NICAA Golden Meals Participant Information Form

#

Last Name (Print) ______ First Name ______ Middle Initial ______

Date of Birth ______ Social Security # ______ Today's Date ______

Type of Contact: Walk-In ______ Field ______ Phone ______ Provider/Site ______ No. ______

Sex: Male ______ Female ______

Address ______ Apt.# ______ City ______ State ______ Zip ______

Phone # ______ County ______ Township ______

Referral Source	Enrolment/Entitlements (Circle All)		Client Speaks English
1. Newspaper	1. Medicaid	7. LIHEAP	1. Yes
2. Senior Center	2. Medicare	8. Homestead Exp.	2. No
3. Social Services	3. Circuit Breaker	9. Unknown	
4. Relative/Friend	4. SSI	10. Tax Exp. Freeze	
5. Health Care Provider	5. Food Stamps	11. CCP Service	
6. City Hall	6. CB Pharmacy	12. QMB/S1IB	

Race	Household Composition	GEN (below poverty)
1. Caucasian	1. Lives Alone (if yes, circle GSN)	1 person $958 2 Persons $1293
2. African American	2. With Spouse	1. Yes
3. Hispanic (may be of any race)	3. With Children	2. No
4. Native American/Alaskan Native	4. With Relatives	

Living Arrangement	Veteran	Rural Resident	G.S.N.	MIN G.E.N.
1. Homeowner	1. Yes	1. Yes	1. Yes	1. Yes
2. Subsidized	2. No	2. No	2. No	2. No
3. Mobile Home				
4. Nursing Home				
5. Renter	**Frail**		**Nutritional Risk**	
6. Retirement	1. Yes		1. Yes	
7. Lives with other	2. No		2. No	

Physician ______ Client Impairment ______

Emergency Contact ______ Phone H ______ W ______

Relationship ______ Address ______

Rolling Stone: Yes ______ No ______

Needs Home Delivered Meal because: Long Term Care Discharge ______ Hospital Discharge ______

Unable to Shop/Prepare Food ______ No Other Resource too Provide Meal ______

Homebound Due to Illness ______

Name: ____________________

NUTRITIONAL HEALTH RISK - Annual update required of this section

	YES	NO
I have an illness or condition that has made me change the kind or amount of food I eat.	2	0
I eat less that two meals a day.	3	0
I don't eat very many fruits and vegetables, or milk products.	2	0
I have three or more drinks of beer, liquor or wine almost every day.	2	0
I have tooth or mouth problems that make it hard for me to eat.	2	0
I don't always have enough money to buy the food I need.	4	0
I eat alone most of the time.	1	0
I take 3 or more prescribed or over the counter drugs a day.	1	0
Without wanting to, I have lost or gained 10 pounds in the last six months.	2	0
I am not always physically able to shop, cook and/or feed myself.	4	0

Add YES scores: 0-2 Low 3-5 Moderate 6 or more High **TOTAL**

Is there anything we need to know about how to find or deliver the meal to your home?

____

____

____

Y N Are you Aware of our agency's donation agreement policy?

Y N Are you willing to call our agency to cancel the meal if for any reason you will not be home?

Do you have…				Can you safely and efficiently operate a …		
	Y	N	Fridge	Fridge	Y	N
	Y	N	Freezer	Freezer	Y	N
	Y	N	Microwave	Microwave	Y	N
	Y	N	Stove	Stove	Y	N

Y N Do you need in-home help or help with other benefits and services (medication, fuel, transportation)?

Y N Permission to refer?

Referral Form completed too (List) ____________________

Disposition: Home Delivered Meals Authorized - Starting Date: ____________________

Denied: (reason) ____________________

Completed By: ____________________ **Date:** ____________

Reassessment by: ____________________ **Date:** ____________

Reassessment by: ____________________ **Date:** ____________

Name: ______________________

HOME DELIVERED MEAL ASSESSMENT

Y	**N**	**Are you able to leave your home on a daily basis (vs. only for doctor appointments)**
Y	**N**	**Are you able to drive? If No, how do you get groceries?** ______________________
Y	**N**	**Are you able to prepare a hot meal daily?**
Y	**N**	**Are you able to prepare light meal such as cereal or a sandwich?**
Y	**N**	**Do you have difficulty chewing, swallowing, or cutting your food?**

HDM meals needed:	**Hot - circle days:**	**Mon**	**Tues**	**Wed**	**Thu**	**Fri**		
	Sacks	**Mon**	**Tues**	**Wed**	**Thu**	**Fri**		
	Frozen - circle days:	**Mon**	**Tues**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**

Y	**N**	**Has your physician ordered a therapeutic diet? Type:** ______________________
Y	**N**	**Do you have a food allergy?**
Y	**N**	**Do you have a microwave?**
Y	**N**	**Are you able to safely reheat frozen meals in the microwave or oven?**
Y	**N**	**Is there a spouse or disabled child living with you who is unable to cook and is in need of a meal?**
Y	**N**	**Do you need Special utensils to eat your meal? Type:** ______________________

Expected service duration:

_______ **One month or less** _______ **Up to 6 months**

_______ **Up to year or more** _______ **Congregate possibility in future**