

**TITLE III – OLDER AMERICANS ACT  
INITIAL ANNUAL HOME-DELIVERED MEALS ASSESSMENT**

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Referral Date:

Assessment Date:

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**SECTION 1: PERSONAL DATA**

Name:

Address:

Phone:

Birthdate:

Age:

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**SECTION 2: ELIGIBILITY REQUIREMENTS – must have a yes marked in either  
Question 1 or Question 2 to be eligible for Home-Delivered Meals.**

1. Has difficulty leaving his/her house and is therefore unable to participate in the Title III Congregate Meals Program due to illness (including a terminal illness), incapacitating disability, isolation, lack of transportation, or physical, emotional, or behavioral conditions that would make receiving their service at a congregate nutrition site difficult and/or intolerable for them and/or others.

No      Yes

Additional Comments:

2. Physically or mentally unable to obtain food and prepare meals, and there is no one else available, willing or able to obtain food and prepare meals.

No      Yes

Additional Comments:

# INITIAL/ANNUAL HOME-DELIVERED MEALS ASSESSMENT, Cont.

Name:

Date:

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## SECTION 3: DIRECTIONS TO and DESCRIPTION OF HOME

**Directions to Home:**

**Description of Home:**

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## SECTION 4: EMERGENCY CONTACTS

Name:

Address:

City/State/Zip:

Phone:

Name:

Address:

City/State/Zip:

Phone:

Name:

Address:

City/State/Zip:

Phone:

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## SECTION 5: PHYSICIAN INFORMATION

**Name:**

**Phone:**

**Name:**

**Phone:**

**Name:**

**Phone:**

INITIAL/ANNUAL HOME-DELIVERED MEALS ASSESSMENT, Cont.

Name:

Date:

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**SECTION 6: LIVING SITUATION**

Lives Alone

Lives with Spouse/Significant Other

Lives with Child/Children

Lives with Others (Specify):

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**SECTION 7: HEALTH STATUS**

1. Ambulation:      Full Walker/Cane      Partial Wheelchair      Crutches Bedfast

2. Vision:      Adequate      Partial      Blind

3. Hearing:      Adequate      Partial      Deaf

4. Other Incapacitating Disabilities (Specify):

5. Other Major Health Problems/Illnesses (Specify):

6. Recently released from Hospital:      No      Yes  
If yes, please specify date of release.

7. Special Diet Requirements:      No      Yes  
If yes, please list:

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**SECTION 8: NUTRITIONAL HEALTH/MEAL PREPARATION CAPACITY**

1. Nutritional Health Assessment Score:

2. Do you know anyone who could or would be willing to prepare meals for you:

No      Yes

If yes, who:

3. Would you accept frozen/shelf stable meals:      No      Yes

INITIAL/ANNUAL HOME-DELIVERED MEALS ASSESSMENT, Cont.

Name:

Date:

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**SECTION 9: ISOLATION FACTORS**

1. Do you have transportation available to you?      No      Yes

2. How do you secure groceries and other necessities?

3. If transportation were provided, would/could you come to a nutrition site to eat with others?      No      Yes

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**SECTION 10: OTHER COMMENTS**

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***I certify that the information provided in this assessment is true and accurate and has been given to the best of my ability.***

\_\_\_\_\_  
Applicant Signature  
(Document on service recipient signature line if assessment was conducted via phone.)

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date