

Lifescape Home Delivered Meal Intake Form
705 Kilburn Ave Rockford IL 61101

Client # _____

Client Name: _____

Date of intake: ____ \ ____ \ ____

Address: _____

Diet: General Diabetic Other: _____

City, State, Zip: _____

Microwave: Yes No
Can you reheat frozen meals? _____

Phone: (____) _____ - _____

Needs HDM because of:

SSN: _____ - _____ - _____

- Hospital Discharge
- LTC Discharge
- Loss Of Support
- Illness \ Injury
- Other: _____

D.O.B. ____ \ ____ \ ____

Monthly Income: \$ _____ G.S.N Yes ___ No ___

Impairments: (sight, hearing, mobility) _____

Sex: Male Female

Lives With: Alone Spouse Children Relatives Non-Relatives # in Household: _____

Race: White Black Hispanic Other: _____

Speaks English: Yes No Other: _____ Limitations: Yes ___ No ___

Marital Status: Single Married Widowed Divorced

Transportation: Own Car Public Trans Senior Trans Family\Friend No Transportation

Currently Assisted By: Family Friends Agency: _____ Medical Alert System: _____

Emergency Contact:

Alternate Contact:

Name: _____

Name: _____

Relation: _____

Relation: _____

Day Phone: (____) _____ - _____

Day Phone: (____) _____ - _____

Evening Phone: (____) _____ - _____

Evening Phone: (____) _____ - _____

PHYSICIAN'S INFORMATION

Name: _____ Phone: (____) _____ - _____ Fax (____) _____ - _____ Hosp: _____

Meal Service:

Hot Meals	Mon _____	Tue _____	Wed _____	Thur _____	Fri _____
Dinner Sacks	Mon _____	Tue _____	Wed _____	Thur _____	Fri _____
Frozen Meals	Mon _____	Tue _____	Wed _____	Thur _____	Fri _____

Donation Statement if other than participant:

Delivery Instructions:

Send To: _____

Relation To Participant: _____ Phone: (____) _____ - _____

Referral Source:

Name of Person making referral: _____ Phone: (____) _____ - _____

Agency of Referral or Relation to participant: _____

Revised 3/2008

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Nutritional Health Risk

	Yes	No
Have you made changes in the way you eat due to illness or medical condition?	2	0
Do you eat at least 2 meals per day?	0	3
Do you eat some fruits or vegetables everyday?	0	1
Do you use some milk products daily?	0	1
Do you have 3 or more drinks of beer, liquor, or wine almost every day?	2	0
Do you have tooth or mouth problems that may make it hard for you to eat?	2	0
Do you eat alone most of the time?	1	0
Do you take 3 or more prescribed or over the counter medication a day?	1	0
Are you usually physically able to shop, cook, and/or feed yourself?	0	2
Have you lost or gained 10 pounds in the last 6 months without wanting to?	2	0
Do you always have enough money for the food you need?	0	4
Add YES Scores: 0-2 Low 3-5 Moderate 6 Or More High	Total:	Yes No

Home Delivered Meal Assessment

- Y N Are you able to leave your home on a daily basis (vs. only for doctor appointments)
- Y N Are you able to drive? If no, how do you get your groceries?
- Y N Are you able to prepare a hot main meal?
- Y N Are you able to prepare a light meal such as a cereal or a sandwich?
- Y N Do you have difficulty chewing, swallowing, or cutting your food?
- Y N Do you have a food allergy? If yes, list:
- Y N Is there a spouse or disabled child who is unable to cook and in need of a meal?
- Y N Do you need special utensils to eat your meal? Type:

Benefits

- 1 = Medicaid
- 2 = Medicare
- 3 = Circuit Breaker Tax
- 4 = SSI
- 5 = Food Stamps
- 6 = Circuit Breaker Pharmacy
- 7 = LIHEAP \$1,300 or \$1,750
- 8 = Homestead Exempt = TxBreak
- 9 = Unknown
- 10 = Tax Exempt Freeze = Giveup
- 11 = CCP Services
- 12 = QMB/SLIB = PA Insurance

Veteran

- 1 = Veteran
- 2 = Spouse of Veteran
- 3 = Not a Veteran
- 4 = Unknown

Circuit Breaker (65+)

- 1 = Household income less than \$22,218 \ 29,480
- 2 = Newly eligible new guidelines (over \$22,218)
- 3 = Completed Circuit Breaker application
- 4 = First time filing for Circuit Breaker
- 5 = Medicaid (help provided in applying for Medicaid)

Living Arrangement

- 1 = Home Owner
- 2 = Renter
- 3 = Adult Home
- 4 = Cong Facility
- 5 = Nursing Home
- 6 = Senior Housing
- 7 = Other
- 8 = Unknown
- 9 = Homeless

- Y N Are you aware of our agency's donation agreement policy?
- Y N Are you willing to call our agency to cancel the meal if for any reason you will not be home
- Y N Are you able to provide a meal for yourself should we not be able to deliver to you in severe weather?
- Y N Do you need in-home help or help with other benefits and services (meds, fuel, transportation)?
- Y N Permission to refer? Y N Referral Form completed to:

Have you or any of your family members worked for a company located in Winnebago \ Ogle County? (circle one)

Name of company: _____

Disposition:

Denied (reason) _____
 Home Delivered Meals Authorized Start Date _____
 Completed By _____

Expected Duration:

- ___ 1 Month or less
- ___ Up to 6 Months
- ___ Up to 1 year or more
- ___ Congregate possibility

Route # Mon Tue Wed Thur Fri

NIAAA HOMEMAKER DEMONSTRATION REGISTRATION FORM

Nutritional Assessment

(Must be done prior to receiving homemaker service).

Instructions: Circle the Client's response to each statement.

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

Assessment of Need for Assistance with ADL's and IADL's

(Must be completed prior to receiving Homemaker Service.)

Instructions: Circle the number or letter that corresponds to the statement (see Key) which most closely describing the clients ability with regard to each Activity of Daily Living (ADL's) and Instrumental Activity of Daily Living (IADL's)

Key:	0	Independent / No impairment	A	Needs assistance but refuses
	1	Min. Assist / Mild impairment	D	Does not know if needed
	2	Mod. Assist / Some impairment	E	Elects not to answer
	3	Max. Assist / Total impairment		

Activities of Daily Living (ADL's)								Instrumental Activities of Daily Living (IADL's)							
Eating:	0	1	2	3	A	D	E	** <i>Preparing Meals:</i>	0	1	2	3	A	D	E
Dressing:	0	1	2	3	A	D	E	Being Alone:	0	1	2	3	A	D	E
Bathing:	0	1	2	3	A	D	E	Medication Management:	0	1	2	3	A	D	E
Toileting:	0	1	2	3	A	D	E	Money Management:	0	1	2	3	A	D	E
Transferring:*	0	1	2	3	A	D	E	Telephone Use:	0	1	2	3	A	D	E
Grooming:	0	1	2	3	A	D	E	Heavy Housework:	0	1	2	3	A	D	E
* in and out of bed or chair								Light Housework:	0	1	2	3	A	D	E
								** <i>Transportation:</i>	0	1	2	3	A	D	E
** Note statement #5 in the Nutritional Risk Assessment and the first and last statements in the IADL Assessment. Clients must be unable to shop, cook and/or feed themselves and require assistance with Meal Preparation and Transportation to qualify for Home Delivered Meals.															