Home Delivered Meal Assessment Form

Welcome! Please tell us a bit about yourself so we can offer services that best meet your needs. All your personal information is confidential. Please see the attached FAQs for more information.

# Registration and Eligibility Section – Must Be Completed Prior to Service

First Name: Click or tap here to enter text.

Middle Name (if applicable): Click or tap here to enter text.

Last Name: Click or tap here to enter text.

Nickname (if applicable): Click or tap here to enter text.

Date of Birth: Click or tap here to enter text.

Age: Click or tap here to enter text.

## If you are under age 60, please select your eligibility for home delivered meals:

[ ] Self-declared spouse of participating individual aged 60+

60+ Spouse’s Full Name: Click or tap here to enter text.

The following individuals are only eligible when there is no waitlist for home delivered meals:

[ ] Volunteer for the meal programs

[ ] Individual with disabilities who lives with an active participant aged 60+

60+ Participant’s Full Name: Click or tap here to enter text.

# Contact Information Section

Home Phone: Click or tap here to enter text.

Cell Phone: Click or tap here to enter text.

Email: Click or tap here to enter text.

Home Address Line 1: Click or tap here to enter text.

Home Address Line 2 (Apt/Unit/Floor): Click or tap here to enter text.

County: Click or tap here to enter text.

City: Click or tap here to enter text.

State: Click or tap here to enter text.

Zip: Click or tap here to enter text.

Mailing address is the same as home address [ ]

Mailing Address Line 1: Click or tap here to enter text.

Mailing Address Line 2 (Apt/Unit/Floor): Click or tap here to enter text.

City: Click or tap here to enter text.

State: Click or tap here to enter text.

Zip: Click or tap here to enter text.

# Demographics Section – Used for Anonymous Reporting to Our Funders

* Gender (select all that apply):

[ ] Male

[ ] Female

[ ] Non-binary/Third gender

[ ] Transgender

[ ] Another gender not listed: Click or tap here to enter text.

[ ] Refuse to answer question

* Ethnicity:

[ ] Hispanic or Latino/a/e

[ ] Not Hispanic or Latino/a/e

[ ] Refuse to answer question

* Racial Identity (select all that apply):

[ ] American Indian or Alaska Native

[ ] Asian or Asian American

[ ] Black or African American

[ ] Middle Eastern or North African

[ ] Native Hawaiian or Pacific Islander

[ ] White

[ ] Another identity not listed: Click or tap here to enter text.

[ ] Refuse to answer question

* Do you live alone or with others?

[ ] Alone

[ ] With others

[ ] Refuse to answer question

* Is your income above or at/below the amount listed for your household size in the table:

[ ] Above

[ ] At/below

[ ] Refuse to answer question

## Income Levels Table

|  |  |  |
| --- | --- | --- |
| Household Size | Monthly Income | Annual Income |
| 1 | $1,304 | $15,650 |
| 2 | $1,763 | $21,150 |

Use the table to determine if your income is above or at/below the monthly or annual income listed for your household size. For each additional person, add $5,500 to annual income.

# Communication Section

What is your primary language? Click or tap here to enter text.

# Service Access and Support Section

* Health Insurance (select all that apply):

[ ] Medicare

[ ] Medicare Advantage

[ ] Medicaid

[ ] Medicaid Waiver(s)

[ ] VA

[ ] Private

[ ] None
[ ] Other insurance: Click or tap here to enter text.

[ ] Refuse to answer question

* Can you access this service through another benefit or program? For example, through Medicaid HCBS or Medicare Advantage benefits?

[ ] Yes

[ ] No

[ ] Refuse to answer question

[ ] I don’t know

* Do you have reliable outside support for food access and/or meal preparation (for example, from family, friends, or a caregiver)?

[ ] Yes

[ ] No

[ ] Refuse to answer question

* Could you participate in meals at a congregate site?

[ ] Yes

[ ] No

[ ] Refuse to answer question

* Are you homebound? Select “Yes” if any of the following statements are true for you:
	+ You need the help of another person to leave your home, or
	+ You have a health condition or disability that makes it difficult to leave your home on a regular basis, or
	+ You are only able to leave your home infrequently and for short periods of time

[ ] Yes

[ ] No

[ ] Refuse to answer question

* Are you isolated from community resources? Examples of community resources include stores, banks, health services, and senior center activities. Select “Yes” if any of the following statements are true for you:
	+ You live in a remote area, or
	+ You have a health condition or disability that makes it difficult for you to access community resources, or
	+ You have financial or technology challenges that make it difficult for you to access community resources, or
	+ You cannot drive or use public transportation, or
	+ You do not feel welcome in your community due to cultural or language barriers

[ ] Yes

[ ] No

[ ] Refuse to answer question

# Nutrition Screening Section

## Nutrition Risk Score

Determine your nutritional health. If the statement is true for you, select the “Yes” checkbox and add the “Yes Score” points to your total score.

1. Do you have an illness or condition that has made you change the kind and/or amount of food you eat?

[ ] Yes, if yes, add 2 to your total score

[ ] No, if no, add 0 to your total score

[ ] Refuse to answer question

1. Do you eat fewer than 2 meals per day?

[ ] Yes, if yes, add 3 to your total score

[ ] No, if no, add 0 to your total score

[ ] Refuse to answer question

1. Do you eat few fruits, vegetables, or milk products?

[ ] Yes, if yes, add 2 to your total score

[ ]  No, if no, add 0 to your total score

[ ] Refuse to answer question

1. Do you have 3 or more drinks of beer, liquor, or wine almost every day?

[ ] Yes, if yes, add 2 to your total score

[ ] No, if no, add 0 to your total score

[ ] Refuse to answer question

1. Do you have tooth or mouth problems that make it hard for you to eat?

[ ] Yes, if yes, add 2 to your total score

[ ] No, if no, add 0 to your total score

[ ] Refuse to answer question

1. Are there times you do not have enough money to buy the food you need?

[ ] Yes, if yes, add 4 to your total score

[ ] No, if no, add 0 to your total score

[ ] Refuse to answer question

1. Do you eat alone most of the time?

[ ] Yes, if yes, add 1 to your total score

[ ] No, if no, add 0 to your total score

[ ] Refuse to answer question

1. Do you take 3 or more different prescribed or over the counter drugs a day?

[ ] Yes, if yes, add 1 to your total score

[ ] No, if no, add 0 to your total score

[ ] Refuse to answer question

1. Without wanting to, have you lost or gained 10 pounds in the last 6 months?

[ ] Yes, if yes, add 2 to your total score

[ ] No, if no, add 0 to your total score

[ ] Refuse to answer question

1. Are there times you’re physically unable to shop, cook, and/or feed yourself?

[ ] Yes, if yes, add 2 to your total score

[ ] No, if no, add 0 to your total score

[ ] Refuse to answer question

Total Nutrition Risk Score (Total “Yes” Score): Click or tap here to enter text.

Total Nutrition Risk Score Meaning: 0-2 = No Risk, 3-5 = Moderate Risk, 6 or more = High Risk

If you are at high nutrition risk – speak with a qualified health or social service professional.

## The Hunger Vital Sign

For each of the following statements please tell us which one is “often true”, “sometimes true” or “never true”, for the past 12 months:

1. I worried whether my food would run out before I got money to buy more

[ ] Never True

[ ] Sometimes True

[ ] Often True

[ ] Refuse to answer question

1. The food that I bought just didn't last and I didn't have money to get more

[ ] Never True

[ ] Sometimes True

[ ] Often True

[ ] Refuse to answer question

If you answered often true or sometimes true to either or both questions above, you are at risk for food insecurity. For food and nutrition resources, call the confidential Food Resource Hotline toll-free at 855-855-4626.

## Nutrition Counseling

Are you interested in receiving nutrition counseling?

[ ] Yes
[ ] No

# Activities of Daily Living

For each activity, please mark the level of help you need.

1. Bathing or showering

[ ] Independent: I don’t need any help with this activity

[ ] Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

[ ] Dependent: I always need help from another person to do this activity

[ ] Refuse to answer question

1. Dressing - Putting on and taking off clothing and shoes

[ ] Independent: I don’t need any help with this activity

[ ] Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

[ ] Dependent: I always need help from another person to do this activity

[ ] Refuse to answer question

1. Using the bathroom - Getting to and on/off the toilet, managing clothing, wiping

[ ] Independent: I don’t need any help with this activity

[ ] Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

[ ] Dependent: I always need help from another person to do this activity

[ ] Refuse to answer question

1. Transferring In/Out of Bed/Chair - Getting in and out of sitting or lying positions

[ ] Independent: I don’t need any help with this activity

[ ] Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

[ ] Dependent: I always need help from another person to do this activity

[ ] Refuse to answer question

1. Walking/Getting Around the House

[ ] Independent: I don’t need any help with this activity

[ ] Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

[ ] Dependent: I always need help from another person to do this activity

[ ] Refuse to answer question

1. Eating and drinking

[ ] Independent: I don’t need any help with this activity

[ ] Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

[ ] Dependent: I always need help from another person to do this activity

[ ] Refuse to answer question

Comments on ADLs: Click or tap here to enter text.

# Instrumental Activities of Daily Living

For each activity, please mark the level of help you need.

1. Meal Preparation - Planning, making, and cleaning up meals

[ ] Independent: I don’t need any help with this activity

[ ] Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

[ ] Dependent: I always need help from another person to do this activity

[ ] Refuse to answer question

1. Shopping - Selecting and paying for food, household supplies, clothing, and other items

[ ] Independent: I don’t need any help with this activity

[ ] Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

[ ] Dependent: I always need help from another person to do this activity

[ ] Refuse to answer question

1. Medication Management - Getting prescriptions filled and taking medications as prescribed

[ ] Independent: I don’t need any help with this activity

[ ] Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

[ ] Dependent: I always need help from another person to do this activity

[ ] Refuse to answer question

1. Money Management - Budgeting, using cards and bank accounts, paying bills

[ ] Independent: I don’t need any help with this activity

[ ] Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

[ ] Dependent: I always need help from another person to do this activity

[ ] Refuse to answer question

1. Using a Telephone - Making and receiving calls

[ ] Independent: I don’t need any help with this activity

[ ] Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

[ ] Dependent: I always need help from another person to do this activity

[ ] Refuse to answer question

1. Light Housework – Tidying up, sweeping, vacuuming, mopping, cleaning kitchen and bathroom surfaces, taking out garbage

[ ] Independent: I don’t need any help with this activity

[ ] Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

[ ] Dependent: I always need help from another person to do this activity

[ ] Refuse to answer question

1. Heavy Housework – Deep cleaning the home, moving light furniture to clean under/behind

[ ] Independent: I don’t need any help with this activity

[ ] Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

[ ] Dependent: I always need help from another person to do this activity

[ ] Refuse to answer question

1. Transportation – Driving, walking, or using other forms of available transportation, like buses

[ ] Independent: I don’t need any help with this activity

[ ] Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

[ ] Dependent: I always need help from another person to do this activity

[ ] Refuse to answer question

Comments on IADLs: Click or tap here to enter text.

* Does anyone help you with ADL or IADL activities?

[ ] Yes
[ ] No

[ ] Refuse to answer question

* + If yes, who is assisting you? Click or tap here to enter text.

# Emergency Contact Section

Name: Click or tap here to enter text.

Phone: Click or tap here to enter text.

Relationship: Click or tap here to enter text.

[ ] Refuse to provide contact

Are you interested in learning about nutrition and a healthy diet? If yes, you're invited to enroll in Text2LiveHealthy, a nutrition education program delivered to you via text message. Scan this QR code with your phone’s camera to enroll or text the word FRUIT to 97699. Message & Data Rates May Apply. Text HELP for information. Text STOP to 97699 to opt out. No purchase necessary. For Privacy Policy and Terms and Conditions, visit [Text 2 Live Healthy](https://coloradosph.cuanschutz.edu/text2livehealthy).



# Disclosures and Waivers

I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service providers and I give my consent to do so.

Signature: Click or tap here to enter text.

Date: Click or tap here to enter text.

If filled out by someone other than the client (for example a caregiver or assessor, please check here [ ]  and sign below)

Filled out by: Click or tap here to enter text.

Date: Click or tap here to enter text.