Participant Assessment Form (C-2 Home-Delivered Meals) Page 1 of 3

ppFor Staff Use Only	Participant ID (SAMS):	☐ Initial Assessment	☐ Reassessment
Assessment Date: (mm/dd/yyyy)		Reassessment Due: (Select Month)	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12
HDM Schedule	☐ Temporary ☐ Permanent	HDM Started: / HDM Terminated:	Meals Needed For: ☐Mon ☐Tue ☐Wed ☐Thu ☐Fri ☐Sat ☐Sun ☐Frozen _____
Service Eligibility: ☐Self (Aged 60/+ & homebound) ☐Spouse of qualified individual ☐Disabled and living with qualified individual			
Name of the Qualified Individual (for accompanying participant):			
Referral Source: ☐Family Member ☐ ☐Medical Professional ☐TV ☐Newspaper ☐Website ☐Other_____ ☐Decline		Name of Referral Source:	
Reason for Referral:			
Refrigeration & Heating Facilities in Place: ☐Y ☐N	Client's Mental Status: ☐Alert ☐Clear ☐Confused ☐Forgetful ☐Sad		

PLEASE PRINT

I. PERSONAL INFORMATION AND DEMOGRAPHICS

Enter in SAMS

1. Participant's Name: _____ (First) _____ (Last) _____ (Middle Initial)

2. Maiden Name/ AKA: _____ **3. Date of Birth:** _____ (mm/dd/yyyy)

4. Residential Address: _____ (Street) _____ (City/Town) _____ (Zip Code)

5. Mailing Address: _____ (Street) _____ (City/Town) _____ (Zip Code)

6. Home Number: ( ) - **Alternate Number:** ( ) -

7. Directions to Residence: _____

8. Rural? ☐No ☐Yes ☐Declined to state

9. Sex at Birth: ☐Female ☐Male ☐Decline to State

10. Gender: ☐Female ☐Male ☐Transgender Male to Female ☐Transgender Female to Male ☐Genderqueer/Gender Non-Binary ☐Declined to state ☐Not Listed/Other_____

11. Sexual Orientation: ☐Straight/Heterosexual ☐Bi-Sexual ☐Gay/Lesbian/Same-Gender Loving ☐Questioning/Unsure ☐Declined to state ☐Not Listed/Other_____

12. Race:
- ☐1. White
- ☐2. Native Am./Alaskan
- ☐3. Asian
- ☐4. Black/African American
- ☐5. Pacific Islander
- ☐6. Other Race
- ☐7. Declined to State

12(a). Nationality if Race is Asian or Pacific Islander:
- ☐30. Chinese
- ☐31. Japanese
- ☐32. Filipino
- ☐33. Korean
- ☐34. Vietnamese
- ☐35. Asian Indian
- ☐36. Laotian
- ☐37. Cambodian
- ☐38. Other Asian
- ☐50. Guamanian
- ☐51. Hawaiian
- ☐52. Samoan
- ☐53. Other Pacific Islander

13. Ethnicity: ☐Hisp. or Lat. ☐Not Hisp. or Lat. ☐Declined to state

14. In Poverty? ☐Don't know ☐No ☐Yes ☐Declined to state

15. I Live: ☐Not Alone ☐Unknown ☐Alone ☐Declined to state

16. Veteran: ☐Veteran ☐Not Veteran ☐Decline To State

$12,140/year or $1,012/month in 2018 for single-person household.
$16,460/year or $1,372/month in 2018 for two-person household.

17. Employment Status: ☐1. Full Time ☐2. Part Time ☐3.Retired ☐4. Unemployed ☐5. Declined to state

18. Relationship Status: ☐1. Single ☐2. Married ☐3. Domestic Partner ☐4. Separated ☐5. Divorced ☐6. Widowed ☐7. Declined to state

II. CONTACTS

	Name of Contact	Phone		
(1)			☐ Family/Relative ☐ Emergency Contact	☐ Caregiver/Helper ☐ Primary Physician
(2)			☐ Family/Relative ☐ Emergency Contact	☐ Caregiver/Helper ☐ Primary Physician
(3)			☐ Family/Relative ☐ Emergency Contact	☐ Caregiver/Helper ☐ Primary Physician

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III. ACTIVITIES OF DAILY LIVING ASSESSMENT

Enter in SAMS

***Instructions**: Rate ADLs and IADLs according to the scale at the right. ADLs and IADLs count one (1) each for adding the totals, unless the rating is "1". ADLs have a maximum total of "6", and IADLs have a maximum total of "8".*

Rating Scale

1 – Independent	4 – Lots of Human Help
2 – Verbal Assistance	5 – Dependent
3 – Some Human Help	6 – Declined to State

Activities of Daily Living (ADLs)

	ADLs	Rating
1.	EATING	☐1 ☐2 ☐3 ☐4 ☐5 ☐6
2.	BATHING	☐1 ☐2 ☐3 ☐4 ☐5 ☐6
3.	TOILETING	☐1 ☐2 ☐3 ☐4 ☐5 ☐6
4.	TRANSFERRING	☐1 ☐2 ☐3 ☐4 ☐5 ☐6
5.	WALKING	☐1 ☐2 ☐3 ☐4 ☐5 ☐6
6.	DRESSING	☐1 ☐2 ☐3 ☐4 ☐5 ☐6

Participant Total ADLs ☐

COMMENTS:

_____

_____

_____

_____

_____

Instrumental Activities of Daily Living (IADLs)

	ADLs	Rating
1.	MEAL PREPARATION	☐1 ☐2 ☐ ☐4 ☐5 ☐6
2.	SHOPPING	☐1 ☐2 ☐3 ☐4 ☐5 ☐6
3.	MEDICATION MANAGEMENT	☐1 ☐2 ☐3 ☐4 ☐5 ☐6
4.	MONEY MANAGEMENT	☐1 ☐2 ☐3 ☐4 ☐5 ☐6
5.	USING TELEPHONE	☐1 ☐2 ☐3 ☐4 ☐5 ☐6
6.	HEAVY HOUSEWORK	☐1 ☐2 ☐3 ☐4 ☐5 ☐6
7.	LIGHT HOUSEWORK	☐1 ☐2 ☐3 ☐4 ☐5 ☐6
8.	TRANSPORTATION	☐1 ☐2 ☐3 ☐4 ☐5 ☐6

Participant Total IADLs ☐

COMMENTS:

_____

_____

_____

_____

_____

_____

IV. NUTRITION RISK ASSESSMENT

Enter in SAMS

***Instructions:** Read the statements below and check "Yes" or "No". Add up the risk rating numbers of those checked "Yes" to get your nutrition score.*

☐ **DECLINED** TO GIVE INFORMATION REGARDING NUTRITIONAL RISK **(Check if declined.)**		**Risk Rating**
1. I have an illness or condition that made me change the kind and/or amount of food I eat.	☐ No ☐ Yes	2
2. I eat fewer than 2 meals per day.	☐ No ☐ Yes	3
3. I eat few fruits or vegetables, or milk products.	☐ No ☐ Yes	2
4. I have 3 or more drinks of beer, liquor or wine almost every day.	☐ No ☐ Yes	2
5. I have tooth or mouth problems that make it hard for me to eat.	☐ No ☐ Yes	2
6. I don't always have enough money to buy the food I need.	☐ No ☐ Yes	4
7. I eat alone most of the time.	☐ No ☐ Yes	1
8. I take 3 or more different prescribed or over-the-counter drugs a day.	☐ No ☐ Yes	1
9. Without wanting to, I have lost or gained 10 pounds in the last 6 months.	☐ No ☐ Yes	2
10. I am not always physically able to shop, cook and/or feed myself.	☐ No ☐ Yes	2

Total Nutrition Rating Score (Add the risk ratings of the questions answered "Yes.") **Participant's Nutrition Rating Score**: ☐

0-2	***Good!** Recheck your nutritional score in 6 months*
3-5	***You are at MODERATE NUTRITIONAL RISK.** See what you can do to improve your eating habits and lifestyle. Your Area 1 Agency on Aging, Senior Center, Lunch Site, Health Department, or physician can help. Re-evaluate your nutritional score in 3 months.*
Over 6	***You are at High nutritional risk.** You may want to talk with your doctor, dietician, or other qualified health or social services professional. Talk with them about how to improve your nutritional health.*

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Consent Form

VOLUNTARY CONTRIBUTION TO HOME-DELIVERED MEALS SERVICE

Home-Delivered Meals is a federally funded program and you may receive this service at no cost to yourself. Please know, however, that the federal funds do not cover all the costs of providing this service. This program appreciates contributions from participants in the program and others to help cover the costs of the service.

1. Based on our suggested donation of $ 3.00 /meal, the **suggested donation** is approximately $ 60.00 per month per person. _____

2. Does anyone help you with your finances? ☐Family Member ☐Accountant ☐Payee ☐Money Manager ☐Friend

3. If this person is not present at the intake meeting, may we contact them to ask for a donation to help cover the cost of this service? ☐Yes ☐No

4. If yes, please provide the following contact information of the person who assists you:

_____ (Name) _____ (Number) _____ (Address)

5. Please deliver donation reminder ☐by mail / ☐by meal delivery driver (check one).

6. **Signature (either client or agent):** _____ (Client) _____ (Agent) _____ (Date)

REFERRALS

7. ☐Suggested by staff, client makes contact (written permission not required)
8. ☐Staff will be making the referral to other agencies (always requires the participant's written permission for each referral)

9. Comments and observations: _____

10. **PERMISSION FOR REFERRAL:** I, _____, give permission to _____ to provide confidential information to _____ to _____, regarding my needs for assistance.

11. **Signature (either client or agent):** _____ (Client) _____ (Agent) _____ (Date)

12. Comments: _____

13. Client provided copy of Grievance policy _____

14. **Signature (either client or agent):** _____ (Client) _____ (Agent) _____ (Date)

15. **ASSESSMENT COMPLETED BY:** Assessor's Signature: _____ (Staff) _____ (Date)