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
- ❑ 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:

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 4/19/18

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 am not always physically able to shop, cook, and\or feed myself.*	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

Phone 815-963-1609

Lifescape Home Delivered Meals Intake Form

705 Kilburn Ave Rockford IL 61101

Fax 815-963-1627

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= CCP 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______