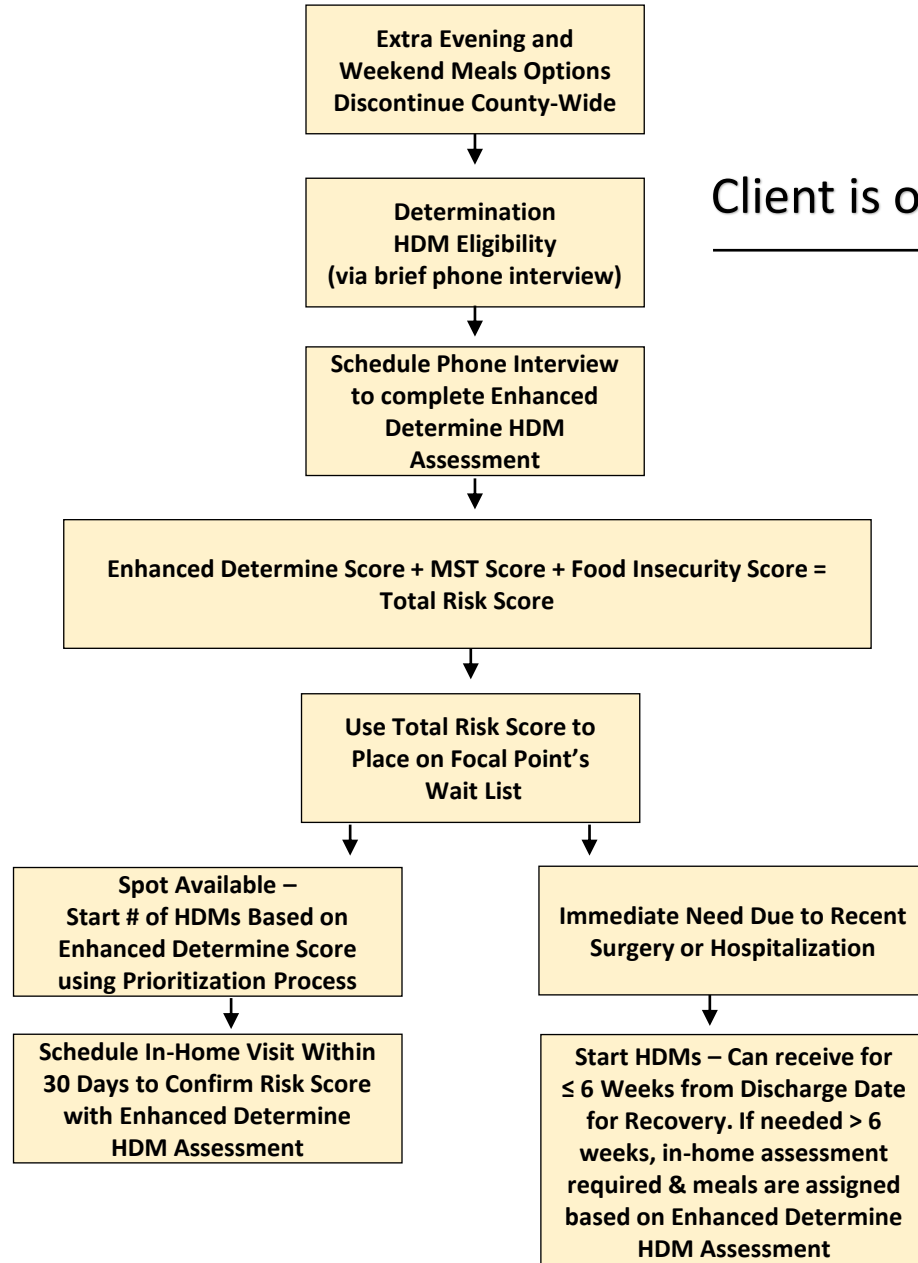
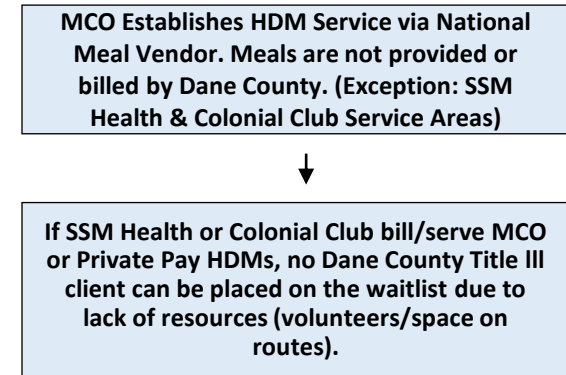


Title III HDMs



Client is on MCO/PARTNERSHIP/IRIS

MCO/Private Pay HDMs



Key:

HDM – Home Delivered Meal
MCO – Managed Care Organization
IRIS – Include, Respect, I Self-Direct
MST – Malnutrition Screening Tool
Title III – Government Funded Meals



2025-2026 Dane County Senior Nutrition Program
Home-Delivered Meals Assessment/Reassessment Cover Sheet

Recipient:		Assessment Date:	
Focal Point:		HDM Start Date:	
Case Manager:			

Please complete the following assessment information to verify eligibility.

Is the person on Care Wisconsin, My Choice Family Care, iCare, IRIS or ANY MCO? If YES, refer the client to their Partnership or Family Care Case or Care Manager to authorize home-delivered meals. DO NOT CONTINUE BELOW.

☐ Yes ☐ No

BASIC ELIGIBILITY REQUIREMENTS: Must Check ONLY One.

- ☐ **Age 60+:** Is frail and/or currently essentially homebound by reason of illness, disability or isolation. Homebound is defined as "does not leave home under normal circumstances."
- ☐ **Relational Exception:** A spouse of a person eligible for HDM's regardless of age or condition, if assessment concludes it is in the best interest of the homebound older individual.
- ☐ **Relational Exception:** A disabled individual who resides at home with an eligible older individual participating in the program.

- ☐ Eligible to receive meals for ☐ 3 months ☐ 6 months ☐ 1 year
- ☐ Not eligible to receive meals (please indicate reason below)
- # of Meals per week: Check the box that corresponds with the Nutrition Risk Score
 - ☐ 0-2 = 2 days per week
 - ☐ 3-5 = 3 days per week
 - ☐ 6+ = 5 days per week
- ☐ Case Manager overriding Nutrition Risk Score and approving # of meals each week.

Reason for override:

2025-2026 HOME DELIVERED MEAL ASSESSMENT

Name (First, MI, Last):		Date of Assessment:															
Residential Address (Fire No. & Street):		Date of Birth (month/day/year):															
City/State/Zip:		Ethnicity: <input type="checkbox"/> Hispanic or Latinx <input type="checkbox"/> Not Hispanic or Latinx															
Telephone Number (with Area Code)/Email Address:		Household <input type="checkbox"/> I live alone <input type="checkbox"/> I live with others															
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Declined to Answer	Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Declined to Answer	Income Status: Is your income below the following Federal Income Guidelines? <input type="checkbox"/> Yes <input type="checkbox"/> No <table><thead><tr><th># in Home</th><th>Month</th><th>Year</th></tr></thead><tbody><tr><td>1</td><td>\$1,305</td><td>\$15,650</td></tr><tr><td>2</td><td>\$1,763</td><td>\$21,150</td></tr><tr><td>3</td><td>\$2,221</td><td>\$26,650</td></tr><tr><td>4</td><td>\$2,680</td><td>\$32,150</td></tr></tbody></table>	# in Home	Month	Year	1	\$1,305	\$15,650	2	\$1,763	\$21,150	3	\$2,221	\$26,650	4	\$2,680	\$32,150
# in Home	Month	Year															
1	\$1,305	\$15,650															
2	\$1,763	\$21,150															
3	\$2,221	\$26,650															
4	\$2,680	\$32,150															

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

Check each ADL that you/the client have/has difficulty in completing or need help with:	No Help Needed	Needs Help
Bathing: Gets in/out of the bath/shower, uses faucets, washes, dries oneself safely	<input type="checkbox"/>	<input type="checkbox"/>
Dressing: Dress and undress safely	<input type="checkbox"/>	<input type="checkbox"/>
Toileting: Uses toilet and cleans oneself	<input type="checkbox"/>	<input type="checkbox"/>
Transferring: Moves in/out of bed/chair	<input type="checkbox"/>	<input type="checkbox"/>
Feeding: Gets food/drink from plate, bowl, cup into mouth and uses utensils	<input type="checkbox"/>	<input type="checkbox"/>
Continence: Exercises complete self-control	<input type="checkbox"/>	<input type="checkbox"/>

TOTAL Number of Needs Help ADLs

Instrumental Activities of Daily Living (IADLs)

Check **Needs Help** for each IADL that you/the client *cannot* perform without help (supervision, cuing, or hands-on assistance). Check **No** for each IADL you *can* complete without help.

	No Help	Needs Help
Food Preparation: Plans, prepares, and serves adequate meals independently	<input type="checkbox"/>	<input type="checkbox"/>
Shopping: Takes care of all shopping needs independently.	<input type="checkbox"/>	<input type="checkbox"/>
Responsibility for Own Medications: Takes medication in correct dosages at correct time.	<input type="checkbox"/>	<input type="checkbox"/>
Ability to Handle Finances: Handles financial matters and/or day-to-day purchases.	<input type="checkbox"/>	<input type="checkbox"/>
Housekeeping: Participates in housekeeping tasks.	<input type="checkbox"/>	<input type="checkbox"/>
Laundry: Launders some items independently.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Mode of Transportation: Travels unassisted via personal vehicle, public transportation, or taxi.	<input type="checkbox"/>	<input type="checkbox"/>
Ability to Use a Telephone: Dials and/or answers the telephone.	<input type="checkbox"/>	<input type="checkbox"/>
TOTAL Number Needs Help IADLs		<input type="text" value="1"/>

Enhanced DETERMINE Questions Pathways

DETERMINE Question	If Yes, ask Follow Up Questions	Referral/Intervention Options (Person-Centered Plan)
<p><i>I have an illness or condition that made me change the kind and/or amount of food I eat.</i></p> <p><input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0)</p>	<p>What acute or chronic conditions do they have?</p> <p><input type="checkbox"/> Recent falls? <input type="checkbox"/> Recent Surgery? <input type="checkbox"/> Do they follow a special diet? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes</p> <p>If yes, specify:</p>	<p><input type="checkbox"/> Refer to Dietitian for Nutrition Counseling. <input type="checkbox"/> Refer to a Healthcare provider for a special diet or medically tailored meal order. <input type="checkbox"/> Refer to MD for f/u if they didn't go in after a recent fall. <input type="checkbox"/> Refer to <i>Mind Over Matter, Healthy Bowls, Healthy Bladder (MOM)</i>. Evidence Based Online or In-person program for incontinence. <input type="checkbox"/> Refer to Aging Mastery Program (AMP) offered by Focal Points.</p>
<p><i>I eat fewer than 2 meals a day.</i></p> <p><input type="checkbox"/> Yes (3) <input type="checkbox"/> No (0)</p> <p>(If Yes, ask what they typically eat in a day and when. Record below)</p>	<p><input type="checkbox"/> No appetite <input type="checkbox"/> Unable to prepare food. <input type="checkbox"/> Unable to shop for food. <input type="checkbox"/> Cannot afford food. <input type="checkbox"/> I sometimes forget to eat. <input type="checkbox"/> Can they open the food? <input type="checkbox"/> Do they have working equipment to cook or reheat food or to store it properly, i.e. working fridge? <input type="checkbox"/> Do they have enough food for their pet? <input type="checkbox"/> Are they raising grandchildren? <input type="checkbox"/> 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:</p> <ul style="list-style-type: none"> How often do you feel that you lack companionship? <input type="checkbox"/> Hardly Ever, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Often How often do you feel left out? <input type="checkbox"/> Hardly Ever, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Often How often do you feel isolated from others? <input type="checkbox"/> Hardly Ever, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Often 	<p><input type="checkbox"/> Refer to Dietitian for Nutrition Counseling <input type="checkbox"/> If concerned about med side effects affecting appetite https://www.drugs.com/ <input type="checkbox"/> Complete FoodShare Application. <input type="checkbox"/> Provide a list of food pantries and community meals and Senior Dining Sites. <input type="checkbox"/> Provide list of activities to reduce loneliness and Focal Point newsletter. <input type="checkbox"/> Arrange for transportation to the sites/ food pantry. <input type="checkbox"/> Arrange for a proxy food pantry shopper. <input type="checkbox"/> Arrange for grocery delivery. <input type="checkbox"/> Provide a list of online stores that deliver. (Remember Walmart and Aldi-InstaCart) <input type="checkbox"/> Refer to ADRC to explore adaptive equipment. <input type="checkbox"/> Refer to Grand Parents Raising Grandchildren support group and programs.</p>

Page 1 Total:

<p><i>I eat few fruits, vegetables or milk products.</i></p> <p><input type="checkbox"/> Yes (2)</p> <p><input type="checkbox"/> No (0)</p>	<p><input type="checkbox"/> Cannot chew fresh F/V.</p> <p><input type="checkbox"/> No access to fresh fruits and veggies.</p> <p><input type="checkbox"/> Cannot peel or cut fresh produce.</p> <p><input type="checkbox"/> Do not know how to prepare F/V.</p> <p><input type="checkbox"/> Lactose Intolerant</p> <p><input type="checkbox"/> Ask what fruits & veggies and dairy products they typically eat and list below.</p> <p><input type="checkbox"/> Meds limit what they are able to eat.</p> <p><input type="checkbox"/> Cannot have leafy green veggies</p>	<p><input type="checkbox"/> Refer to Dietitian for Nutrition Counseling.</p> <p><input type="checkbox"/> Refer to ADRC for Adaptive Equipment Evaluation.</p> <p><input type="checkbox"/> Complete FoodShare Application.</p> <p><input type="checkbox"/> Offer transportation for shopping.</p> <p><input type="checkbox"/> Recommend Lactaid or Calcium and Vit. D fortified Juice if available.</p> <p><input type="checkbox"/> Offer Senior Farmers Market Vouchers if available.</p>
<p><i>I have 3 or more drinks of beer, liquor, or wine almost every day.</i></p> <p><input type="checkbox"/> Yes (2)</p> <p><input type="checkbox"/> No (0)</p>	<p><input type="checkbox"/> Are they a widower or live alone?</p> <p><input type="checkbox"/> Ask about their appetite. (Poor/Fair/Good)</p> <p><input type="checkbox"/> Ask what meds they take, as many are affected by alcohol.</p> <p><input type="checkbox"/> Ask if they feel lonely or depressed. If yes, ask, In general:</p> <ul style="list-style-type: none"> How often do you feel that you lack companionship? <input type="checkbox"/> Hardly Ever, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Often How often do you feel left out? <input type="checkbox"/> Hardly Ever, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Often How often do you feel isolated from others? <input type="checkbox"/> Hardly Ever, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Often 	<p><input type="checkbox"/> Refer to Dietitian for Nutrition Counseling.</p> <p><input type="checkbox"/> Refer to Stepping On + Stepping Up Your Nutrition Falls Prevention Class</p> <p><input type="checkbox"/> Refer to support group if wanted.</p> <p><input type="checkbox"/> 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.</p>
<p><i>I have tooth or mouth problems that makes it hard for me to eat.</i></p> <p><input type="checkbox"/> Yes (2)</p> <p><input type="checkbox"/> No (0)</p>	<p><input type="checkbox"/> Dentures? Full or partial. Do they fit?</p> <p><input type="checkbox"/> Have their own teeth.</p> <p><input type="checkbox"/> Edentulous (No teeth)</p> <p><input type="checkbox"/> Dry mouth?</p> <p><input type="checkbox"/> Swallowing problems?</p> <p><input type="checkbox"/> They have visited the dentist in the past year. If no, why? _____</p> <p><input type="checkbox"/> Ask about brushing/flossing habits.</p> <p><input type="checkbox"/> If they have a caregiver, ask if any challenges with feeding and oral healthcare.</p> <p><input type="checkbox"/> They smoke or chew tobacco</p>	<p><input type="checkbox"/> Refer to Dietitian for Nutrition Counseling.</p> <p><input type="checkbox"/> Rec. healthcare provider review meds to see if they are causing dry mouth.</p> <p><input type="checkbox"/> Provide a list of free or no cost dentists.</p> <p><input type="checkbox"/> Refer to ADRC for adaptive equipment/ easy-grip toothbrush.</p> <p><input type="checkbox"/> Provide information about good oral hygiene for older adults.</p> <p><input type="checkbox"/> Ask if interested in quitting tobacco use and make an appropriate referral.</p> <p><input type="checkbox"/> Review insurance plans that include dental care during open enrollment.</p>

Page 2 Total:

<p><i>I don't always have enough money to buy the food I need.</i></p> <p><input type="checkbox"/> Yes (4)</p> <p><input type="checkbox"/> No (0)</p>	<p><input type="checkbox"/> Ask if they get food from the food pantry, family, neighbors, etc. to make ends meet.</p> <p><input type="checkbox"/> Do they manage their own money?</p> <p><input type="checkbox"/> Do they know the meals are offered on a contribution basis?</p>	<p><input type="checkbox"/> Refer to Dietitian for tips on how to make meals on a budget.</p> <p><input type="checkbox"/> Complete FoodShare Application.</p> <p><input type="checkbox"/> Provide a list of food pantries and community meals.</p>
<p><i>I eat alone most of the time.</i></p> <p><input type="checkbox"/> Yes (1)</p> <p><input type="checkbox"/> No (0)</p>	<p><input type="checkbox"/> Concerned about social isolation or loneliness.</p> <p><input type="checkbox"/> Seems depressed. Why? _____</p> <p>If yes, ask, In general:</p> <ul style="list-style-type: none"> How often do you feel that you lack companionship? <input type="checkbox"/> Hardly Ever, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Often How often do you feel left out? <input type="checkbox"/> Hardly Ever, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Often How often do you feel isolated from others? <input type="checkbox"/> Hardly Ever, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Often <p><input type="checkbox"/> Do they have a pet(s)? _____</p> <p><input type="checkbox"/> What do they feed the pet? _____</p> <p><input type="checkbox"/> Do they have a smartphone, tablet, or computer?</p> <p><input type="checkbox"/> Interested in learning how to Skype, Zoom, Facetime, etc.?</p> <p><input type="checkbox"/> Do they have internet access? If no, why not? _____</p> <p><input type="checkbox"/> Are they a Veteran? If yes, are they interested in the Honor Flight or other programs and services from the VA?</p>	<p><input type="checkbox"/> Refer to Dietitian for Nutrition Counseling.</p> <p><input type="checkbox"/> Arrange transport to Senior Dining Site if interested on the _____ days of the week.</p> <p><input type="checkbox"/> Offer Friendly Visit, phone call.</p> <p><input type="checkbox"/> Refer to community meals and senior dining locations.</p> <p><input type="checkbox"/> Provide information on the free Easy Tablet Help for Seniors App.</p> <p><input type="checkbox"/> Tell them about or help them review eligibility for discounted internet and devise at https://www.everyoneon.org/</p> <p><input type="checkbox"/> Connect with Technology buddy to get them up socially connected.</p> <p><input type="checkbox"/> Provide information about local Senior Center and other community clubs/organizations/communities of faith that align with their interests.</p> <p><input type="checkbox"/> Provide Craft or Coloring Kits</p> <p><input type="checkbox"/> Refer to Volunteer Coordinator or RSVP.</p> <p>There may be things they can do at home to stay engaged.</p>
<p><i>I take 3 or more different prescribed or over-the-counter drugs a day.</i></p> <p><input type="checkbox"/> Yes (1)</p> <p><input type="checkbox"/> No (0)</p>	<p><input type="checkbox"/> Ask what herbs, supplements, vitamins, and other OTC medicines they take. (List below) _____</p> <p><input type="checkbox"/> Are they taking their meds as prescribed? If not, why? _____</p> <p><input type="checkbox"/> Do they understand the instructions of how and when to take meds? _____</p>	<p><input type="checkbox"/> Refer to Dietitian for Nutrition Counseling.</p> <p><input type="checkbox"/> Rec. medication review with pharmacist.</p> <p><input type="checkbox"/> Refer to Pharmacist/healthcare provider to check for drug/nutrient interactions.</p> <p><input type="checkbox"/> Suggest or provide a pillbox to help them manage their meds</p> <p><input type="checkbox"/> Encourage them to tell their MD all the over-the-counter supplements they take.</p> <p><input type="checkbox"/> Review insurance options for prescription drug coverage during open enrollment.</p> <p><input type="checkbox"/> Tell them about Drugs.com if they are interested in knowing more about their meds or supplements.</p>

Page 3 Total:

<p><i>Without wanting to, I have lost or gained 10 pounds in the last 6 months.</i></p> <p><input type="checkbox"/> Yes (2)</p> <p><input type="checkbox"/> No (0)</p>	<p><input type="checkbox"/> Any change in condition or life event change to help determine the root cause.</p> <p><input type="checkbox"/> Ask about their sleep habits.</p> <p><input type="checkbox"/> Ask about their energy level and strength.</p>	<p><input type="checkbox"/> Refer to Dietitian for Nutrition Counseling.</p> <p><input type="checkbox"/> Other:</p>
<p><i>I am not always physically able to shop, cook, and/or feed myself.</i></p> <p><input type="checkbox"/> Yes (2)</p> <p><input type="checkbox"/> No (0)</p> <p>Page 4 Total:</p> <p>FINAL DETERMINE SCORE</p>	<p><input type="checkbox"/> Does someone else prepare meals for them? Who?</p> <p><input type="checkbox"/> Do they use a lot of convenience foods? What types?</p> <p><input type="checkbox"/> Do they have any adaptive equipment? Know how to use it? Or are interested in about it?</p> <p><input type="checkbox"/> Able to open boxes, packages, cans?</p> <p><input type="checkbox"/> Able to prepare food?</p> <p><input type="checkbox"/> Ask if they exercise? If yes, what and how often.</p>	<p><input type="checkbox"/> Refer to Dietitian for Nutrition Counseling.</p> <p><input type="checkbox"/> Refer to Evidence based classes as appropriate.</p> <p><input type="checkbox"/> Refer to ADRC for adaptive equipment.</p> <p><input type="checkbox"/> Provide list of exercise or movement classes/ programs</p>
<p>ASK EVERYONE and enter score</p>	<p>2 question MST score</p> <p>1. Have you recently lost weight without trying? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, how much weight have you lost?</p> <p><input type="checkbox"/> 2-13 lbs. (Score 1)</p> <p><input type="checkbox"/> 14-23 lbs. (Score 2)</p> <p><input type="checkbox"/> 24-33 lbs. (Score 3)</p> <p><input type="checkbox"/> 34 lb. or more (Score 4)</p> <p><input type="checkbox"/> Unsure (Score 2)</p> <p>Weight loss score <input type="text"/></p> <p>2. Have you been eating poorly because of a decreased appetite?</p> <p><input type="checkbox"/> No (Score 0)</p> <p><input type="checkbox"/> Yes (Score 1)</p> <p>Appetite Score <input type="text"/></p> <p>Total Score for question 1 and 2 <input type="text"/></p>	<p>How to Score:</p> <p>MST = 0 or 1 = NOT At Risk (Eating well with little or no weight loss)</p> <p>MST= 2 or more = At Risk (Eating poorly and/or recent weight loss)</p> <p><input type="checkbox"/> Refer to Dietitian for Nutrition Counseling.</p>

<p>ASK EVERYONE</p> <p><input type="checkbox"/> Food Secure</p> <p><input type="checkbox"/> Food Insecure**</p>	<p>Food Access Questions</p> <p>1. "We worried whether our food would run out before we got money to buy more."</p> <p><input type="checkbox"/> Often true**</p> <p><input type="checkbox"/> Sometimes true**</p> <p><input type="checkbox"/> Never true</p>	<p><input type="checkbox"/> Refer to Dietitian for Nutrition Counseling.</p> <p><input type="checkbox"/> Complete FoodShare Application.</p> <p><input type="checkbox"/> Provide a list of food pantries and community meals.</p>
	<p>2. "The food that we bought just didn't last, and we didn't have money to get more."</p> <p><input type="checkbox"/> Often true**</p> <p><input type="checkbox"/> Sometime true**</p> <p><input type="checkbox"/> Never true</p>	



OFFICE USE ONLY	
DETERMINE Score: _____	
DETERMINE Nutrition Risk Level:	
<input type="checkbox"/> Low Risk (0-2)	
<input type="checkbox"/> Moderate Risk (3-5)	
<input type="checkbox"/> High Risk (6 or more)	
	DETERMINE Score (0-21)
	MST Malnutrition Screen Score (0-5)
	Food Insecurity Score (0-1)
	Total Risk Score (0-27) (For Placement on Wait List)
	Short-Term Recovery Need for Meals \leq 6 Weeks

MST Malnutrition Screen Score
<input type="checkbox"/> Not at Risk (0 to 1)
<input type="checkbox"/> At Risk (2 or more)
** Food Insecure/
<input type="checkbox"/> Yes (1)
<input type="checkbox"/> No (0)
<input type="checkbox"/> Use total risk score to place on focal point wait list. Start meals as spot(s) become available. # of meals is determined by DETERMINE nutrition risk level.

FAQs

1. **Relational Exceptions:** A spouse or disabled individual who resides at home with an eligible homebound individual, will start meals at the same time as them, if it is in the best interest of the homebound individual.
2. **What if their recovery phase is longer than 6 weeks?** Must have in-home reassessment to continue before 6 week period expires. Enhanced Determine Nutrition Risk Score determines the number of meals received. If no longer homebound, meal service will stop.
3. **How often are individuals on the wait list reassessed?** Annually, but if their condition worsens – have the individual call to be reassessed, as this may move them up the list if their Total Risk Score increases.
4. **How many wait lists are there and who manages it?** One wait list per focal point – managed by that focal point.
5. **Do I need to complete an in-home assessment prior to placing on the wait list?** No – phone assessment is adequate.
6. **Do I need to complete an in-home assessment prior to starting meals?** No, completed within 30 days of meals starting.
7. **Private Pay meals are not an option for focal points.** Except for Colonial Club & SSM Health. If a wait list occurs due to lack of volunteers or space on routes, private pay and MCO clients will NOT be served before Title III clients.
8. **What happens when one focal point has an available meal spot but another one doesn't? Does that focal point have to give up their available meal spot to the other focal point?** No, you don't lose your spots. Each focal point keeps their assigned number of meal spots. (We'll have adults going on and off due to surgeries or hospitalizations, so these periodically empty meal spots are important.)
9. **How would the amount of meals per focal point or meal site be assigned?** If there ever was a freeze or wait list that needed to start – the amount of meals you're serving at your site (would remain the same). Let's say Middleton is serving 80 HDMs each day – they would keep all 80 of those HDM spots and someone would have to come off the list for them to add an individual that may need 5 HDMs. Their meals served would never go above that 80 HDM count per day. (This is why it's required to utilize Dane County's prioritization policy – not everyone automatically receives 5 meals when they start – it's based on their Enhanced Determine Nutrition Risk Level Score.