Phone 815-963-1609 | **Lifescape Home Delivered Meals Intake Form** | Fax 815-860-1710

705 Kilburn Ave Rockford IL 61101

Client Name:____________________________________ **MI** ____

Address:____

City, State, Zip:_____________________________________

Phone: (________) __________ - ____________

Cell: (________) __________ - ____________

SSN: ___________ - ___________ - _____________

D.O.B. _____________________________

Monthly Income: $_________________

Date of intake:_____________________

Diet: General Diabetic Other:________

Microwave: **Yes** **No**

Can you reheat frozen meals? ________

Y N Older individual at risk of institutional placement?

- ❑ Hospital Discharge
- ❑ LTC Discharge
- ❑ 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:

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______

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 8/2024

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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 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:

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Benefits

1= Medicaid	6= LIHEAP
2= Medicare	7= Homestead Exempt = TxBreak
3= Circuit Breaker Tax	8= Unknown
4= SSI	9 = Tax Exempt Freeze =Giveup
5= Food Stamps	10= CCP Services
	11= QMB/SLIB = PA Insurance

Veteran

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

Living Arrangement

1 = Home Owner	6 = Senior Housing
2 = Renter	7 = Other
3 = Adult Home	8 = Unknown
4 = Cong Facility	9 = Homeless
5 = Nursing Home	

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______