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

Referral Date:

Assessment Date:

SECTION 1: PERSONAL DATA

Name:

Address:

Phone:

Birthdate:

Age:

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:

Name: Date:

SECTION 3: DIRECTIONS TO and DESCRIPTION OF HOME

Directions to Home:

Description of Home:

SECTION 4: EMERGENCY CONTACTS

Name:
Address:
City/State/Zip:
Phone:

Name:
Address:
City/State/Zip:
Phone:

Name:
Address:
City/State/Zip:
Phone:

SECTION 5: PHYSICIAN INFORMATION

Name:
Phone:

Name:
Phone:

Name:
Phone:

Name: _____ Date: _____

SECTION 6: LIVING SITUATION

☐ Lives Alone ☐ Lives with Spouse/Significant Other

☐ Lives with Child/Children

☐ Lives with Others (Specify): _____

SECTION 7: HEALTH STATUS

1. Ambulation: ☐ Full ☐ Partial ☐ Crutches ☐ Walker/Cane ☐ Wheelchair ☐ 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: _____

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

Name: Date:

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**

SECTION 10: OTHER COMMENTS

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