Phone 815-963-1609 **Lifescape Home Delivered Meals Intake Form** **Fax 815-963-1627**
705 Kilburn Ave Rockford IL 61101

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
❑ LTC Discharge
D.O.B. _______________ ❑ Loss Of Support
❑ Illness \ Injury
Monthly Income: $_____ **G.S.N** Yes___ No___ ❑ 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:
Name:_____
Relation:_____
Day Phone: (_____**)** _____ - _____
Evening Phone: (_____**)** _____ - _____

Alternate Contact:
Name:_____
Relation:_____
Day 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:
Send To:_____
_____
_____
Relation To Participant:_____ Phone: (_____) _____ - _____

Delivery Instructions:
_____
_____
Do you have dogs in the home? #_____

Referral Source:
Name of Person making referral:_____ Phone:(_____)_____-_____
Agency of Referral or Relation to participant:_____
How did you hear about Lifescape? _____

Revised 8/1/2011

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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
***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

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

Key:	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)**	
Eating:	0 1 2 3 A D E	***Preparing Meals**	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: Bed or Chair	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
		Light Housework:	0 1 2 3 A D E
		Transportation:	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.

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Benefits

1= Medicaid
2= Medicare
3= Circuit Breaker Tax
4= SSI
5= Food Stamps
6= Circuit Breaker Pharma
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 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)

FOR OFFICE USE ONLY

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

Napis ID _____ Tower ID _____ Napis Nutritional Risk Score _____

Route # Mon____ Tue_____ Wed_____ Thur_____ Fri_____