WESTERN ILLINOIS AREA AGENCY ON AGING
Aging & Disability Resource Center

Nutrition Assessment for Home Delivered Meals

EMERGENCY NEED: ☐

Currently receiving home delivered meals from another source: ☐Yes ☐No	Days participant to receive meals (check all that apply): ☐M ☐T ☐W ☐ R ☐F ☐All M-F ☐Weekend ☐Second Meals	**AgingIS Entry Date:** **Staff Initials:**

Last Name:	**First Name:**		
Phone:	**House #:**	**Street:**	
Apt/ Suite/ Bldg.:	**City:**	**State:**	**Zip:**
County:	**Rural (RI, Mercer, Henry=No)** ☐Yes ☐No		**Township:**
Date of Birth: / /	**Gender:** ☐Male ☐Female ☐Gender Identity-Other ☐Decline to answer		
Sexual Orientation: ☐Straight ☐Lesbian ☐Gay ☐Bi- sexual ☐Transgender ☐Queer/Questioning ☐Decline to answer			
Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino	**Primary Race:** ☐White ☐Black/African American ☐American Indian or Alaskan Native ☐Asian ☐Native Hawaiian or Pacific Islander		
Number in Household:	**Primary Language:** ☐English ☐Spanish ☐Other: _____		
Low Income? ☐Yes ☐No Single: $1,561/month Married: $2,114 /month	**Medicaid?** ☐Yes ☐No (Participant has Medicaid coverage or services)	Are you a Veteran? ☐Yes ☐No	

NUTRITION RISK SCREEN

Instructions: Read each statement to the participant and mark appropriate response. Calculate the total points by adding the number in parenthesis for each Yes response. (No does not have points.)

1. I have an illness or condition that has made me change the kind or amount of food I eat.	☐Yes (2)	☐No
2. I eat less than two meals a day.	☐Yes (3)	☐No
3. I eat few fruits and vegetables, or milk products.	☐Yes (2)	☐No
4. I have three or more drinks of beer, liquor or wine almost every day.	☐Yes (2)	☐No
5. I have tooth or mouth problems that make it hard for me to eat.	☐Yes (2)	☐No
6. I don't always have enough money to buy the food I need.	☐Yes (4)	☐No
7. I eat alone most of the time.	☐Yes (1)	☐No
8. I take three or more different prescribed or over-the-counter drugs a day	☐Yes (1)	☐No
9. Without wanting to, I have lost or gained ten pounds in the last six months.	☐Yes (2)	☐No
10. I am not always physically able to shop, cook, and/or feed myself. (this can be on a temporary basis)	☐Yes (2)	☐No

TOTAL POINTS: _____/ 21 possible points

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6 OR MORE POINTS REQUIRED TO QUALIFY

ASSESSMENT OF NEED FOR ASSISTANCE WITH ADL'S AND IADL'S

Instructions: Assess the participant's need for assistance for each Activities of Daily Living (ADL's) and Instrumental Activities of Daily Living (IADL's). Circle the corresponding key number or letter that closely describes their need.

Key				
	0	Independent - No impairment	**A**	Needs assistance but refuses
	1	Minimum Assistance - Mild impairment	**D**	Does not know if needed
	2	Moderate Assistance - Some impairment	**E**	Elects not to answer
	3	Maximum Assistance - Total impairment		

Activities of Daily Living (ADL's)					Instrumental Activities of Daily Living (IADL's)				
Eating	0	1	2	3	Laundry	0	1	2	3
Bathing	0	1	2	3	Shopping	0	1	2	3
Grooming	0	1	2	3	Light Housework	0	1	2	3
Dressing	0	1	2	3	Heavy Housework	0	1	2	3
Toileting	0	1	2	3	Telephone Use	0	1	2	3
Walking/Mobility:	0	1	2	3	Financial Management	0	1	2	3
Transferring (in/out of bed/chair)	0	1	2	3	Transportation	*0*	*1*	*2*	*3*
					Meal Preparation	*0*	*1*	*2*	*3*
					Medication Management	0	1	2	3

Frozen and Cold Meal Options (does not affect eligibility)
Does the older adult have a working freezer and/or refrigerator to store meals and working microwave and/or oven to prepare meals? ☐ Yes ☐ No
Can the older adult use the freezer, refrigerator, microwave, and oven unsupervised? ☐ Yes ☐ No
If no, who will assist with heating of meals? _____

Other Information
Can the older adult feed self? ☐ Yes ☐ No
If no, who assists? _____

If help is needed, what type? (check all that apply)
☐Cutting ☐Puree ☐Feeding

Does older adult have difficulty swallowing? ☐ Yes ☐ No

ADDITIONAL INFORMATION
ATTENTION: ONLY complete this section if the older adult is <u>eligible</u> to receive Home Delivered Meals

Reason why older adult is eligible to receive meals (check all that apply)
☐Homebound (or person scored 6 or higher on Nutrition Screen)
☐Permanently Disabled
☐Temporarily Disabled (i.e. illness, recovering from surgery, unable to leave their home for various reasons, etc.)
☐Respite for caregiver

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☐Meal for spouse of HDM recipient or person with disability living with an eligible HDM participant

☐Other (specify): _____

If older adult qualifies on a temporary basis (i.e. temporarily disabled), reassessment should occur within 6 weeks. Date of Reassessment: _____

Special Diet Needs ☐General ☐Diabetic **Dietary restrictions**: _____

Emergency Contact Name: _____ Relationship to participant: _____

Address: _____ Phone: _____

Driver Instructions (check all that apply)

☐Ring doorbell ☐Knock loudly ☐Beware of dog(s) ☐Other:_____

Older Adult will benefit from Home Delivered Meals because: (check all that apply)

☐ Meals will increase nutritional intake as Older Adult has limited income

☐ Older Adult has difficulty cooking, tires easily

☐ Older Adult is recovering from surgery, illness, etc.

☐Other (specify) _____

Staff Signature: _____ **Date:**_____