PSA 28 HDM In-Take Form

Title III C Elderly Nutrition Program
Items marked with (*) are **required**
(DTS) is *Declined to State*

Route #

# of Days

In-Take Date:________ Active Date:________ Active Date:________ Active Date:________

Inactive Date:________ Inactive Date:________ Inactive Date:________
(denote inactive reasons on page 5 HDM Inactive Notes)

*First Name	*MI	*Maiden Name	*Last Name

*Date of Birth

*Last 4 Digits of SSN ___ ___ ___ ___

*Home Phone | Alternate Phone | Email Address:

*Address ❑ apartment complex? | *City | *Zip Code

***Relationship/Marital Status**
❑ Married ❑ Widowed ❑ Single ❑ Divorced/Separated
❑ Domestic Partner ❑ Declined to State
***Head of Household?** ❑ Yes ❑ No
***Veteran:** ❑ Yes ❑ No ***Veteran Dependent:** ❑ Yes ❑ No
***Rural:** ❑ Yes ❑ No
Education Level: ❑ Competed 8th grade ❑ Competed 9th-11th grade ❑ Competed 12th grade ❑ 1-3 years of college ❑ 4 years of college ❑ over 4 years of college ❑ unknown

***Estimated household income**
$ __________
❑ Individual ❑ Household
❑ Monthly ❑ Annually
❑ Below Poverty
❑ Above Poverty
❑ Receiving Social Security

***Medicare ID's**
Medicare A:_____
Medicare B:_____

***Language**
❑ English
❑ Non-English
❑ Interpreter

*Cognitive Impairment: ❑ None ❑ Early Onset Dementia ❑ Mild ❑ Moderate ❑ Severe ❑ Alzheimer's Disease
*Disability: ❑ Yes ❑ No *Stroke: ❑ Yes ❑ No *History of Mental Illness: ❑ Yes ❑ No

*Lives Alone? ❑ Yes ❑ No
Lives with: ____________________
in household: ________________

***Social Worker/Caregiver Contact Info:**

***Special Delivery Instructions**

***Emergency Contact**
Name: ______________________________
Phone: ______________________________
Relationship: ______________________________
Email: ______________________________

Race/Ethnicity** ***(Check all that apply)

☐ White	☐ Cambodian	☐ Hispanic/Latino
☐ Black	☐ Laotian	☐ Amer. Indian/Alaska
☐ Chinese	☐ Asian Indian	☐ Other Pacific Islander
☐ Korean	☐ Other Asian	☐ Multiple Race
☐ Filipino	☐ Guamanian	☐ Other Race
☐ Japanese	☐ Hawaiian	☐ Declined to State
☐ Vietnamese	☐ Samoan	

***Gender Identity:**
❑ Not Answered ❑ Female ❑ Male ❑ Genderqueer/Gender Non-Binary
❑ Transgender Female to Male ❑ Transgender Male to Female ❑ Not Listed/Other Please Specify ____________________
***Sex at Birth:**
❑ Not Answered ❑ Female ❑ Male ❑ Declined/Not Stated
***Sexual Orientation:**
❑ Declined/Not Stated ❑ Straight/Heterosexual ❑ Bisexual ❑ Gay/Lesbian/Same Gender Loving
❑ Questioning/Unsure ❑ Not Listed/Other Please Specify ________________________________

Eligibility (*(Check all that apply)*
❑ Are you over 60 years old?
❑ Are you HOMEBOUND due to illness, disability or isolation?
❑ Are you a spouse of a qualifying senior?
❑ Are you an individual with a disability who resides with a qualifying senior?
❑ Are you FRAIL?
ELIGIBLE TO RECEIVE HDM ❑ Yes ❑ No Intake Staff Initial:________
Explain why not eligible:

Name:	Last 4 Digits of SSN:

***ADLs and IADLs** (Activities of Daily Living and Instrumental Activities of Daily Living)
Please rate your functional abilities for the following activities:

ADL	Value	ADL	Value	IADL	Value	IADL	Value	IADL	Value	TOTAL ADL/IADL VALUE:
Eating		Transferring		Meal Preparation		Money Management		Light Housework		
Bathing		Walking		Shopping		Telephone		Transportation		
Toileting		Dressing		Medication Management		Heavy Housework				________

Rating Scale (Value): **1=Independent 2=Verbal Assistance 3=Some Help. 4=Lots of Help. 5=Dependent**
Note: total value will be used for waiting list prioritization

Able to take out garbage: ❑ Yes ❑ No Can Answer Door: ❑ Yes ❑ No Architectural Barriers: ❑ Yes ❑ No	NOTES:

CONDITIONS IN THE PAST 12 MONTHS:			
Risk of Elder Abuse	Yes	No	If Yes, Please explain
1. Do you feel taken care of at home? (neglect)			
2. Has anyone talked to you in a way that made you feel shamed or threatened (verbal)			
3. Has anyone talked to you in a way that made you feel shamed or threatened (verbal)			
4. Has anyone tried to force you to sign important documents? (financial)			
5. Does anyone make you do things you don't want to do? (physical, sexual, financial)			
If any of above questions is YES, then mark YES here: **Abuse/Negligence/**			
Risk of Fall	Yes	No	If Yes, Please explain
1. Have you fallen in the past 3 months?			
2. Have you been hospitalized for a fall within the past six months?			
3. Do you use or have been advised to use a cane or walker to get around safely?			
4. Do you sometimes feel unsteady when walking?			
5. Do you steady yourself by holding onto furniture when walking at home?			
6. Are you worried about falling?			
7. Do you need to push with someone else's hands to stand up from a chair?			
8. Do you have some trouble stepping up onto a curb?			
9. Do you often have to rush to the toilet?			
10. Do you have lost some feeling in your feet?			

11. Do you take medicine that sometimes makes you feel light-headed or more tired than usual?			
12. Do you take medicine to help with sleep or improve your mood?			
13. Do you often feel sad or depressed?			
Risk of Social Isolation	Yes	No	If No, Please explain
1. Have you spent time together with family/friends in the last two weeks?			
2. Do you have anyone with whom you trust to discuss personal matters and problems?			
3. Do you consider yourself close to the people you come to contact with, and people care about you?			
4. Do you constantly experience a general sense of emptiness?			
5. Do you often feel rejected?			

NOTES:

Name:		Last 4 Digits of SSN:
Nutritional Assessment ***(completed twice annually and data in SAMS)***	**Circle if Yes**	**Comments**
1. Has the client made any changes in lifelong eating habits because of health issues?	2	
2. Does the client eats fewer than 2 meals per day?	3	
3. Does the client eat few (less than 5) vegetables or fruits, or milk products per day?	2	
4. Does the client have 3 or more drinks of beer, liquor or wine almost every day?	2	
5. Does the client have biting, chewing or swallowing problems that make it difficult to eat?	2	
6. Does the client sometimes not have enough money to buy food?	4	
7. Does the client eat alone most of the time?	1	
8. Does the client take 3 or more different prescribed or over-the-counter drugs per day?	1	
9. Without wanting to, has the client lost or gained 10 pounds in the past 6 months?	2	
I10. Is the client not always physically able to shop, cook and/or feed themselves (or to get someone to do it for them)?	2	
0-2: low risk 3-5: moderate risk 6 or more: high risk **Total Score Today:**		
Nutritional Assessment NOTES:		
Date Referral(s) Made: ____ Nutritionist (nutrition education or nutritional counseling) ____ Social Worker/ Case Manager/ APS ____ Medical Doctor ____ Mental Health Practitioner ____ Pharmacist ____ Dentist ____ Fall Prevention Program ____ Other: Indicate referral agency here:		

Name:			Last 4 Digits of SSN:
Dietary and General Questions	Yes	No	If Yes, Please add comments
Do you have any dietary restrictions due to health conditions?			
Do you have any food allergies?			
Do you have a working refrigerator?			
Do you have a working microwave?			
Are you physically and mentally able to open the food containers?			
Are you physically and mentally able to reheat a meal?			
Are there pets? Dog (number)_____ Cat (number)______ Other_______			
Have you recently been discharged from the hospital?			Discharge date:
Do you have any contagious illness/condition?			
NOTES:			

____ ____________

Staff Completing Assessment, Name and Title Date

Participant Consent:

I understand that the information I am providing on this form is for registration purposes. I understand it will be kept confidential and that the Area Agency on Aging and Meal Service Providers may use it to help identify other services for which I may benefit.

I authorize to release information to caregiver, emergency contact, or social worker during program participation.

____ ____________

Signature of participant or participant's representative Date

*Representative's relationship to participant:*________________

Name: Last 4 Digits of SSN:

HDM INACTIVE NOTES:

Inactive Date:___________ by Staff___________________________
Reasons:

Inactive Date:___________ by Staff___________________________
Reasons:

Inactive Date:___________ by Staff___________________________
Reasons:

Name:____________________________________ **Date:**__________

1. FUNCTIONAL ABILITY *(If applicable, check only one for each functional ability)*

Assistive Device:	☐ Cane/crutch	☐ Walker	☐ Wheelchair assist	☐ Wheelchair confined
Vision:	☐ Good	☐ Limited	☐ Legally Blind	☐ Blind
Hearing:	☐ Good	☐ Limited	☐ Hearing Aide	☐ Deaf
Speech:	☐ Good	☐ Limited	☐ None	☐ Sign
Reheat Frozen Meals:	☐ Good	☐ Limited	☐ None	☐ Care Taker

2. SUPPORT SYSTEM *(Check all that apply)*

Attend Day Treatment? ☐ No ☐ Yes: days/week?	Alone during the day only? ☐ No ☐ Yes: Days/week?
Needs Respite Care? ☐ No ☐ Yes: days/week? Hrs/day?	Are meals provided? ☐ No ☐ Yes: Days/week?
Formal paid caregiver? ☐ No ☐ Yes: days/week? Hrs/day?	Are meals provided? ☐ No ☐ Yes: Days/week?
Regular friend/relative? ☐ No ☐ Yes: days/week? Hrs/day?	Are meals provided? ☐ No ☐ Yes: Days/week?

Case Manager? No ☐ Yes ☐	Name:	Agency:		Phone:

Infrequent friend/relative care? ☐ No ☐ Yes Specify:

Comments:

3. APPLIANCE INFORMATION

Appliance (*Check all that apply*): ☐ Refrigerator ☐ Freezer ☐ Range/Stove ☐ Oven/Toaster ☐ Microwave ☐ Other, specify:

4. MEDICATION(S) AND SUPPLEMENT(S) *(If applicable, check only one within each)*

Prescribed medication:	☐ Don't know	☐ No	☐ Yes, how many?	Specify:
Over-the-counter medication:	☐ Don't know	☐ No	☐ Yes, how many?	Specify:
Supplements:	☐ Don't know	☐ No	☐ Yes, how many?	Specify:
Herbal:	☐ Don't know	☐ No	☐ Yes, how many?	Specify:

Comments:

5. HEALTH AND AGING-RELATED PROBLEMS *(Check all that apply)*

☐ Terminal illness	Mutliple Discharges from Hosptal? Yes ☐ No ☐	Recent Discharge Date:	Hospitalization reason:

Usual Weight (lbs):	Current Weight (lbs):	Current Height (ft):

☐ Alcoholism	☐ Chronic Obstructed Pulmonary Disease	☐ Frequent Falling	☐ *Obesity*
☐ Anxiety	☐ Depression	☐ Gastrointestinal problems	☐ Osteoporosis
☐ Asthma/other breathing problems	☐ Diabetes: Insulin	☐ High Blood Pressure current level: ______	☐ Parkinson's
☐ Back/Neck Problems	☐ Diabetes: oral	☐ High Cholesterol current level: ______	☐ Pneumonia
☐ Bone Fractures	☐ Dialysis	☐ Incontinence	☐ Severe Underweight/ Malnutrition
☐ Bone Pain	☐ Eating/chewing problems	☐ Insomnia	☐ Skin Changes(dry, edema, lesions)
☐ Cancer, specify :	☐ Food Allergies, specify:	☐ Need Continuous Oxygen Aide	☐ Stroke, Year:

☐ Other – Specify:

Comments:

8. MEAL REQUEST *(If applicable, check only one within each)*

Appetite:	☐ Excellent ☐ Good ☐ Fair ☐ Poor	Nutrition Risk Score:
Meal Choice:	☐ Weekday Frozen ☐ Weekend Frozen	

9. Qualifies for HDM SERVICE ☐ No ☐ Yes Start Date: __________

Route:__________________

Reasons if NO:

10. INTAKE STAFF INFORMATION

Intake Staff Name: Lisa DeRose-Hernandez	Signature:	
Title: CANV Meals on Wheels Program Director	Phone:707.253.6100	Extension:111