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| **Home-Delivered Meal Intake** **XXXXXXX**This form is designed to be completed by an intake staff member.Items marked with asterisk (\*) are required. | **(Office Use Only**)Route#: \_\_\_\_\_\_\_\_\_Start Date: \_\_\_\_\_\_\_\_\_ | **(Office Use Only)**Intake Date:\_\_\_\_\_\_\_\_\_\_Referred by:\_\_\_\_\_\_\_\_\_\_Entered by: \_\_\_\_\_\_\_\_\_\_ |
| Last 4 digits of Social Security #*Optional*  |
| **\*Unique Participant ID:** **\* Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** | **\*Termination Date: \*Reason:**  |
| **\*First Name:**  | **\*Last Name:** Middle Initial: | [ ]  New client [ ]  In-Home Reassessment [ ]  Change in information  |
| **\*Address:** | **\*City:** | **\*Zip:** |
| Mailing Address: Same As Residential? [ ]  Yes | City: | Zip Code: |
| **\*Home Phone**: ( )Alternate Phone: ( ) | Emergency Contact Name: Phone: ( ) Relationship:2nd Contact Name:Phone: ( ) Relationship: |
| **\*Living Arrangement**[ ]  Alone[ ]  Lives with\_\_\_\_\_\_\_\_ [ ]  Decline to state | **\*What is your total monthly income?** [ ]  less than $1,215 per month for 1 person [ ]  more than $1,216 per month for 1 person [ ]  less than $1,644 per month for 2 people  [ ]  more than $1,645 per month for 2 people [ ]  Decline to state | **\*Rural Area?**[ ]  Yes [ ]  No[ ]  Decline to state |
| **\*Ethnicity:** (Check One)Hispanic [ ]  Yes [ ]  No [ ]  Decline to state  | **\*Language**:[ ]  English speaking [ ]  Need interpreter[ ]  Non-English/Language: |
| **\*Race**: (Check all that apply)

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| [ ]  White  | [ ]  Black  | [ ]  American Indian/Alaska Native  | [ ]  Asian Indian | [ ]  Other Asian  |
| [ ]  Cambodian  | [ ]  Filipino  | [ ]  Japanese  | [ ]  Korean  | [ ]  Guamanian  |
| [ ]  Hawaiian  | [ ]  Samoan  | [ ]  Other Pacific Islander | [ ]  Laotian  | [ ]  Vietnamese  |
| [ ]  Chinese  | [ ]  Decline to state  |  |  |  |

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| **\*ADLs and IADLs (Activities of Daily Living and Instrumental Activities of Daily Living)**Please rate your functional abilities for the following activities. |
| **ADLs** | **Rated Value** | **IADLs** | **Rated Value** | **IADLs** | **Rated Value** | **RATING SCALE**1 = Independent2 = Verbal Assistance3 = Some Human Help4 = Lots of Human Help5 = Dependent6 = Decline to state |
| Eating |   | Meal Preparation |   | Light Housework |   |
| Bathing |   | Shopping |   | Transportation |   |
| Toileting  |   | Medication Management |   | Notes: |
| TransferringIn/Out of Chair |   | Money Management |   |
| Walking  |   | Using Telephone |   |
| Dressing |  | Heavy Housework |  |
| Eligibility:[ ]  Are you homebound due to an illness, disability, or isolation? [ ]  Are you a spouse of a person who is homebound? [ ]  Are you an individual with a disability who resides with a homebound meal recipient?   | Prioritization: |

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| \*Nutritional Assessment: | Circle if yes | Comments |
| I have an illness or condition that made me change the kind and/or amount of food I eat. | 2 |  |
| I eat fewer than 2 meals per day? | 3 |  |
| I eat few fruits or vegetables or milk products. | 2 |  |
| I have 3 or more drinks of beer, liquor or wine almost every day. | 2 |  |
| I have tooth or mouth problems that make it hard for me to eat. | 2 |  |
| I don’t always have enough money to buy the food I need. | 4 |  |
| I eat alone most of the time. | 1 |  |
| I take 3 or more different prescribed or over-the-counter drugs a day. | 1 |  |
| Without wanting to, I have lost or gained 10 pounds in the last 6 months. | 2 |  |
| I am not always physically able to shop, cook and/or feed myself.  | 2 |  |
| [ ]  Decline to state Total Score (0-2: low risk; 3-5: moderate risk; 6 or more: high risk) |  |  |

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| **\*What is your gender?** (Check one)[ ]  Male[ ]  Female[ ]  Transgender Female to Male[ ]  Transgender Male to Female[ ]  Genderqueer/Gender Non-binary[ ]  Not Listed, please specify:\_\_\_\_\_\_[ ]  Decline to state | **\*What was your sex at birth?** (Check one)[ ]  Male[ ]  Female[ ]  Decline to state | **How do you describe your sexual orientation or sexual identity?** (Check one)[ ]  Straight/Heterosexual[ ]  Bisexual[ ]  Gay/Lesbian/Same-Gender Loving[ ]  Questioning/Unsure[ ]  Not listed, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Decline to state |

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|  | Yes | No | Comments |
| Do you have any dietary restrictions?  |  |  |  |
| Do you have a working refrigerator? |  |  |  |
| Do you have a working microwave? |  |  |  |
| Are you physically and mentally able to open the food containers? |  |  |  |
| Are you physically and mentally able to reheat a meal? |  |  |  |
| Are there pets? |  |  |  |

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| Special instructions for meal delivery: |

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| Non-Senior Status:  | 🞎 Spouse of a Senior 🞎 Essential Volunteer🞎 Disabled Living with a Senior | Are you a: Veteran Yes 🞎 No 🞎  Spouse of a Veteran Yes 🞎 No 🞎 |

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| PRIMARY PHYSICIAN INFORMATION |
| Name: Phone Number: |

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| Mobility: | Must Use: | Vision: | Hearing: |
| 🞎  | Adequate | 🞎  | Cane | 🞎  | Good | 🞎  | Good |
| 🞎  | Limited | 🞎  | Crutches | 🞎  | Limited | 🞎  | Limited |
| 🞎  | Bedbound | 🞎  | Walker | 🞎  | Blind | 🞎  | Deaf |
|  |  | 🞎  | Wheelchair |  |  |  |  |

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| Other Health Problems: |
| 🞎  | Arthritis  | 🞎  | Heart/Blood Pressure Problems | 🞎  | Recent Hospitalization |
| 🞎  | Diabetes | 🞎  | Incontinence  | 🞎  | Stroke |
| 🞎  | Emphysema | 🞎  | Paralysis, Full/Partial | 🞎 Other (Describe)  |
| 🞎  | Fracture | 🞎  | Parkinson’s, Palsy  |

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| OtherService/Referrals | AlreadyReceives: | Referredto: | Comments |
| Case Management | 🞎  | 🞎  |  |
| Medi-Cal | 🞎  | 🞎  |  |
| In-Home Supportive Services | 🞎  | 🞎  |  |
| Health Services | 🞎  | 🞎  |  |
| Information & Assistance | 🞎  | 🞎  |  |
| Transportation | 🞎  | 🞎  |  |
| Other (Describe) | 🞎  | 🞎  |  |
| Termination of Meals |  | Date: |
| Reason (Check One) |  | Placed In: |
| 🞎 | Recovered | 🞎 | Moved from area |  | 🞎 | Nursing Home | 🞎 | Residential Care |
| 🞎 | Hospitalized | 🞎 | Deceased |  | 🞎 | Board & Care | 🞎 | Other |

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| 🞎  | CARE Application Completed. If not completed due to ineligibility, list in the findings why it was not completed. |
| 🞎  | Mailed CARE application to PG&E (no postage necessary). |
| 🞎 | Already enrolled in CARE. |
| **Date** | **Findings** | **By**(please initial) |

**Participant/Person Completing Form -- Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**