Phone 815-963-1609 **Lifescape Home Delivered Meals Intake Form** **Fax 815-860-1710**
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: $_____

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
2= Medicare
3= Circuit Breaker Tax
4= SSI
5= Food Stamps
6= LIHEAP
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_____