State of Illinois
Illinois Department on Aging

☐ New Client ☐ Reassessment ☐ Ineligible/Termination
Reason: _____

Nutrition Referral/Assessment for Home Delivered Meals

This form must be completed and forwarded to the appropriate Home Delivered Meal nutrition provider agency.

Referral Source: ☐ Care Coordination Unit (CCU) _____
☐ Managed Care Organization (MCO) _____
☐ Area Agency on Aging ☐ Nutrition Provider

Days Older Adult to Receive Meals (Check all that apply): ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Friday ☐ All M-F ☐ Weekend ☐ 2nd meals

Type of Meal(s): ☐ Hot ☐ Cold ☐ Frozen **Special Notes:**

Priority Level: ☐ High ☐ Intermediate ☐ Low

Duration of meals (Check only one): ☐ Short Term ☐ Long Term Re-evaluate Date: _____

Special Diet Needs: ☐ General ☐ Diabetic ☐ Low sodium ☐ Other (specify): _____

Older Adult Demographic Information

Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Cell Phone: _____

Authorized Representative: _____ Phone: _____

Emergency Contact Name #1: _____
Relationship: _____
Daytime/Cell Phone: _____

Emergency Contact Name #2: _____
Relationship: _____
Daytime/Cell Phone: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (Check all that apply):
☐ White
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaskan Native
☐ Asian or Asian American

What is your gender? (Check only one)
☐ Male ☐ Female
☐ Other

Are you a Veteran?
☐ Yes ☐ No

Marital Status:
☐ M ☐ D
☐ S ☐ W
☐ Domestic Partner
☐ Legally Separated

Type of Housing:
☐ Home
☐ Apt (# :_____)
☐ Other (specify):
_____
_____

Subsidized Housing:
☐ Yes ☐ No

Below Poverty? ☐ Yes ☐ No

Monthly Income: _____

# of Individuals in Household: _____

Limited English Speaking: ☐ Yes ☐ No If yes, primary language spoken: _____

Nutrition Risk Screen (circle points under Yes or No)	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 than two meals a day.	3	0
I eat few 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 three or more different prescribed or over-the-counter drugs a day.	1	0
Without wanting to, I have lost or gained ten pounds in the last six months.	2	0
I am not always physically able to shop, cook, and/or feed myself.	2	0
TOTAL		

Six or more points = High Nutritional Risk

☐ Nutritional Risk was explained to client.
☐ Client is considered at High Nutritional Risk. A recommendation was made to follow-up with a healthcare provider.

Impairment/Problem with Activity of Daily Living 0 No Assist = No; 1-3 Assist = Yes; 4 Unknown = No			Impairment/Problem with Instrumental Activities of Daily Living 0 No Assist = No; 1-3 Assist = Yes; 4 Unknown = No		
	PTS	**Yes/No**		**PTS**	**Yes/No**
Eating			Laundry		
Bathing			Shopping		
Grooming			Light Housework		
Dressing			Heavy Housework		
Toileting			Telephone		
Walking/Mobility			Financial Management		
Transferring (in/out of bed/chair)			Transportation		
			Meal Preparation		
			Medication		
Total Points			**Total Points**		
Total "Yes"= _____ Total "No"= _____			**Total "Yes"= _____ Total "No"= _____**		

Additional Nutrition Information

Who does the grocery shopping? _____

How often? _____

Can Older Adult feed self? ☐ Yes ☐ No
If no, who assists? _____
What type of help: ☐ Cutting ☐ Feeding ☐ Opening Containers

Is anyone available to prepare food? ☐ Yes ☐ No If yes, who? _____
What days? _____
Which meals? _____

Does Older Adult have difficulty chewing/poor dental health?
☐ Yes ☐ No

Older Adult's kitchen facilities/equipment (Check all that apply):
☐ Kitchen ☐ Kitchen privileges ☐ Freezer w/ available space
☐ Refrigerator ☐ Stove ☐ Microwave

Is Older Adult able to use these appliances unsupervised (Check all that apply):
☐ Stove ☐ Microwave ☐ Freezer ☐ Refrigerator

Older Adult food source for the weekends:

Dietary restrictions:

Food Allergies: ☐ Yes ☐ No If yes, specify: _____

NOTE: It is the client's responsibility to review the weekly menu and bring any allergy concerns to the attention of the nutrition provider. When feasible, the provider will supply a special meal to meet the dietary needs of the client.

Are you currently receiving food assistance benefits? ☐ **Yes** ☐ **No** (Examples: SNAP, SFMNP, TEFAP)

Reason/Eligibility for Home Delivered Meals: (Check all that apply)
☐ Homebound ☐ Permanently disabled ☐ Temporarily Disabled ☐ Respite for Caregiver
☐ Meal for Spouse or Disabled Adult in Home ☐ Other (specify): _____

Older Adult will benefit from Home Delivered Meals because (Check all that apply):
☐ Older Adult has difficulty cooking, tires easily ☐ Older Adult is recovering from surgery, illness, etc.
☐ Meals will increase nutritional intake as Older Adult has a limited income
☐ Other (specify): _____

Currently receiving home delivered meals from another source (e.g. family, church, etc.)**:** ☐ Yes ☐ No

Major Health Problems (check all that apply)

Ambulation: ☐ Full ☐ Partial ☐ Assisted ☐ Bedfast

Vision: ☐ Full ☐ Limited ☐ Glasses ☐ Blind

Hearing: ☐ Full ☐ Hard of Hearing ☐ Hearing Aid ☐ Deaf

Determination of Need (DON) score: *(If Known)* _____

Other major health concerns (describe): _____

Priority Level Screening Questions (After client is determined to be "eligible" for HDMs)	
1. (a): If you had groceries available, would you be able to use them to prepare hot meals? ☐ **Yes** *(Go to Question 2a)* ↓ ☐ **No** *(Go to Question 1b)*➔	**1. (b):** Do you have reliable help with meal preparation? ☐ **Yes** *(Go to Question 2)* ☐ **No (STOP – Check High Priority Level)**

2. During the last month…	***Circle Answer***
(a)...how often was this statement true? The food that I/we bought just didn't last, and I/we didn't have money to get more?	**Often=1 pt; Sometimes=1 pt; Never=0 pts**
(b)...how often was this statement true? I/we could not afford to eat balanced meals?	**Often=1 pt; Sometimes=1 pt; Never=0 pts**
(c)...did you or other adults in your household ever cut the size of your meals because there wasn't enough money for food?	**Yes=1 pt; No=0 pts**
(d)...did you or other adults in your household ever skip meals because there wasn't enough money for food?	**Yes=1 pt; No=0 pts**
(e)...did you ever eat less than you felt you should because there wasn't enough money for food?	**Yes=1 pt; No=0 pts**
(f)...were you ever hungry but didn't eat because you couldn't afford enough food?	**Yes=1 pt; No=0 pts**
Total points 2a-2f:_____	
3. Are you able to get groceries into your home when you need them? **Refer to total points when selecting.*	☐ Yes or No AND 0-1 point – Low ☐ Yes or No AND 2-6 points – Intermediate
0-1 Point AND "No" = Low Priority (May benefit from Grocery Shopping Services or Food Delivery.) **2-6 Points = Intermediate Priority** (May benefit from additional nutrition services.)	
Check the appropriate Priority Level Box at the top of Page 1	

Other Contacts Information	
Primary Physician Name:_____	Primary Physician Phone:_____
For Home Delivered Meal Providers:	
☐ Referred client to Community Care Program (CCP) for additional Home and Community Based Services. ☐ The HDM client was informed of the possibility that foods may contain or come into contact with food allergens.	

Authorization of Release of Information

I give permission to _____ to send a copy of this assessment form to the Home Delivered Meal (HDM) Provider, _____, and to discuss my needs with the HDM Provider, Care Coordination Unit (CCU), Managed Care Organization (MCO), and/or the AAA.

Older Adult Signature: _____ ☐ * Verbal Consent Provided Date:

I certify this Older Adult meets eligibility criteria for Home Delivered Meals under the Older Americans Act.

Signature:_____	Date:_____
Case Manager Name:_____	Phone:_____
Organization:_____	Email:_____

HDM Start Date:	Reassessment Date:	Termination Date:

Driver Instructions: (Check all that apply) ☐ Ring bell ☐ Knock loudly ☐ Beware of dog(s) ☐ Other:

* Verbal consent can be provided in the event of a pandemic, civil unrest, or other circumstance that prevents a client from providing their written consent/signature.

Completed by (For Referring Agencies Only):	
Name of Referring Agency:_____	Phone #:_____
Address: _____	