**FORM C-2**

## Home-Delivered Meals Provider

This form is designed to be completed by an intake staff. Items marked with an asterisk (*) are required.

Route:

Intake Date: _____
Active Date: _____ Inactive Date: _____
Active Date: _____ Inactive Date: _____
Active Date: _____ Inactive Date: _____

***Unique Participant ID:**

***Termination Date:** **Reason:**

***Date of Birth:**
/ /

☐ New client
☐ Annual reassessment
☐ Change in information

First Name:

Last Name:

Home Address

City:

***Zip Code**

Home Phone: ( )
Alternate Phone: ( )

Emergency Contact Name:
Address:
Phone: ( ) Relationship:

***Living Arrangement # of household members:**
☐ Declined/not stated

***What is your approximate household income?**
$_____ per ☐ month ☐ year
☐ Declined/not stated

***Rural Area:**
☐ Yes ☐ No
☐ Declined/not stated

***What is your gender? (Check only one)**
☐ Male ☐ Female
☐ Transgender Male to Female
☐ Transgender Female to Male
☐ Genderqueer/Gender Non-binary
☐ Not Listed, please specify:
_____
☐ Declined/not stated

***What was your sex at birth? (Check only one)**
☐ Male
☐ Female
☐ Declined/not stated

***How do you describe your sexual orientation or sexual identity? (Check only one)**
☐ Straight/Heterosexual
☐ Bisexual
☐ Gay/Lesbian/Same-Gender Loving
☐ Questioning/Unsure
☐ Not Listed, please specify:
_____
☐ Declined/not stated

***Have you ever served in the United States military?**
☐ Yes ☐ No
☐ Declined/not stated

***Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?**
☐ Yes ☐ No
☐ Declined/not stated

***If you identify as being military affiliated, check below if: "I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for12 months."**
☐ Yes ☐ No
Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.

***Ethnicity:** (Check one)
Hispanic ☐ Yes ☐ No ☐ Declined/not stated

Language:
☐ English Speaking ☐ Need interpreter ☐ Non-English/Language

***Race: (Check all that apply)**
☐ White ☐ Black ☐ American Indian/Alaska Native Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian
☐ Vietnamese ☐ Other Asian Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander ☐ Declined/not stated

**ADLs: 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 |
|---|---|---|---|---|---|---|
| Feeding | | Meal Preparation | | Light Housework | | 1 – Independent<br>2 – Verbal Assistance<br>3 – Some Human Help<br>4 – Lots of Human Help<br>5 – Dependent<br>6 - Declined to State |
| Dressing | | Shopping | | Heavy Housework | | |
| Bathing | | Manage Medication | | Notes: | | |
| Transferring In/Out of Chair | | Money Management | | | | |
| Walking | | Telephone | | | | |
| Toileting | | Transportation | | | | |

Eligibility:
☐ Are you homebound due to an illness, disability, or isolation?
☐ Are you a spouse of a home-delivered meal recipient?
☐ Are you an individual with a disability who resides with a home-delivered meal recipient?

Prioritization:

| ***Nutritional Risk Assessment:** | **Circle if yes** | |
|---|---|---|
| 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 past 6 months. | 2 | |
| I am not always physically able to shop, cook, and/or feed myself. | 2 | |
| Total Score: | | |
| ***Is Nutrition Risk Total Score 0-5 or 6+ ?** | **0-5** | **6+** |
| | | |
| ☐ **Declined to State** | | |

| | 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? | ☐ | ☐ | |
| Have you recently been discharged from the hospital? | ☐ | ☐ | |

Referral(s) Made:
☐ Nutritional education/counseling for at risk client
☐ Other:
☐ Other:

Notes:

_____ _____

Staff Completing Assessment Date