

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 Lifescape? _____

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 eat less than two meals a day	Yes	No	Unknown	Elects not to answer
I eat few fruits and vegetables, or milk products.	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
I have tooth or mouth problems that make it hard for me to eat.	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 alone most of the time.	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
Without wanting to, I have lost or gained ten pounds in the last six months.	Yes	No	Unknown	Elects not to answer
<i>**I am not always physically able to shop, cook, and/or feed myself.</i>	Yes	No	Unknown	Elects not to answer

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		
	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	Laundry:	0	1	2	3	A D
Bathing:	0	1	2	3	A D	Shopping:	0	1	2	3	A D
Grooming:	0	1	2	3	A D	Light Housework:	0	1	2	3	A D
Dressing:	0	1	2	3	A D	Heavy Housework:	0	1	2	3	A D
Toileting:	0	1	2	3	A D	Telephone Use:	0	1	2	3	A D
Walking\Mobility	0	1	2	3	A D	Financial Mgmt:	0	1	2	3	A D
Transferring:	0	1	2	3	A D	Transportation:	0	1	2	3	A D
						Meal Preparation:	0	1	2	3	A D
						Medication:	0	1	2	3	A D

****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.**

- 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 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= LIHEAP \$1,459 or \$1,966
- 7= Homestead Exempt = TxBreak
- 8= Unknown
- 9= Tax Exempt Freeze = Giveup
- 10= COP Services
- 11= QMB/SLIB = PA Insurance

Veteran

- 1 = Veteran
 - 2 = Spouse of Veteran
 - 3 = Not a Veteran
 - 4 = Unknown
- Year of Discharge: _____
- Branch of Service: _____

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 have access to weather closing listings on television?
- 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:

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

Aging IS: _____ Tower ID _____ Napis Nutritional Risk Score _____

Route # Mon ___ Tue ___ Wed ___ Thur ___ Fri ___