State of Illinois
Illinois Department on Aging

Nutrition Referral for Home Delivered Meals

Emergency Need: ☐

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 (circle all that apply): M T W R F All M-F Weekend 2nd Meals
Type of meal(s): Hot Cold Frozen
Special Notes:

Older Adult Demographic Information

Name:	Authorized Rep:	
Address:	DOB:	Phone: Rep:
Ethnicity: Hispanic or Latino / Not Hispanic or Latino Race: White Non Hispanic / African American White Hispanic / Native Hawaiian or Pacific Islander American Indian or Alaskan Native / Other Race Asian / Two or More Races	Marital Status: M__D____S____W__ Legally Separated ____ Domestic Partner ____	Gender: M____ F____ Other_____
Limited English Speaking: Yes No If yes, primary language spoken:	Below Poverty: Yes No Monthly Income:	Lives Alone: Yes No Type of Housing: Home Apt Subsidized Housing: Yes No

Nutrition Risk Screen (circle points under 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.	2	0	I eat alone most of the time.	1	0
I eat less than two meals a day.	3	0	I take three or more different prescribed or over-the-counter drugs a day.	1	0
I eat few fruits and vegetables, or milk products.	2	0			
I have three or more drinks of beer, liquor or wine almost every day.	2	0	Without wanting to, I have lost or gained ten pounds in the last six months.	2	0
I have tooth or mouth problems that make it hard for me to eat.	2	0	I am not always physically able to shop, cook and/or feed myself.	2	0
I don't always have enough money to buy the food I need.	4	0			
Totals			**Totals**		

Six or more points = high nutritional risk **Combined column totals: _____/21 possible points**

Impairment/Problem with Activity of Daily Living 0 No Assist = No; 1-3 Assist = Yes; 4 Unknown = No	**Pts**	**Y/N**	**Impairment/Problem with Instrumental Activities of Daily Living 0 No Assist = No; 1-3 Assist = Yes; 4 Unknown = No**	**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		
Total Points			**Totals Points**		
Total "Yes" = _____ Total "No" = _____			**Total "Yes" = _____ Total "No" = _____**		

Major Health Problems (circle all that apply)

Ambulation: Full Partial Assisted Bedfast	Other major health concerns (describe):
Vision: Full Limited Glasses Blind	
Hearing: Full Hard of Hearing Hearing Aid Deaf	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: (circle all that apply) Swallowing Indigestion Heartburn Vomiting Diarrhea Constipation
Usually how much of each meal does the Older Adult eat? (circle one) Under 25% 25% 50% 75% Over 75%	How is the Older Adult's appetite in general? (circle one) Poor Fair Good Excellent
Older Adult's kitchen facilities/equipment: (circle all that apply) Kitchen Kitchen privileges Stove Microwave Refrigerator Freezer w/available space	Is Older Adult able to use these appliances unsupervised: (circle 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: (circle 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: (circle all that apply)

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

Duration of meals: (circle one) Short term Long term

Other Contacts Information

Physician Name:	Physician Phone:
Emergency Contact Name:	Home phone: Cell phone:
Address:	
Emergency Contact Name:	Home phone: Cell phone:
Address:	

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 this Older Adult meets eligibility criteria for Home Delivered Meals under the Older Americans Act.

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

HDM Start Date:	Reassessment Date:	Termination Date:

Driver instructions: (circle all that apply) Ring bell Knock loudly Beware of dog(s) Other: _____