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| **PSA 28 HDM In-Take Form**  Title III C Elderly Nutrition Program Items marked with (\*) are **required**  (DTS) is *Declined 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 5 HDM Inactive Notes)* | |
| **\*Special Delivery Instructions** | |
| \*First Name | | \*MI | | \*Maiden 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:** | | | | | **\*Digital Access:**  ❑ Computer/Tablet ❑ Smart Phone  ❑ Internet  **\*Digital Skills:**  ❑ Texting ❑ Email ❑ Social Media  ❑ Search Engine | | |
| **\*Doctor Contact Info:** | | | | |
| **\*Emergency Contact**  **Name:**  **Phone:**  **Email:**  **Relationship:** | | | | | | |  |  |  | | --- | --- | --- | | 🞎 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 a 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:* | | | | | | | | | | |

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| Name: Last 4 Digits of SSN: |

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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=Some Help. 4=Lots of Help. 5=Dependent**  *Note: total value will be used 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 don’t 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. Have you been hospitalized for a fall within the past six months? |  |  |  |
| 3. Do you use or have been advised 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 at 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 some trouble stepping up onto a curb? |  |  |  |
| 9. Do you often have to rush to the toilet? |  |  |  |
| 10. Do you have lost some 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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| Name: Last 4 Digits of SSN: | | |
| **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 almost 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 most 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 |  |
| I10. 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: low risk 3-5: moderate risk 6 or more: high 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  \_\_\_\_ Pharmacist  \_\_\_\_ Dentist  \_\_\_\_ Fall Prevention Program  \_\_\_\_ Other:  Indicate referral agency here: | | |

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| Name: Last 4 Digits of SSN: |

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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\_\_\_\_\_\_\_ |  |  |  |
| Have you recently been 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 it will be kept confidential and that the Area Agency on Aging and Meal Service Providers may use it to help identify other services for 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 to participant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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| Name: Last 4 Digits of SSN: |

**HDM INACTIVE NOTES:**

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

Reasons:

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

Reasons:

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

Reasons: