HOME DELIVERED MEAL REGISTRATION/ASSESSMENT

Name (First, MI, Last): Click or tap here to enter text.

Date of Registration/Assessment: Click or tap here to enter text.

Residential Address (Fire No. & Street): Click or tap here to enter text.

Date of Birth (month/day/year): / /

City/State/Zip: Click or tap here to enter text.

Gender: ☐ Male ☐ Female

Telephone Number/Email Address: Click or tap here to enter text.

Race:

☐ American Indian or Native Alaskan
☐ Asian or Asian American
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White (non-Hispanic)
☐ White-Hispanic
☐ Other_____

Ethnicity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Living Arrangement:

Lives Alone
☐ Yes ☐ No

Income Status:

Is your income below the following Federal Income Guidelines?
☐ Yes ☐ No

# in Home	Month	Year
1	$1,073	$12,880
2	$1,452	$17,420
3	$1,830	$21,960
4	$2,208	$26,500

ACTIVITIES OF DAILY LIVING (ADLs) and INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

Check each ADL that you/the client have/has difficulty in completing or need help with:

	No	Yes
Getting in and out of the bath or shower or preparing the bath, washing and drying	☐	☐
Dressing and undressing	☐	☐
Completing toilet activities and personal care	☐	☐
Getting in and out of bed or a chair	☐	☐
Using utensils and eating without help	☐	☐
Walking up and down a flight of stairs or walking without assistance	☐	☐

TOTAL Number of Yes ADLS ____

Check each IADL that you/the client have/has difficulty in completing or need help with:

	No	Yes
Preparing own meals	☐	☐
Medication management	☐	☐
Handling bill paying, banking, etc	☐	☐
Doing heavy housework and outside chores	☐	☐
Doing light housework	☐	☐
Shopping for personal items and/or groceries	☐	☐
Traveling in a van, taxi, bus or car	☐	☐
Answering the telephone or calling out on the telephone	☐	☐

TOTAL Number of Yes IADLS ____

Enhanced DETERMINE Questions Pathways

DETERMINE Question	If Yes, ask Follow Up Questions	Referral/Intervention Options (Person-Centered Plan)
I have an illness or condition that made me change the kind and/or amount of food I eat. ☐ Yes (2) ☐ No (0) **Page 1 Total**: Click or tap	What acute or chronic conditions do they have? Click or tap here to enter text. ☐ Recent falls? ☐ Recent Surgery? ☐ **Do they follow a special diet?** If yes, specify: Click or tap here to enter text.	☐ Refer to Registered Dietitian for Nutr. Ed and/or Nutrition Counseling. ☐ Refer to a Healthcare provider for a special diet or medically tailored meal order. ☐ Refer to MD for f/u if they didn't go in after a recent fall. ☐ Refer to ***Stepping Up Your Nutrition*** (online or in-person class). ☐ Refer to *Mind Over Matter, Healthy Bowls, Healthy Bladder (MOM).* Evidence-Based Online program for incontinence ☐ Refer to Aging Mastery Program (AMP) offered by Focal Points. ☐ Refer to Healthy Living with Diabetes ☐ Refer to Living Well w/Chronic Cond. ☐ Other EB Classes: Click or tap here to enter text.

I eat fewer than 2 meals a day. ☐ Yes (3) ☐ No (0) (If Yes, ask what they typically eat in a day and when. Record below) Click or tap here to enter text.	☐ No appetite ☐ Unable to prepare food. ☐ Unable to shop for food. ☐ Cannot afford food. ☐ I sometimes forget to eat. ☐ Can they open the food? ☐ Do they have working equipment to cook or reheat food or to store it properly, i.e. working fridge? Click or tap here to enter text. ☐ Do they have enough food for their pet? ☐ Are they raising grandchildren? ☐ Ask about culture and religious beliefs to see if this is one of the reasons. ☐ Ask if they feel lonely or depressed. **If yes,** ask, In general: • How often do you feel that you lack companionship? ☐ Hardly Ever, ☐ Some of the time, ☐ Often • How often do you feel left out? ☐ Hardly Ever, ☐ Some of the time, ☐ Often • How often do you feel isolated from others? ☐ Hardly Ever, ☐ Some of the time, ☐ Often	☐ Refer to Dietitian for further assessment. ☐ If concerned about med side effects affecting appetite https://www.drugs.com/ ☐ Complete FoodShare Application. ☐ Provide a list of food pantries and community meals and Senior Dining Sites. ☐ Provide list of activities to reduce loneliness and Focal Point newsletter. ☐ Arrange for transportation to the sites/food pantry. ☐ Arrange for a proxy food pantry shopper. ☐ Arrange for grocery delivery. ☐ Provide a list of online stores that deliver. (Remember Walmart and Aldi-InstaCart) ☐ Refer to ADRC to explore adaptive equipment. ☐ Refer to Grand Parents Raising Grandchildren support group and programs.
I eat few fruits, vegetables or milk products. ☐ Yes (2) ☐ No (0)	☐ Cannot chew fresh F/V. ☐ No access to fresh fruits and veggies. ☐ Cannot peel or cut fresh produce. ☐ Do not know how to prepare F/V. ☐ Lactose Intolerant ☐ Ask what fruits & veggies and dairy products they typically eat and list below. Click or tap here to enter text. ☐ Meds limit what they are able to eat. ☐ Cannot have leafy green veggies	☐ Refer to Dietitian for Nutr. ed and/or Counseling. ☐ Refer to ADRC for Adaptive Equipment Evaluation. ☐ Complete FoodShare Application. ☐ Offer transportation for shopping. ☐ Recommend Lactaid or Calcium and Vit. D fortified Juice if available. ☐ Offer Senior Farmers Market Vouchers if available.
I have 3 or more drinks of beer, liquor, or wine almost every day. ☐ Yes (2) ☐ No (0)	☐ Are they a widower or live alone? ☐ Ask about their appetite. (Poor/Fair/Good) ☐ Ask what meds they take, as many are affected by alcohol. Click or tap here to enter text. ☐ Ask if they feel lonely or depressed. If yes, ask, In general: • How often do you feel that you lack companionship? ☐ Hardly Ever, ☐ Some of the time, ☐ Often • How often do you feel left out? ☐ Hardly Ever, ☐ Some of the time, ☐ Often • How often do you feel isolated from others? ☐ Hardly Ever, ☐ Some of the time, ☐ Often	☐ Refer to Dietitian for further assessment. ☐ Refer to Stepping On Falls Prevention Class ☐ Refer to Stepping Up Your Nutrition Class (If available) ☐ Refer to support group if wanted. ☐ Provide resources available from the National Institute for Alcohol Abuse and Addiction to help make informed decisions about drinking alcohol, including Rethinking Drinking: Alcohol and Your Health.
I have tooth or mouth problems that makes it hard for me to eat. ☐ Yes (2) ☐ No (0) **Page 2 Total**: Click or tap	☐ Dentures? Full or partial. Do they fit? Click or tap here to enter text. ☐ Have their own teeth. ☐ Edentulous (No teeth) ☐ Dry mouth? ☐ Swallowing problems? ☐ They have visited the dentist in the past year. If no, why? _____ ☐ Ask about brushing/flossing habits. ☐ If they have a caregiver, ask if any challenges with feeding and oral health care. ☐ They smoke or chew tobacco	☐ Refer to dietitian for follow up. ☐ Rec. healthcare provider review meds to see if they are causing dry mouth. ☐ Ask if a Veteran? If yes, refer to VA for a dental assessment. ☐ Provide a list of free or no cost dentists. ☐ Refer to ADRC for adaptive equipment/ easy-grip toothbrush. ☐ Provide information about good oral hygiene for older adults. ☐ Ask if interested in quitting tobacco use and make an appropriate referral. ☐ Review insurance plans that include dental care during open enrollment.

I don't always have enough money to buy the food I need. ☐ Yes (4) ☐ No (0)	☐ Ask if they get food from the food pantry, family, neighbors, etc.to make ends meet. ☐ Do they manage their own money? ☐ Do they know the meals are offered on a contribution basis?	☐ Refer to dietitian for tips on how to make meals on a budget. ☐ Complete FoodShare Application. ☐ Provide a list of food pantries and community meals.
I eat alone most of the time. ☐ Yes (1) ☐ No (0)	☐ Concerned about social isolation or loneliness. ☐ Seems depressed. Why? Click or tap here to enter text. If yes, ask, In general: • How often do you feel that you lack companionship? ☐ Hardly Ever, ☐ Some of the time, ☐ Often • How often do you feel left out? ☐ Hardly Ever, ☐ Some of the time, ☐ Often • How often do you feel isolated from others? ☐ Hardly Ever, ☐ Some of the time, ☐ Often ☐ Do they have a pet(s)? Click or tap here to enter text. ☐ What do they feed the pet? Click or tap here to enter text. ☐ Do they have a smartphone, tablet, or computer? ☐ Interested in learning how to Skype, Zoom, Facetime, etc.? ☐ Do they have internet access? If no, why not? Click or tap here to enter text. ☐ Are they a Veteran? If yes, are they interested in the Honor Flight or other programs and services from the VA?	☐ Refer to dietitian for follow-up ☐ Arrange transport to Senior Dining Site if able and interested on _____ days of the week. ☐ Offer Friendly Visit, phone call. ☐ Refer to community meals and senior dining locations. ☐ Refer to Sip & Swipe or Tablet/Smart Phone Training ☐ Provide information on the free ***Easy Tablet Help for Seniors*** App. ☐ Tell them about or help them review eligibility for discounted internet and devise at https://www.everyoneon.org/ ☐ Connect with Technology buddy to get them up socially connected. ☐ Provide information about local Senior Center and other community clubs/organizations/communities of faith that align with their interests. ☐ Provide Craft or Coloring Kits ☐ Refer to Volunteer Coordinator or RSVP. There may be things they can do at home to stay engaged. ☐ Refer to Veterans Office for Honor Flight or Click or tap here to enter text.
I take 3 or more different prescribed or over-the-counter drugs a day. ☐ Yes (1) ☐ No (0)	☐ Ask what herbs, supplements, vitamins, and other OTC medicines they take. (List below) Click or tap here to enter text. ☐ Are they taking their meds as prescribed? If not, why? Click or tap here to enter text. ☐Do they understand the instructions of how and when to take meds? Click or tap here to enter text.	☐ Refer to Dietitian for follow-up. ☐ Rec. medication review with pharmacist. ☐ Refer to Pharmacist/healthcare provider to check for drug/nutrient interactions. ☐ Suggest or provide a pillbox to help them manage their meds ☐ Encourage them to tell their MD all the over-the-counter supplements they take. ☐ Review insurance options for prescription drug coverage during open enrollment. ☐Tell them about Drugs.com if they are interested in knowing more about their meds or supplements.
Without wanting to, I have lost or gained 10 pounds in the last 6 months. ☐ Yes (2) ☐ No (0)	☐ Any change in condition or life event change to help determine the root cause. ☐ Ask about their sleep habits. ☐ Ask about their energy level and strength.	☐ Refer to dietitian for follow-up. ☐ Other: Click or tap here to enter text.
I am not always physically able to shop, cook, and/or feed myself. ☐ Yes (2) ☐ No (0) **Page 3 Total**: --- **FINAL DETERMINE SCORE _____**	☐ Does someone else prepare meals for them? Who? Click or tap here to enter text. ☐ Do they use a lot of convenience foods? What types? Click or tap here to enter text. ☐ Do they have any adaptive equipment? Know how to use it? Or are interested in learning about it? ☐ Able to open boxes, packages, cans? ☐ Able to prepare food? ☐ Ask if they exercise? If yes, what and how often. Click or tap here to enter text.	☐ Refer to dietitian. ☐ Refer to Evidence based classes as appropriate. Click or tap here to enter text. ☐ Refer to Stepping Up Your Nutrition Class (in available) ☐ Refer to ADRC for adaptive equipment. ☐ Provide list of exercise or movement classes/programs

ASK EVERYONE and enter score _____	**2 question malnutrition screen MST** 1. Have you recently lost weight **without trying?** ☐ Yes ☐ No If Yes, how much weight have you lost? ☐ 2-13 lbs. (Score 1) ☐ 14-23 lbs. (Score 2) ☐ 24-33 lbs. (Score 3) ☐ 34 lb. or more (Score 4) ☐ Unsure (Score 1) **Weight loss score** _____ 2. Have you been eating poorly because of a decreased appetite? ☐ No (Score 0) ☐ Yes (Score 1) **Appetite Score**_____ **Total Score for question 1 and 2** _____	**How to Score:** **MST = 0 or 1 = NOT At Risk** (Eating well with little or no weight loss) **MST= 2 or more = At Risk** (Eating poorly and/or recent weight loss) ☐ Ask if ok to refer to Dietitian for follow-up.
ASK EVERYONE ☐ Food Secure ☐ Food Insecure ***A response of "often true" or "sometimes true" to either question = positive screen for Food Insecurity.***	**Two Question Food Insecurity Questions** I'm going to read you two statements that people have made about their food situation. **For each statement, please tell me whether the statement was often true, sometimes true, or never true** for your household in the last 12 months. 1. "We worried whether our food would run out before we got money to buy more." Was that often true, sometimes true, or never true for your household in the last 12 months? _____ 2. "The food that we bought just didn't last, and we didn't have money to get more." Was that often, sometimes, or never true for your household in the last 12 months? _____	☐ Refer to Dietitian. ☐ Complete FoodShare Application. ☐ Provide a list of food pantries and community meals.
DETERMINE Score: Click or tap here to enter text. **DETERMINE Nutrition Risk Level:** ☐ **Low Risk (0-2)** ☐ **Moderate Risk (3-5)** ☐ **High Risk (6 or more)**		***MST Malnutrition Screen Score:*** ☐ Not at Risk (0 to 1) ☐ At Risk (2 or more) ***Food Insecure?*** ☐ Yes ☐ No ☐ **Recorded the MST Score and Food Security Response in SAMs Special Use Fields**

Emergency Contact: Click or tap here to enter text. Relationship: Click or tap here to enter text.

Phone: Click or tap here to enter text. Email: Click or tap here to enter text.

Program Contributions

☐ Participant would like a contribution letter mailed to his/her home.
☐ Participant will make contributions directly. Do NOT mail a contribution letter.
☐ Someone else who will be contributing on his/her behalf for meals. Send contribution letter to:

Name: Click or tap here to enter text.

Address: Click or tap here to enter text.

Phone: Click or tap here to enter text. Email: Click or tap here to enter text.

Requested start date: Click or tap to enter a date.

Reassessment due: Click or tap to enter a date.

Person Conducting Assessment: Click or tap here to enter text. **Date:** Click or tap to enter a date.