

Date:

Meals on Wheels Assessment Form – The Senior Hub

Welcome! Please tell us a bit about yourself so we can offer services that best meet your needs. We ask for demographic information to meet requirements from our funders. All your personal information is confidential.

Contact & Demographic Information:

First Name: _____ Middle Name: _____

Last Name: _____ Nickname: _____

Date of Birth: _____ Age: _____

Home Address Line 1: _____

Line 2 (Apt/Unit/Floor #): _____ City: _____

Zip: _____ County: _____ State: _____

Mailing Address Line 1: _____

Line 2 (Apt/Unit/Floor #): _____ City: _____

Zip: _____ County: _____ State: _____

Location Comments (additional directions for home or mailing address):

Home Phone: _____ Cell Phone: _____

Email: _____

Gender: Male Female Non-Binary/Third Gender

Identify as: Transgender Cisgender (identify with your gender from birth)

Gender not listed: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race, select all that apply:

American Indian or Alaska Native Middle Eastern or North African

Asian or Asian American Native Hawaiian or Pacific Islander

Black or African American White

Race not listed: _____

Do you live: Alone With Others

Optional Demographics:

Total Monthly Income: _____

Number of people in your household (including you): _____

Marital Status:

Single (never married) Domestic Partner/Committed Relationship/Common Law

Married Divorced Separated Widow

Veteran Status: are you a veteran? Yes No Spouse of Veteran

Communication & Service Needs:

Health Insurance (select all that apply):

Medicare Medicare Advantage Medicaid Medicaid Waiver
 None Other: _____

Would you like to hear about other services? Yes No

If yes, how can we contact you? Email Mail Phone

What services are you interested in? _____

Housing:

Own	<input type="checkbox"/>
Rent	<input type="checkbox"/>
Other permanent housing	<input type="checkbox"/>
Homeless	<input type="checkbox"/>
Other	<input type="checkbox"/>

Education:

Grades 0-8	<input type="checkbox"/>
Grades 9-12/Non-Graduate	<input type="checkbox"/>
High School Graduate/ Equivalency Diploma	<input type="checkbox"/>
12 th grade + Some Post-Secondary	<input type="checkbox"/>
2 or 4 years College Graduate	<input type="checkbox"/>
Graduate of other post-secondary school	<input type="checkbox"/>

Work Status:

Employed Full-Time	<input type="checkbox"/>
Employed Part-Time	<input type="checkbox"/>
Migrant Seasonal Farm Worker	<input type="checkbox"/>
Unemployed (Short-Term, 6 months or less)	<input type="checkbox"/>
Unemployed (Long-Term, more than 6 months)	<input type="checkbox"/>
Unemployed (Not in Labor Force)	<input type="checkbox"/>
Retired	<input type="checkbox"/>

Emergency Contact:

Primary Emergency Contact:

Name: _____

Phone: _____ Relationship: _____

Secondary Emergency Contact or Caregiver (if applicable):

Name: _____

Phone: _____ Relationship: _____

Power of Attorney (if applicable):

Name: _____

Phone: _____ Relationship: _____

Type of Power of Attorney: _____

Health and Home Conditions

Homebound/Geographically Isolated

Is the client homebound or in a geographically isolated location? Yes No

Health Conditions

Do you/does the client have any of the following conditions? Check all that apply:

- Dementia or Alzheimer's
- DD / ID
- Autism
- Diabetes
- Epilepsy/Seizure disorder
- Intellectual Disability
- Mental Illness
- Memory Problems
- Mobility Impairment
- Hearing Impairment
- Visual impairment (cannot be corrected with glasses)
- Physical Disabilities
- Traumatic Brain Injury

Does the client need supervision? Yes No

Is the client medically dependent on any of the following:

- Insulin
- Oxygen
- Dialysis

Hearing Aids:

- Uses
- Not Applicable

Glasses and Contacts:

- Uses
- Not Applicable

Mobility Devices

Does the client use or need (but does not currently have) any mobility devices?

- Yes
- No

If yes, which mobility devices does the client currently use or need? Select all that apply:

- | | | |
|-------------------------|-------------------------------|--------------------------------|
| Cane | <input type="checkbox"/> Uses | <input type="checkbox"/> Needs |
| Crutches | <input type="checkbox"/> Uses | <input type="checkbox"/> Needs |
| Walker | <input type="checkbox"/> Uses | <input type="checkbox"/> Needs |
| Wheelchair | <input type="checkbox"/> Uses | <input type="checkbox"/> Needs |
| Electric Scooter | <input type="checkbox"/> Uses | <input type="checkbox"/> Needs |

Other Mobility Device:

Home Conditions and Pets

Does anyone smoke inside the client's home? Yes No

Are there any pets in the household? Yes No

If yes, please list pets:

Are any of your pets uncomfortable with visitors to the home?

Yes No Not Applicable

Other Home Condition Concerns or Details:

Nutrition Screening:

Determine your nutritional health. If the statement is true for you, check the box in the "Yes" column and add the points in the "Yes Score" column to your total score.

Nutrition Risk Score Questions	Yes	No	Yes Score
Do you have an illness or condition that has made you change the kind and/or amount of food you eat?	<input type="checkbox"/>	<input type="checkbox"/>	2
Do you eat fewer than 2 meals per day?	<input type="checkbox"/>	<input type="checkbox"/>	3
Do you eat few fruits, vegetables, or milk products?	<input type="checkbox"/>	<input type="checkbox"/>	2
Do you have 3 or more drinks of beer, liquor, or wine almost every day?	<input type="checkbox"/>	<input type="checkbox"/>	2
Do you have tooth or mouth problems that make it hard for you to eat?	<input type="checkbox"/>	<input type="checkbox"/>	2
Are there times you do not have enough money to buy the food you need?	<input type="checkbox"/>	<input type="checkbox"/>	4
Do you eat alone most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	1
Do you take 3 or more different prescribed or over the counter drugs a day?	<input type="checkbox"/>	<input type="checkbox"/>	1
Without wanting to, have you lost or gained 10 pounds in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	2
Are there times you're physically unable to shop, cook, and/or feed yourself?	<input type="checkbox"/>	<input type="checkbox"/>	2
Total Nutrition Risk Score	<i>Total "Yes" Score:</i>		

Total Nutrition Risk Score: 0-2 = No Risk, 3-5 = Moderate Risk, 6 or more = High Risk

If you are at high nutrition risk – take action! Speak with a qualified health or social service professional about your nutritional health. Providers – if the client is at high nutrition risk, please make a case note and appropriate referral.

Are you interested in receiving nutrition counseling? Yes No

Activities of Daily Living and Instrumental Activities of Daily Living:

For each activity, please mark the level of help you (or the client) needs.

Independent: no help needed

Verbal assistance: needs direction, intermittent monitoring or reminder to complete activity

Some human help: needs some assistance, constant supervision not required

Lots of human help: needs assistance and supervision to complete most parts of activity

Dependent: totally dependent on help for completing activity, needs constant supervision

Activities of Daily Living (ADLs)	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the Bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring In/Out of Bed/Chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking/Getting Around the House	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments on ADLs: _____

Instrumental Activities of Daily Living (IADLs)	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Money Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using a Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments on IADLs: _____

Are you receiving assistance with ADLs or IADLs from anyone? Yes No

If yes, who is assisting you: _____

In Home Services Eligibility:

Can the client perform chore activities without help? Yes No

Comment on the client's inability to perform chore services: _____

Client requires Home Health Aide based on physician's orders? Yes No

Does the client have cognitive impairment None Mild Moderate Severe

Disclosures and Waivers

I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service provider and I herewith give my consent to do so.

Signature: _____ **Date:** _____

For Office Use Only –

(If filled out by assessor or via phone, please have assessor check here and sign below)

Filled Out By: _____ **Date:** _____

Home Delivered Meal NSIP Eligibility

- Individual Aged 60+
- Self-Declared Spouse of individual aged 60+
- Volunteer for the meal programs
- Individual with disabilities living with individual aged 60+ and individual 60+ receives home delivered meals
- Tribal Age Specification

In-Home Services Eligibility (Adult Day, Home Health Aide, Homemaker, Personal Care)

- 2+ ADLs (adult day, home health aide, personal care)
- 2+ IADLs (homemaker only)
- and/or Cognitive impairment (all)
- and Physician's order (home health aide only)

Chore Eligibility:

- Unable to perform chores without help

Case Management Services Eligibility:

- Individual Aged 60+

The Senior Hub

Clients Notes: (driving instructions, allergies, etc.)

How to Submit Form:

Please email this completed form to ewilling@seniorhub.org or mail to

The Senior Hub
c/o Emma Willing
10190 Bannock St. Suite 106
Northglenn CO 80260

There may be a waitlist for the program, we will let you know when we receive it and if there is a waitlist for your area. If you have any questions, please call us at (303) 426 – 4408 x210