ Transgender-Male ☐ Other

Residential Address	City	State	ZIP Code

Mailing Address	City	State	ZIP Code

County	Telephone Number (include area code)	Emergency Contact Name and Phone Number

Ethnicity	Race (check one)
☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown	☐ White ☐ White-Hispanic ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan ☐ Native Hawaiian/Pacific Islander

Primary Language	Lives Alone	Income Below Poverty
☐ English ☐ Other	☐ Yes ☐ No	☐ Yes ☐ No

Is the older individual a spouse or dependent disabled child of an eligible home-delivered consumer?
☐ Yes ☐ No

Individual Eligibility Category (If not a spouse or disabled child; check any/all that apply)
- ☐ Congregate older individual requesting home-delivered meals due to short-term illness
- ☐ Older individual has limited physical mobility
- ☐ Older individual is unable to tolerate a group situation due to physical or mental disability or substance abuse
- ☐ Older individual lives in a remote geographic location where no congregate meal site exists
- ☐ Older individual lives in a remote geographic location that prohibits access due to transportation issues

Do you have ability to prepare frozen meals?	Do you have freezer space to store frozen meals?
☐ Yes ☐ No	☐ Yes ☐ No

NUTRITION SCREENING CHECKLIST

1. Do you have an illness and/or condition that made you change the kind and/or amount of food you eat?	☐ Yes ☐ No
2. Do you eat <u>less than</u> 2 meals a day?	☐ Yes ☐ No
3. The majority of days do you eat <u>less than</u> 1 1/2 to 3 cups of fruits and/or vegetables?	☐ Yes ☐ No
4. The majority of days do you eat and/or drink <u>less than</u> 3-8 oz cups of dairy products (such as milk, yogurt or cheese) every day?	☐ Yes ☐ No
5. Do you have 3 or more drinks of alcohol almost every day?	☐ Yes ☐ No
6. Do you have any tooth and/or mouth problems that make it hard for you to eat?	☐ Yes ☐ No
7. Sometimes do you not have enough money to buy enough food?	☐ Yes ☐ No
8. Do you eat alone most of the time?	☐ Yes ☐ No
9. Do you take 3 or more prescriptions or over-the-counter medications per day?	☐ Yes ☐ No
10. Without wanting to, have you lost and/or gained 10 pounds in the last 6 months?	☐ Yes ☐ No
11. Are you sometimes <u>not</u> physically able to shop, cook, and/or feed yourself?	☐ Yes ☐ No

ACTIVITIES OF DAILY LIVING

1. What is your ability to bathe/shower yourself? ☐ Independent ☐ Requires Assistance	2. What is your ability to dress yourself? ☐ Independent ☐ Requires Assistance
3. What is your ability to use the restroom facilities on your own? ☐ Independent ☐ Requires Assistance	4. What is your ability to physically transfer on your own? ☐ Independent ☐ Requires Assistance
5. Do you have any bowel and bladder (incontinence) issues? ☐ Independent ☐ Requires Assistance	6. Are you able to feed yourself? ☐ Independent ☐ Requires Assistance

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

1. Can you use the telephone on your own? ☐ Independent ☐ Requires Assistance	2. Can you do your own shopping? ☐ Independent ☐ Requires Assistance
3. Are you able to prepare meals? ☐ Independent ☐ Requires Assistance	4. Can you do your own housework? ☐ Independent ☐ Requires Assistance
5. Can you do your own laundry? ☐ Independent ☐ Requires Assistance	6. Can you arrange your own transportation? ☐ Independent ☐ Requires Assistance
7. Can you manage your own medications? ☐ Independent ☐ Requires Assistance	8. Can you manage your money? ☐ Independent ☐ Requires Assistance

USE OF INFORMATION

The information that is provided on this form is for home-delivered meal assessment only. The information is used by the Department of Health and Human Services - Aging Services to create reports for the Federal Government and to help identify other services that may be beneficial such as the Nutrition Counseling. This information will ***not*** be released/shared with anyone other than the above-mentioned parties unless I sign a separate consent (Release of Information).

Name of Meal Site