

All information is CONFIDENTIAL.

Home-Delivered Meal Intake This form is designed to be completed by an intake staff member. Items marked with asterisk (*) are required.		(Office Use Only) To-Go Meals: _____ Route: _____ Start Date: _____		(Office Use Only) Intake Date: _____ Referred by: _____ Entered by: _____																					
*Unique Participant ID: _____		*Date of Birth: ____/____/____		*Termination Date: _____																					
*First Name: _____		*Last Name: _____		Middle Initial: _____																					
				<input type="checkbox"/> New client <input type="checkbox"/> In-Home Reassessment <input type="checkbox"/> Change in information																					
*Address: _____		*City: _____		*Zip: _____																					
Mailing Address: Same As Residential? <input type="checkbox"/> Yes		City: _____		Zip Code: _____																					
*Home Phone: Cell Phone: _____		Emergency Contact Name: _____ Phone: _____ Relationship: _____ 2nd Contact Name: _____ Phone: _____ Relationship: _____																							
*Living Arrangement <input type="checkbox"/> Alone <input type="checkbox"/> Lives with _____ <input type="checkbox"/> Decline to state		*What is your total monthly income? <input type="checkbox"/> less than \$1,255 per month for 1 person <input type="checkbox"/> more than \$1,256 per month for 1 person <input type="checkbox"/> less than \$1,703 per month for 2 people <input type="checkbox"/> more than \$1,704 per month for 2 people <input type="checkbox"/> Decline to state		*Rural Area? X Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to state																					
*Ethnicity: (Check one) Hispanic/ Latino <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to state			*Language: <input type="checkbox"/> English speaking <input type="checkbox"/> Need interpreter <input type="checkbox"/> Non-English/Language: _____																						
*Race: (Check all that apply) <table style="width:100%;"> <tr> <td><input type="checkbox"/> White</td> <td><input type="checkbox"/> Black</td> <td><input type="checkbox"/> American Indian/Alaska Native</td> <td><input type="checkbox"/> Asian Indian</td> <td><input type="checkbox"/> Other Asian</td> </tr> <tr> <td><input type="checkbox"/> Cambodian</td> <td><input type="checkbox"/> Filipino</td> <td><input type="checkbox"/> Japanese</td> <td><input type="checkbox"/> Korean</td> <td><input type="checkbox"/> Guamanian</td> </tr> <tr> <td><input type="checkbox"/> Hawaiian</td> <td><input type="checkbox"/> Samoan</td> <td><input type="checkbox"/> Other Pacific Islander</td> <td><input type="checkbox"/> Laotian</td> <td><input type="checkbox"/> Vietnamese</td> </tr> <tr> <td><input type="checkbox"/> Chinese</td> <td><input type="checkbox"/> Decline to state</td> <td></td> <td></td> <td></td> </tr> </table>						<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Filipino	<input type="checkbox"/> Japanese	<input type="checkbox"/> Korean	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Samoan	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Laotian	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Chinese	<input type="checkbox"/> Decline to state			
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*ADLs and IADLs (Activities of Daily Living and Instrumental Activities of Daily Living) Please rate your functional abilities for the following activities.																									
ADLs	Rated Value	IADLs	Rated Value	IADLs	Rated Value																				
Eating		Meal Preparation		Light Housework																					
Bathing		Shopping		Transportation																					
Toileting		Medication Management		Notes:																					
Transferring In/Out of Chair		Money Management																							
Walking		Using Telephone																							
Dressing		Heavy Housework																							
RATING SCALE 1 = Independent 2 = Verbal Assistance 3 = Some Human Help 4 = Lots of Human Help 5 = Dependent 6 = Decline to state																									

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Eligibility: <input type="checkbox"/> Are you homebound due to an illness, disability, or isolation? <input type="checkbox"/> Are you a spouse of a person who is homebound? <input type="checkbox"/> Are you an individual with a disability who resides with a homebound meal recipient?	Prioritization:
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*Nutritional Assessment:	Circle if yes	Comments
I have an illness or condition that made me change the kind and/or amount of food I eat.	2	
I eat fewer than 2 meals per day?	3	
I eat few fruits or vegetables or milk products.	2	
I have 3 or more drinks of beer, liquor or wine almost every day.	2	
I have tooth or mouth problems that make it hard for me to eat.	2	
I don't always have enough money to buy the food I need.	4	
I eat alone most of the time.	1	
I take 3 or more different prescribed or over-the-counter drugs a day.	1	
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2	
I am not always physically able to shop, cook and/or feed myself.	2	
<input type="checkbox"/> Decline to state <div style="float: right;">Total Score</div> <div style="clear: both;"></div> (0-2: low risk; 3-5: moderate risk; 6 or more: high risk)		

Food Insecurity	
Do you have enough money to purchase fresh fruit, vegetables, meats, dairy, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you worry your food will run out before you can buy more?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you lost weight because there wasn't enough money for food?	<input type="checkbox"/> Yes <input type="checkbox"/> No

*What is your gender? (Check one) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Decline to state	*What was your sex at birth? (Check one) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Decline to state	How do you describe your sexual orientation or sexual identity? (Check one) <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not listed, please specify: _____ <input type="checkbox"/> Decline to state
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	Yes	No	Comments
Do you have any dietary restrictions?			
Do you have a working refrigerator?			
Do you have a working microwave?			
Are you able to open food containers?			
Are you able to reheat a meal?			
Are there pets in the home?			

Special instructions for meal delivery:

Non-Senior Status:

- ☐ Spouse of a Senior
☐ Essential Volunteer
☐ Disabled Living with a Senior

Veteran Status:

- Veteran Yes ☐ No ☐
 Veteran Dependent Yes ☐ No ☐
 Refer to VA Services?** Yes ☐ No ☐
 Decline to State Yes ☐ No ☐

****If you identify as military affiliated, check 'yes' if you consent to A12AA and the CDA transmitting your name and contact information to the Department of Veterans Affairs only for purpose of receiving info on veterans benefits. www.calvet.ca.gov or 1-800-952-5626**

PRIMARY PHYSICIAN INFORMATION

Name:

Phone Number:

Mobility:	Must Use:	Vision:	Hearing:
<input type="checkbox"/> Adequate	<input type="checkbox"/> Cane	<input type="checkbox"/> Good	<input type="checkbox"/> Good
<input type="checkbox"/> Limited	<input type="checkbox"/> Crutches	<input type="checkbox"/> Limited	<input type="checkbox"/> Limited
<input type="checkbox"/> Bedbound	<input type="checkbox"/> Walker	<input type="checkbox"/> Blind	<input type="checkbox"/> Deaf
	<input type="checkbox"/> Wheelchair		

Other Health Problems:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart/Blood Pressure Problems	<input type="checkbox"/> Recent Hospitalization
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Stroke
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Paralysis, Full/Partial	<input type="checkbox"/> Other (Describe)
<input type="checkbox"/> Fracture	<input type="checkbox"/> Parkinson's, Palsy	

Other Service/Referrals	Already Receives:	Referred to:	Comments
Case Management	<input type="checkbox"/>	<input type="checkbox"/>	
Medi-Cal	<input type="checkbox"/>	<input type="checkbox"/>	
In-Home Supportive Services	<input type="checkbox"/>	<input type="checkbox"/>	
Health Services	<input type="checkbox"/>	<input type="checkbox"/>	
Information & Assistance	<input type="checkbox"/>	<input type="checkbox"/>	
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	
CalFresh/Food Commodities	<input type="checkbox"/>	<input type="checkbox"/>	
Other (Describe)	<input type="checkbox"/>	<input type="checkbox"/>	
Termination of Meals		Date:	
Reason (Check One)		Placed In:	
<input type="checkbox"/> Recovered	<input type="checkbox"/> Moved from area	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Residential Care
<input type="checkbox"/> Hospitalized	<input type="checkbox"/> Deceased	<input type="checkbox"/> Board & Care	<input type="checkbox"/> Other

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<u>Date</u>	<u>Comments</u>	<u>By</u> (please initial)

Participant/Person Completing Form -- Signature: _____ Date: _____