

## SIX-MONTH HOME-DELIVERED MEALS RE-EVALUATION

Service Recipient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Nutritional Health Assessment Score: \_\_\_\_\_

**Eligibility Requirements – must have a yes marked in either question 1 or 2 to be eligible for Home-Delivered Meals.**

**1. Homebound – cannot leave his/her house under normal circumstances (and is therefore unable to participate in the Title III congregate meals program) due to illness, including a terminal illness, incapacitating disability, isolation, or lack of transportation.**

\_\_\_\_ No    \_\_\_\_ Yes    Please provide details:

\_\_\_\_\_  
\_\_\_\_\_

**2. Lives Alone – and is physically or mentally unable to obtain food and prepare meals, and there is no one else available to obtain food and prepare meals.**

\_\_\_\_ No    \_\_\_\_ Yes    Please provide details:

\_\_\_\_\_  
\_\_\_\_\_

Eligible for Home-Delivered Meals:    \_\_\_\_ No    \_\_\_\_ Yes

Annual Assessment date: \_\_\_\_\_

\_\_\_\_\_  
Service Recipient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date