

CONFIDENTIAL

Intake date: ___/___/___
Client Q #: _____

AIS CLIENT INTAKE -- SENIOR NUTRITION PROGRAM 2016

* represents information required by the CDA

***FIRST NAME:** _____ ***LAST NAME:** _____ **MI:** _____
STREET ADDRESS: _____ **CITY:** _____ **ZIP:** _____
PHONE: _____ ***BIRTHDATE:** ___/___/___ ***SEX:** (Circle one) Male Female
MARITAL STATUS: (Circle one) Married / Divorced / Never Married / Separated / Widowed / Domestic Partner

***LIVES ALONE:** (Circle "Yes" or "No") Yes No **NUMBER IN HOUSEHOLD** _____

***RURAL** (defined as an unincorporated area with less than 20,000): (Circle "Yes" or "No") Yes No

***INCOME STATUS:** (Circle "Yes" or "No")

If you are single, is your monthly income less than \$990? Yes No

If you are married, is your monthly income less than \$1,335? Yes No

***RACE:** (Circle applicable race)

Decline to State	Missing	Other Race	Multiple Race
American Indian/Native Alaskan	Asian Indian	Black/African American	Cambodian or Laotian
Chinese	Filipino	Guamanian	Hawaiian
Hmong	Japanese	Korean	Other Asian
Other Pacific Islander	Samoan	Vietnamese	White

***ETHNICITY:** (Circle applicable ethnicity) Decline to State Missing Hispanic/Latino Non-Hispanic/Latino

* Assessment of ADLs (2 or more) and IADLs are required for **Home Delivered Meals only**

ADLs Denote: 1 =Independent - 5=Dependent	IADLs (Denote: 1=Independent - 5=Dependent)		
Eating Dressing Bathing	Light Housework	Laundry	Shopping/Errands
Toileting Walking	Meal prep/clean up	Transportation	Telephone
Transferring in & out of bed	Mnge Medications	Money Mngmt	Heavy Housework

* Nutrition Risk Status is required for **both Congregate Meals and Home Delivered Meals**

(Circle "yes" for all that apply)	
I have an illness or condition that made me change the kind and/or amount of food I eat.	Yes
I eat fewer than two meals a day.	Yes
I eat few fruits or vegetables or milk products.	Yes
I have 3 or more drinks of beer, liquor, or wine almost every day.	Yes
I have tooth or mouth problems that make it hard for me to eat.	Yes
I don't always have enough money to buy the food I need.	Yes
I eat alone most of the time.	Yes
I take 3 or more different prescribed or over-the-counter drugs a day.	Yes
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	Yes
I am not always able to physically shop, cook, or feed myself.	Yes

ADDITIONAL INFORMATION

EMERGENCY CONTACT: _____ RELATIONSHIP: _____
 CONTACT TELEPHONE: (_____) _____ (_____) _____
 PRIMARY DOCTOR: _____ TELEPHONE: (_____) _____

*****PROGRAM STAFF TO COMPLETE THE FOLLOWING INFORMATION*****

CARE PLAN SERVICE	START DATE	REASSESSMENT DATE	DIENROLLMENT DATE
Home Delivered Meals	___/___/___	See back of page	___/___/___
Congregate Meals	___/___/___	___/___/___	___/___/___
Transportation	___/___/___	___/___/___	___/___/___

COMPLETE THIS SIDE FOR HOME DELIVERED MEAL CLIENTS ONLY

CLIENT HAS THE FOLLOWING WORKING HOUSEHOLD APPLIANCES:

- Refrigerator and Freezer Oven Microwave

DETERMINATION OF ELIGIBILITY: Completed via: ___ In Person ___ Phone (Written assessment in the participant's home within 2 weeks. Date completed: _____)

Check one of the following eligibility determinant

FRAIL:

- a) UNABLE TO PERFORM AT LEAST 2 ADLS WITHOUT SUBSTANTIAL HUMAN ASSISTANCE, VERBAL REMINDING, PHYSICAL CUEING OR SUPERVISION **OR**
- b) FUNCTIONALLY IMPAIRED DUE TO A COGNITIVE OR OTHER MENTAL IMPAIRMENT AND REQUIRES SUBSTANTIAL SUPERVISION BECAUSE THE INDIVIDUAL BEHAVES IN A MANNER THAT POSES A SERIOUS HEALTH OR SAFETY HAZARD TO HIM/HERSELF OR TO OTHERS

AND HOMEBOUND BY REASON OF ILLNESS, DISABILITY OR ISOLATION

SPOUSE OF HDM ELIGIBLE CLIENT:

ASSESSMENT CONCLUDES THAT IT IS IN THE BEST INTEREST OF THE HDM CLIENT.

INDIVIDUAL WITH A DISABILITY WHO RESIDES AT HOME WITH A HDM CLIENT:

ASSESSMENT CONCLUDES THAT IT IS IN THE BEST INTEREST OF THE HDM CLIENT.

HOME DELIVERED MEAL SERVICES TO BE PROVIDED: *(Check any that apply)*

- TWO HDMS/DAY (if available)
- WEEKLY FROZEN MEAL DELIVERY
- OTHER _____
- DAILY HOT MEAL DELIVERY
- FROZEN WEEKEND HDMS

ADDITIONAL COMMENTS OR DELIVERY INSTRUCTIONS:

I HEREBY DETERMINE CLIENT IS ELIGIBLE TO RECEIVE HOME DELIVERED MEALS:

STAFF SIGNATURE

DATE OF IN-HOME ASSESSMENT

CARE PLAN UPDATED: _____
DATE

STAFF INITIAL

I HEREBY DETERMINE CLIENT HAS BEEN REASSESSED AND IS ELIGIBLE TO RECEIVE HOME DELIVERED MEALS:

DATE: COMPLETED BY: TELEPHONE INTERVIEW FACE TO FACE/IN HOME
 ENTERED INTO Q

DATE: COMPLETED BY: TELEPHONE INTERVIEW FACE TO FACE/IN HOME
 ENTERED INTO Q

DATE: COMPLETED BY: TELEPHONE INTERVIEW FACE TO FACE/IN HOME
 ENTERED INTO Q