State of Illinois
Illinois Department on Aging

☐ New Client ☐ Reassessment ☐ Ineligible/Termination
Reason:

Nutrition Referral/Assessment for Home Delivered Meals

This form must be completed and forwarded to the appropriate Home Delivered Meal nutrition provider agency.

Referral Source: ☐ Care Coordination Unit (CCU) _____
☐ Managed Care Organization (MCO) _____
☐ Area Agency on Aging ☐ Nutrition Provider

Days Older Adult to Receive Meals (Check all that apply): ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Friday ☐ All M-F ☐ Weekend ☐ 2nd meals

Type of meal(s): ☐ Hot ☐ Cold ☐ Frozen **Special Notes:**

Priority Level: Choose

Duration of Meals: (Check only one) ☐ Short Term ☐ Long Term Re-evaluate Date:

Special Diet Needs: ☐ General ☐ Diabetic ☐ Low sodium ☐ Other (specify):

Older Adult Demographic Information

Name: DOB:

Address: City: State: Zip:
Phone: Cell Phone:

Authorized Representative: Phone:

Emergency Contact Name #1:
Relationship:
Daytime/Cell Phone:

Emergency Contact Name #2:
Relationship:
Daytime/Cell Phone:

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (Check all that apply):
☐ White
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaskan Native
☐ Asian or Asian American

What is your gender? (Check only one)
☐ Male ☐ Female
☐ Other

Are you a Veteran?
☐ Yes ☐ No

Marital Status:
☐ M ☐ D
☐ S ☐ W
☐ Domestic Partner
☐ Legally Separated

Type of Housing:
☐ Home
☐ Apt (# :_____)
☐ Other (specify):

Subsidized Housing:
☐ Yes ☐ No

Below Poverty ☐ Yes ☐ No | Monthly Income: | # of Individuals in Household:

Limited English Speaking: ☐ Yes ☐ No If yes, primary language spoken:

Nutrition Risk Screen (select points under Yes or No)	Yes/No
I have an illness or condition that has made me change the kind or amount of food I eat.	Choose
I eat less than two meals a day.	Choose
I eat few fruits and vegetables, or milk products.	Choose
I have three or more drinks of beer, liquor, or wine almost every day.	Choose
I have tooth or mouth problems that make it hard for me to eat.	Choose
I don't always have enough money to buy the food I need.	Choose
I eat alone most of the time.	Choose
I take three or more different prescribed or over-the-counter drugs a day.	Choose
Without wanting to, I have lost or gained ten pounds in the last six months.	Choose
I am not always physically able to shop, cook, and/or feed myself.	Choose
TOTAL	0 **/21 possible points**
Six or more points = High Nutritional Risk	

☐ Nutritional Risk was explained to client.
☐ Client is considered at High Nutritional Risk. A recommendation was made to follow-up with a healthcare provider.

Impairment/Problem with Activity of Daily Living 0 No Assist = No; 1-3 Assist = Yes; 4 Unknown = No			Impairment/Problem with Instrumental Activities of Daily Living 0 No Assist = No; 1-3 Assist = Yes; 4 Unknown = No		
	PTS	**Yes/No**		**PTS**	**Yes/No**
Eating			Laundry		
Bathing			Shopping		
Grooming			Light Housework		
Dressing			Heavy Housework		
Toileting			Telephone		
Walking/Mobility			Financial Management		
Transferring (in/out of bed/chair)			Transportation		
			Meal Preparation		
			Medication		
Total Points	0		**Total Points**	0	
Total "Yes"= 0 **Total "No"=** 0			**Total "Yes"=** 0 **Total "No"=** 0		

Additional Nutrition Information

Who does the grocery shopping?

How often?

Can Older Adult feed self? ☐ Yes ☐ No
If no, who assists?
What type of help: ☐ Cutting ☐ Feeding ☐ Opening Containers

Is anyone available to prepare food? ☐ Yes ☐ No If yes, who?
What days?
Which meals?

Does Older Adult have difficulty chewing/poor dental health?
☐ Yes ☐ No

Older Adult's kitchen facilities/equipment (Check all that apply):
☐ Kitchen ☐ Kitchen privileges ☐ Freezer w/ available space
☐ Refrigerator ☐ Stove ☐ Microwave

Is Older Adult able to use these appliances unsupervised (Check all that apply):
☐ Stove ☐ Microwave ☐ Freezer ☐ Refrigerator

Older Adult food source for the weekends:

Dietary restrictions:

Food Allergies: ☐ Yes ☐ No If yes, specify:

NOTE: It is the client's responsibility to review the weekly menu and bring any allergy concerns to the attention of the nutrition provider. When feasible, the provider will supply a special meal to meet the dietary needs of the client.

Are you currently receiving food assistance benefits? ☐ **Yes** ☐ **No** (Examples: SNAP, SFMNP, TEFAP)

Reason/Eligibility for Home Delivered Meals: (Check all that apply)
☐ Homebound ☐ Permanently Disabled ☐ Temporarily Disabled ☐ Respite for Caregiver
☐ Meal for Spouse or Disabled Adult in Home ☐ Other (specify):

Older Adult will benefit from Home Delivered Meals because (Check all that apply):
☐ Older Adult has difficulty cooking, tires easily ☐ Older Adult is recovering from surgery, illness, etc.
☐ Meals will increase nutritional intake as Older Adult has a limited income
☐ Other (specify):

Currently receiving home delivered meals from another source (e.g. family, church, etc.)**:** ☐ Yes ☐ No

Major Health Problems (Check all that apply)

Ambulation: ☐ Full ☐ Partial ☐ Assisted ☐ Bedfast

Vision: ☐ Full ☐ Limited ☐ Glasses ☐ Blind

Hearing: ☐ Full ☐ Hard of Hearing ☐ Hearing Aid ☐ Deaf

Determination of Need (DON) score: *(If Known)*

Other major health concerns (describe):

Priority Level Screening Questions (After client is determined to be "eligible" for HDMs)	
1. (a): If you had groceries available, would you be able to use them to prepare hot meals? ☐ **Yes** *(Go to Question 2a)* ↓ ☐ **No** *(Go to Question 1b)*➔	**1. (b):** Do you have reliable help with meal preparation? ☐ **Yes** *(Go to Question 2)* ☐ **No (STOP – Check High Priority Level)**
2. During the last month…	
(a)...how often was this statement true? The food that I/we bought just didn't last, and I/we didn't have money to get more?	
(b)...how often was this statement true? I/we could not afford to eat balanced meals?	
(c)...did you or other adults in your household ever cut the size of your meals because there wasn't enough money for food?	
(d)...did you or other adults in your household ever skip meals because there wasn't enough money for food?	
(e)...did you ever eat less than you felt you should because there wasn't enough money for food?	
(f)...were you ever hungry but didn't eat because you couldn't afford enough food?	
Total points 2a-2f	
3. Are you able to get groceries into your home when you need them? **Refer to total points when selecting.* Choose one	
0-1 Point AND "No" = Low Priority (May benefit from Grocery Shopping Services or Food Delivery.) **2-6 Points = Intermediate Priority** (May benefit from additional nutrition services.)	
Check the appropriate Priority Level Box at the top of Page 1	

Other Contacts Information	
Primary Physician Name:	Primary Physician Phone:
For Home Delivered Meal Providers:	
☐ Referred client to Community Care Program (CCP) for additional Home and Community Based Services. ☐ The HDM client was informed of the possibility that foods may contain or come into contact with food allergens.	

Authorization of Release of Information

I give permission to _____ to send a copy of this assessment form to the Home Delivered Meal (HDM) Provider, _____, and to discuss my needs with the HDM Provider, Care Coordination Unit (CCU), Managed Care Organization (MCO), and/or the AAA.

Older Adult Signature:	☐ * Verbal Consent Provided Date:
I certify this Older Adult meets eligibility criteria for Home Delivered Meals under the Older Americans Act.	
Signature:	Date:
Case Manager Name:	Phone:
Organization:	Email:

HDM Start Date:	Reassessment Date:	Termination Date:
Driver Instructions: (Check all that apply) ☐ Ring bell ☐ Knock loudly ☐ Beware of dog(s) ☐ Other:		

*Verbal consent can be provided in the event of a pandemic, civil unrest, or other circumstance that prevents a client from providing their written consent/signature.

Completed by (For Referring Agencies Only):	
Name of Referring Agency:	Phone #:
Address:	