State of Illinois
Illinois Department on Aging

# Nutrition Referral for Home Delivered Meals

Emergency Need: ☐ Yes ☐ No

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

Currently receiving home delivered meals from another source: ☐ Yes ☐ No

Days Older Adult to receive meals (check all that apply): ☐ M ☐ T ☐ W ☐ R ☐ F ☐ All M-F ☐ Weekend ☐ 2nd Meals

Type of meal(s): ☐ Hot ☐ Cold ☐ Frozen

Special Notes: Addt'l Notes

## Older Adult Demographic Information

Name: Authorized Rep:

Address: City:

State: Phone Number: Rep Phone Number:

Date of Birth: Gender: ☐ Male ☐ Female ☐ Other

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Legally Separated ☐ Domestic Partner

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race:
☐ White Non-Hispanic
☐ White Hispanic
☐ American Indian or Alaskan Native
☐ Asian
☐ African American
☐ Native Hawaiian or Pacific Islander
☐ Other Race
☐ Two or More Races

Limited English Speaking: ☐ Yes ☐ No

If yes, primary language spoken: _____

Below Poverty Line: ☐ Yes ☐ No

Monthly Income:

Type of Housing: ☐ Home ☐ Apartment

Subsidized Housing: ☐ Yes ☐ No

Lives Alone: ☐ Yes ☐ No

| Nutrition Risk Screen (check Yes or No) | Y | N | | Y | N |
|---|---|---|---|---|---|
| I have an illness or condition that has made me change the kind or amount of food I eat. | ☐ | ☐ | I don't always have enough money to buy the food I need. | ☐ | ☐ |
| I eat less than two meals a day. | ☐ | ☐ | I eat alone most of the time. | ☐ | ☐ |
| I eat few fruits and vegetables, or milk products. | ☐ | ☐ | I take three or more different prescribed or over-the-counter drugs a day. | ☐ | ☐ |
| I have three or more drinks of beer, liquor or wine almost every day. | ☐ | ☐ | Without wanting to, I have lost or gained ten pounds in the last six months. | ☐ | ☐ |
| I have tooth or mouth problems that make it hard for me to eat. | ☐ | ☐ | I am not always physically able to shop, cook, and/or feed myself. | ☐ | ☐ |

***Six or more points = High nutritional risk*** **COMBINED TOTALS: 0 /21 possible**

| Impairment/Problem with Activity of Daily Living<br>0 – no assist; 1 – min; 2 – mod; 3 – max; 4 – unknown | Pts | Y/N | Impairment/Problem with Instrumental Activities of Daily Living<br>0 – no assist; 1 – min; 2 – mod; 3 – max; 4 – unknown | Pts | Y/N |
|---|---|---|---|---|---|
| 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 | | |
| **Totals** | 0 | | **Totals** | 0 | |
| **Total "Yes": 0 / Total "No": 0** | | | **Total "Yes": 0 / Total "No": 0** | | |

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**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 |

Other major health concerns (describe): **More**

Determination of Need (DON) score:

**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 ☐ Puree ☐ Feeding

Is anyone available to prepare food? ☐ Yes ☐ No

If yes, who? _____ What days? _____ Which meals? _____

Does Older Adult have any of these difficulties with: (check all that apply)

☐ Swallowing ☐ Indigestion
☐ Heartburn ☐ Vomiting
☐ Diarrhea ☐ Constipation

Usually how much of each meal does the Older Adult eat? (check one)

☐ Under 25% ☐ 25% ☐ 50% ☐ 75% ☐ Over 75%

How is the Older Adult's appetite in general? (check one)

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Older Adult's kitchen facilities/equipment: (check all that apply)

☐ Kitchen ☐ Kitchen privileges
☐ Stove ☐ Microwave
☐ Refrigerator ☐ Freezer /available space

Is Older Adult able to use these appliances unsupervised? (check all that apply)

☐ Stove ☐ Microwave ☐ Refrigerator ☐ Freezer

Older Adult food source for the weekends

Special Diet Needs: ☐ General ☐ Diabetic

Condition of the home: ☐ Good ☐ Poor

If poor, specify: _____

Dietary restrictions:

Food allergies:

Reason 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)

☐ Meals will increase nutritional intake as Older Adult has limited income
☐ Older Adult has difficulty cooking, tires easily
☐ Older Adult is recovering from surgery, illness, etc.
☐ Other (specify) _____

Duration of meals: (check one) ☐ Short term ☐ Long term

**Other Contacts Information**

| | | |
|---|---|---|
| Physician Name: | | Physician Phone: |
| Emergency Contact Name: | Home Phone: | Cell Phone: |
| Address: | City: | State: |
| Emergency Contact Name: | Home Phone: | Cell Phone: |
| Address: | City: | State: |

**AUTHORIZATION OF RELEASE OF INFORMATION**

I give permission to _____, to send a copy of this assessment form to the Home Delivered Meal Provider, _____, and to discuss my needs with the Provider and/or the AAA.

Older Adult Signature:_____ Date:

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

| | |
|---|---|
| Case Manager Name: | Phone: |
| Organization: | Email: |
| Signature: | Date: |

| | | |
|---|---|---|
| HDM start date: | Reassessment date: | Termination date: |

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

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