HOME-DELIVERED MEAL PROGRAM REGISTRATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AGING SERVICES DIVISION
SFN 480 (8-2019)

Complete this form to the best of your ability.

Date of Assessment	First Name	Middle Initial	Last Name
Date of Birth	Gender ☐ Female ☐ Male ☐ Unknown/Other		Residential Address

Mailing Address	City	State	ZIP Code

County	Telephone Number (include area code)

Emergency Contact Name	Emergency Contact Telephone Number

Ethnicity
☐ Not Hispanic or Latino
☐ Hispanic or Latino
☐ Unknown

Race (check one)
☐ White ☐ White-Hispanic ☐ Black/African American
☐ Asian ☐ American Indian/Alaskan ☐ Native Hawaiian/Pacific Islander
☐ Other

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

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

Client Eligibility Category (If not homebound, spouse or disabled child; check any/all that apply)
☐ Congregate client requesting home-delivered meals due to short-term illness
☐ Client has limited physical mobility
☐ Client is unable to tolerate a group situation due to physical or mental disability or substance abuse
☐ Client lives in a remote geographic location where no congregate meal site exists
☐ Client 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. Have there been any changes in your eating habits because of health problems?	☐ Yes	☐ No	
2. Do you eat less than 2 meals a day?	☐ Yes	☐ No	
3. Do you eat less than 2 1/2 cups of fruits or vegetables every day?	☐ Yes	☐ No	
4. Do you eat or drink less than two 8 oz cups of dairy products (such as milk, yogurt or cheese) every day?	☐ Yes	☐ No	
5. Are there times when you don't have enough money to buy food?	☐ Yes	☐ No	
6. Does anything in your mouth make it hard to eat?	☐ Yes	☐ No	
7. Do you eat alone most of the time?	☐ Yes	☐ No	
8. Have you had any unexpected weight gain or loss of 10 pounds or more in the past 6 months?	☐ Yes	☐ No	☐ Don't know
9. Are there times when you are unable to shop, cook, feed yourself or find someone to assist you with these tasks?	☐ Yes	☐ No	☐ Don't know
10. Do you have 3 or more drinks of alcohol per day?	☐ Yes	☐ No	
11. Do you take 3 or more prescribed or over-the-counter medications per day?	☐ Yes	☐ No	

ACTIVITIES OF DAILY LIVING

1. In the past 7 days, how do you rate your ability to perform **BATHING** (shower, full tub or sponge bath exclude washing back or hair)? ☐ Independent ☐ Requires Assistance ☐ Total Dependence	2. In the past 7 days, how do you rate your ability to perform **DRESSING?** ☐ Independent ☐ Requires Assistance ☐ Total Dependence
3. In the past 7 days, how do you rate your ability to perform **TOILET USE**? ☐ Independent ☐ Requires Assistance ☐ Total Dependence	4. In the past 7 days, how do you rate your ability to **TRANSFER** (from bed to chair, w/chair to toilet)? ☐ Independent ☐ Requires Assistance ☐ Total Dependence
5. In the past 7 days, how do you rate your ability to **EAT** (feed self)? ☐ Independent ☐ Requires Assistance ☐ Total Dependence	6. In the past 7 days, how do you rate your ability to **WALK IN YOUR HOME?** ☐ Independent ☐ Requires Assistance ☐ Total Dependence

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

1. In the past 7 days, how do you rate your ability to prepare your own **MEALS?** ☐ Independent ☐ Requires Assistance ☐ Total Dependence	2. In the past 7 days, how do you rate your ability to **MANAGE** your own **MEDICATIONS?** ☐ Independent ☐ Requires Assistance ☐ Total Dependence
3. How do you rate your ability to **MANAGE** your own **MONEY?** ☐ Independent ☐ Requires Assistance ☐ Total Dependence	4. How do you rate your ability to do **HEAVY HOUSEWORK?** ☐ Independent ☐ Requires Assistance ☐ Total Dependence
5. How do you rate your ability to do **LIGHT HOUSEWORK?** ☐ Independent ☐ Requires Assistance ☐ Total Dependence	6. In the past 7 days, how do you rate your ability to **SHOP** for yourself? ☐ Independent ☐ Requires Assistance ☐ Total Dependence
7. In the past 7 days, how do you rate your ability to **MANAGE** your own **TRANSPORTATION** needs? ☐ Independent ☐ Requires Assistance ☐ Total Dependence	8. How do you rate your ability to use the **TELEPHONE?** ☐ Independent ☐ Requires Assistance ☐ Total Dependence

USE OF INFORMATION

The information that is provided on this form is for congregate meal registration purposes only. The information is used by the ND Department of Human Services - Aging Services Division 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