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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)   |  |  |  |  |  | | --- | --- | --- | --- | --- | | 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 |  |  |  | | | | | | | | | | | | | | |
| **\*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 = Independent  2 = Verbal Assistance  3 = Some Human Help  4 = Lots of Human Help  5 = Dependent  6 = Decline to state |
| Eating | |  | | Meal Preparation | | |  | Light Housework | | |  | | |
| Bathing | |  | | Shopping | | |  | Transportation | | |  | | |
| Toileting | |  | | Medication Management | | |  | Notes: | | | | | |
| Transferring  In/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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| Other  Service/Referrals | | | | Already  Receives: | | | Referred  to: | | 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: \_\_\_\_\_\_\_\_\_\_\_**