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| **HDM Application Form**Title III C Elderly Nutrition ProgramItems marked with (\*) **required.**(DTS) **Decline to State** | Route ## of Days | **In-Take Date**: \_\_\_\_\_\_Active Date: \_\_\_\_\_\_\_\_Active Date: \_\_\_\_\_\_\_\_Active Date: \_\_\_\_\_\_\_\_\_ | Inactive Date: \_\_\_\_\_\_Inactive Date: \_\_\_\_\_\_Inactive Date: \_\_\_\_\_\_*(denote inactive reasons on page 6 HDM Inactive Notes)* |
| **\*Special Delivery Instructions** |
| \*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 ❑ NoLives with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_# in household *(including client):* **\*Is the temperature of the client’s house appropriate:** ❑ Yes ❑ No | **\*Social Worker/Caregiver Contact Info:** | **\*Digital Access:** ❑ Computer/Tablet ❑ Smart Phone❑ Internet **\*Digital Skills:** ❑ Texting ❑ Email ❑ social media ❑ Search Engine  |
| **\*Doctor Contact Info:** |
| **\*Emergency Contact****Name:** **Phone:** **Email:** **Relationship:**   |

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

\***Race/Ethnicity** ***(Check all that apply)*** |
| **\*Gender Identity:**❑ Not Answered ❑ Female ❑ Male ❑ Genderqueer/Gender Non-Binary ❑ Transgender Female to Male ❑ Transgender Male to Female ❑ Not Listed/Other Please Specify **\*Sex at Birth:** ❑ Not Answered ❑ Female ❑ Male ❑ Declined/Not Stated**\*Sexual Orientation:**❑ Declined/Not Stated ❑ Straight/Heterosexual ❑ Bisexual ❑ Gay/Lesbian/Same Gender Loving❑ Questioning/Unsure ❑ Not Listed/Other Please Specify  |
| **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 it is not eligible:* |

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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: |
| **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:  |

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| **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 the 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? |  |  |  |
| 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 a lost feeling on 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 not, 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 eat fewer than 2 meals per day? | 3 |  |
| 3. Does the client eat a 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 6 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:

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| --- | --- | --- |
| ☐ 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: |
|  |  |  |

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| Date Referral(s) Made:\_\_\_\_ Nutritionist (nutrition education or nutritional counseling) \_\_\_\_ Pharmacist\_\_\_\_ Social Worker/ Case Manager/ APS \_\_\_\_ Dentist\_\_\_\_ Medical Doctor \_\_\_\_ Fall Prevention Program\_\_\_\_ Mental Health Practitioner \_\_\_\_ Other: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.

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Signature of participant or participant’s representative Date

*Representative’s relationship with participant:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HDM INACTIVE NOTES:**

Inactive Date: \_\_\_\_\_\_\_\_ by Staff\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reasons:

Inactive Date: \_\_\_\_\_\_\_\_ by Staff\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reasons:

Inactive Date: \_\_\_\_\_\_\_\_\_\_ by Staff\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reasons: