Smoky Mountain- Meals on Wheels- Intake Questionnaire

Date: _____ _____ Date rcv'd: _____

Applicants Name: _____Gender: _____

Address: _____City_____Zip_____

Phone Number: _____ last 4 digits social security: _____

Date of Birth: _____ _____Current Age: _____

Do you have a caregiver: _____Who? _____How Often? _____

Nearest Relative: _____Phone: _____

Current Living Arrangement: _____ ex: (self, w/spouse, child)

Are you a veteran or spouse of a veteran? _____Branch of service? _____

Type of Residence: _____ (home, apartment, mobile home)

Any family in the area? _____ Who shops/cleans now? _____

Rate your health (1=poor- 10 =great): _____Do you drive? _____

Any overnight stays in the hospital in past year? _____ any falls? _____

Mobility: (walker, wheelchair, cane) _____Any vision/hearing impairments? _____

How many meals eaten a day? _____ Do you often eat alone? _____ _____

Weight loss or gain last 6 months (10 + lbs.) _____Are you a diabetic? _____

Can you prepare meals? _____Can you Microwave meals? _____ if not, can someone help? _____

Are you getting enough help at home? _____Can you go out to eat? _____

Do you have memory problems: _____Allergies? _____

Do you have problems making people understand you? _____

Monthly Income and source: _____

Do you have enough to eat at the end of the month? _____Do you receive food stamps?_____

Have you applied for Options or Choices: _____ Do you pick-up or have someone pick-up food for you @ Community Food Connection? _____ Referred by: _____

Please use other side of Page to describe general health and struggles or special diets. Be as descriptive as possible to expediate and evaluate application/services. Incomplete apps will not be processed.

SENIOR NUTRITION- RAMP
EMERGENCY CONTACT INFORMATION
Blount County Community Action Agency

YOUR NAME: _____ PHONE: _____

BIRTHDAY: _____/_____/_____ CELL: _____
Month Day Year

ADDRESS _____

CITY_____ ZIP_____

EMERGENCY CONTACT :

NAME: _____

ADDRESS: _____

HOME PHONE:_____ CELL PHONE:_____

Family Physician

NAME:_____

ADDRESS: _____

HOME PHONE:_____

This also authorizes the Blount County Community Action Agency Senior Nutrition Program (BCCAA) to contact and/or give information to your contacts, emergency personnel, doctors, police and/or anyone one that will be able to assist you in an emergency situation should it be needed. It also allows BCCAA to follow-up with your status in order to implement or continue services to you.

Client Signature Date

SMOKY MOUNTAIN MEALS ON WHEELS

J Nutrition Screening

1. Has the client made any changes in lifelong eating habits because of health problems?
1 - Yes - 2
2 – No

2. Does the client eat fewer than 2 meals per day?
1 - Yes - 3
2 – No

3. Does the client have 3 or more drinks of beer, liquor or wine almost every day?
1 - Yes - 2
2 – No

4. Does the client eat fewer than five (5) servings (1/2 cup each) of fruits or vegetables every day?
1 - Yes - 1
2 – No

5.Does the client eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day?
1 - Yes - 1
2 - No

6. Does the client have trouble eating well due to problems with chewing /swallowing?
1 - Yes - 2
2 - No

7. Does the client sometimes not have enough money to buy food?
1 - Yes - 4
2 - No

8. Does the client eat alone most of the time?
1 - Yes - 1
2 - No

9. Does the client take 3 or more different prescribed or over-the-counter drugs per day?
1 - Yes - 1
2 - No

10.Without wanting to, has the client lost or gained 10 pounds in the past 6 months?
1 - Yes - 2
2 - No

11. Is the client not always physically able to shop, cook and/or feed themselves (or to get someone to do it for them)?
1 - Yes - 2
2 - No

Total score of Nutritional Risk Questions.

What is the client's nutritional risk score?

12. Is the client at a high nutritional risk level? (Scored 6 or more)
1 - Yes
2 - No

Indicate Struggles

Alzheimer's/Dementia	
Diabetes/Renal	
Cancer	
Heart Disease/ Stroke/ Heart Attack	
Anxiety/Depression/PTSD	
Myalgias	
Parkinson's	
Other (please describe below)	

Other Information regarding health: (diagnosis)

Describe limitations: (ex. Bed ridden, can't stand, lost limb)

Needs/struggles beyond meals: (ex. Wheelchair, grab bars, teeth)

Meals on Wheels is a by donation program and donation envelopes are sent out monthly. There is no set fee for the program in great thanks to our partnerships with Community Food Connection, Second Harvest and the United Way of Blount County. If you can donate great, if you can't you will not receive any different services than your neighbor. The average cost to feed one loved senior per month is $60.

Participant Signature Page

☐ AGE DECLARATION:

I am unable to provide proof of age and I declare that I am 60 years of age or older and that my date of birth, _____ _____ _____, is correct to the best of my knowledge.
month day year

☐ RELEASE OF INFORMATION FOR STATISTICAL REPORTING:

I understand that the information collected will not be identified with me personally. It may be used in statistical reports. I give my permission to use the information for statistical reporting.

☐ REQUEST FOR INTERAGENCY INFORMATION SHARING:

I receive services from more than one program funded through the Tennessee Commission on Aging and the area agency on aging. I request information from my assessment be shared with the agencies listed below that would otherwise have to interview me again to collect the same data.

☐ **AUTHORIZAION FOR REFERRAL FOR SERVICES:**

I give permission for Blount County Community Action Agency, Inc. to contact on my behalf the agencies or persons listed below and to release only such information to them as may be needed to determine the level and types of services that I may need. I also grant permission to the receiving agencies to report back regarding services that I may or may not receive and/or any additional information that may significantly reflect on my need for services:

Information will be shared with the following agencies: (If this section does not apply, write none.)

Agency	Purpose
1. My Physician/911/Sheriff's Dept./Rural Metro	Emergency Services
2. Blount County Community Action Agency, Inc.	Additional services provided by BCCAA
3. _____	_____

☐ **GRIEVANCE PROCEDURE:**

I understand that if I have a serious complaint about not receiving adequate service from Blount County Community Action Agency, Inc. I have a right to complain to the proper authorities with no penalty to me. (AGENCY)

CLIENT AGREEMENT:

By my signature, I affirm that I have read, or have had explained to me, the above statement. The telephone number I need for complaints has been left with me, and I do give the authorization necessary for release of information listed above. Unless otherwise stated this release of information expires in one year.

SIGNATURES

Date	Participant	Employee
Date	Participant	Employee