

Client Name: \_\_\_\_\_ MI \_\_\_\_\_ Date of intake: \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_

Address: \_\_\_\_\_ Diet: General Diabetic Other: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Microwave: Yes No  
Can you reheat frozen meals? \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Y N Older individual at risk of institutional placement?

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Hospital Discharge

D.O.B. \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_  LTC Discharge

Monthly Income: \$ \_\_\_\_\_ G.S.N Yes \_\_\_ No \_\_\_  Loss Of Support

Illness \ Injury

Other: \_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have dogs in the home? # \_\_\_\_\_

Relation To Participant: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Referral Source:**

Name of Person making referral: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Agency of Referral or Relation to participant: \_\_\_\_\_

How did you hear about Lifescope? \_\_\_\_\_

**Nutritional Assessment**

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
<b>**I am not always physically able to shop, cook, and/or feed myself.</b>	<b>Yes</b>	<b>No</b>	<b>Unknown</b>	<b>Elects not to answer</b>
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

- 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:

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

<b>Key:</b>	0	Independent \ No Impairment	A	Needs assistance but refuses
	1	Minimal Assistance \ Mild Impairment	D	Does not know if needed
	2	Moderate Assistance \ Some Impairment	E	Elects not to answer
	3	Maximum Assistance \ Total Impairment		

**Instructions: Circle the number or letter that corresponds with the statement (see above key) which most closely describing the clients ability with regard to each ADL and IADL**

Activities of Daily Living (ADL'S)					Instrumental Activities of Daily Living (IADL'S)					
<b>Eating:</b>	0	1	2	3 A D E	<b>**Preparing Meals</b>	0	1	2	3 A D E	
<b>Dressing:</b>	0	1	2	3 A D E	<b>Being Alone:</b>	0	1	2	3 A D E	
<b>Bathing:</b>	0	1	2	3 A D E	<b>Medication Management:</b>	0	1	2	3 A D E	
<b>Toileting:</b>	0	1	2	3 A D E	<b>Money Management:</b>	0	1	2	3 A D E	
<b>Transferring: Bed or Chair</b>	0	1	2	3 A D E	<b>Telephone Use:</b>	0	1	2	3 A D E	
<b>Grooming:</b>	0	1	2	3 A D E	<b>Heavy Housework:</b>	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.						<b>Light Housework:</b>	0	1	2	3 A D E
						<b>Transportation:</b>	0	1	2	3 A D E

<b>Benefits</b> 1= Medicaid                      7= LIHEAP \$1,300 or \$1,750 2= Medicare                     8= Homestead Exempt = TxBreak 3= Circuit Breaker Tax        9= Unknown 4= SSI                              10= Tax Exempt Freeze =Giveup 5= Food Stamps                11= CCP Services 6= Circuit Breaker Pharmæ 12= QMB/SLIB = PA Insurance		<b>Veteran</b> 1 = Veteran 2 = Spouse of Veteran 3 = Not a Veteran 4 = Unknown
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<b>Circuit Breaker (65+)</b> 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)	<b>Living Arrangement</b> 1 = Home Owner            6 = Senior Housing 2 = Renter                    7 = Other 3 = Adult Home            8 = Unknown 4 = Cong Facility            9 = Homeless 5 = Nursing Home
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Y N Are you aware of our agency's donation agreement policy?                      Y N Discussed Rights & Responsibilities Form

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: \_\_\_\_\_

Additional Information (Optional)

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FOR OFFICE USE ONLY <b>Disposition:</b> Denied (reason) _____ _____ Home Delivered Meals Authorized Start Date _____ Completed By _____	<b>Expected Duration:</b> ___ 1 Month or less ___ Up to 6 Months ___ Up to 1 year or more ___ Congregate possibility
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Napis ID \_\_\_\_\_ Tower ID \_\_\_\_\_ Napis Nutritional Risk Score \_\_\_\_\_

Route #    Mon \_\_\_    Tue \_\_\_    Wed \_\_\_    Thur \_\_\_    Fri \_\_\_