COMMUNITY ACTION OF NAPA VALLEY

HDM Application Form
Title III C Elderly Nutrition Program
Items marked with (*) **required.**
(DTS) **Decline to State**

Route #_____
# of Days_____
***Special Delivery Instructions**

In-Take Date: _____
Active Date: _____
Active Date: _____
Active Date: _____

Inactive Date: _____
Inactive Date: _____
Inactive Date: _____
(denote inactive reasons on page 6 HDM Inactive Notes)

*First Name	*MI	*Birth 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
***Female 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: _____
***Insurance:**
_____

***Language**
❑ English
❑ Other_____
❑ English Fluency
❑ 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 *Diabetic ❑ Yes ❑ No

***Living Arrangement**
Lives Alone ❑ Yes ❑ No
Lives with: _____
in household *(including client):* _____
***Is the temperature of client house appropriate:** ❑ Yes ❑ No

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

***Doctor Contact Info:**

***Digital Access:**
❑ Computer/Tablet ❑ Smart Phone
❑ Internet
***Digital Skills:**
❑ Texting ❑ Email ❑ social media
❑ Search Engine

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

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

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

***Sex at Birth:**
❑ Male ❑ Female

***Sexual Orientation:**
❑ Declined/Not Stated ❑ Straight/Heterosexual ❑ Bisexual ❑ Gay/Lesbian/Same-Gender Loving
❑ Questioning/Unsure ❑ Not Listed/Other Please Specify _____

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Eligibility (***(Check all that apply)***
❑ **Are you over 60 years old?**
❑ **Are you HOMEBOUND due to illness, disability, or isolation?**
❑ **Are you the 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:

*__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= Help. 4=Assistance Help. 5=Dependent**
Note: total value determined for waiting list prioritization

Able to take out garbage: ❑ Yes ❑ No **Can Answer Door: ❑ Yes ❑ No** **Architectural Barriers: ❑ Yes ❑ No** **Confused/Forgetful: ❑ 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 tried to force you to sign important documents? (financial)			
4. Does anyone make you do things you do not want to do? (physical, sexual, financial)			
5. Has anyone hurt you physically (Sexual, Physical)			
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. Recently hospitalized for a fall within the past six months?			
3. Do you use or have received instructions to use a cane or walker to get around safely?			

	Yes	No	If yes, please explain
4. Do you sometimes feel unsteady when walking?			
5. Do you steady yourself by holding onto furniture when walking 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 trouble stepping up onto a curb?			
9. Do you often have to rush to the toilet?			
10. Do you have lost 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?			
4. Do you feel that people care about you?			
5. Do you constantly experience a general sense of emptiness?			
6. Do you often feel rejected?			
NOTES:			

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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 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 majority 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 six months?	2	
10. 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: minimal risk 3-5: moderate risk 6 or more: elevated risk **Total Score Today:**		

Nutritional Assessment NOTES:

What nutrition information would you like to have:

☐ Healthy Eating	☐ Food Safety	☐ Food & Medication Interactions
☐ Weight Gain/Weight Loss	☐ Constipation	☐ High Blood Pressure Management
☐ Osteoporosis	☐ Fat & Cholesterol	☐ Brain Health
☐ Diabetes	☐Vitamins/supplements	☐ Anti-Aging
☐ Exercise/Fitness	☐Heart Health	☐Other:

Date Referral(s) Made:

____ Nutritionist (nutrition education or nutritional counseling)
____ Social Worker/ Case Manager/ APS
____ Medical Doctor
____ Mental Health Practitioner
____ Other:

____ Pharmacist
____ Dentist
____ Fall Prevention Program

Indicate referral agency here:

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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_____			
Recently 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 all documents are confidential and that the Area Agency on Aging and Meal Service Providers may use it to help identify other services from 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: _____

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HDM INACTIVE NOTES:

Inactive Date: _____ by Staff_____
Reasons:

Inactive Date: _____ by Staff_____
Reasons:

Inactive Date: _____ by Staff_____
Reasons: