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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| New  Reassessment  Change  Review  Close | | | | | | | | | | Assessment Date:  Enter Date | | | | | | DAARS ID:  Enter DAARS ID | |
| **PART I: INTAKE INFORMATION** | | | | | | | | | | | | | | | | | |
| 1. **Client Profile & Referral Information** | | | | | | | | | | | | | | | | | |
| First Name: Enter First Name | | | | Last Name: Enter Last Name | | | | | | | | | | | | | M.I. Enter M.I. |
| SSN (*optional*): Enter SSN | Date of Birth: Enter DOB | | | | | | | | | | Phone No. Enter Phone # | | | | | | |
| Mailing  Address: Enter Mailing Address | | | | | | | | | | | | | | | | | |
| City: Enter City | | | | | State: Enter State | | | | | | | | Zip code: Enter Zipcode | | | | |
| **Information for interview was obtained from:** | | | | | | | | | | | | | | | | | |
| Self-report  Medical records  Other (specify): | | | | | | | | | | | | | | | | | |
| *Name of referral source:* Enter Referral Source | | | | | *Phone #:* Enter Phone # | | | | | | | | | *Referral Date:* Enter Date | | | |
| **Eligibility Category:**  60 and over  Spouse of client age 60 and over  Under 60 with a disability  Caregiver of eligible client | | | | | **Eligible Client (associated with Spouse/Caregiver):** | | | | | | | | | | | | |
| Name: | | | Enter Name of Eligible Client | | | | | | | | | |
| SSN: | | | Enter SSN | | | | | | | | | |
|  | | |  | | | | | | | | | |
| 1. **DEMOGRAPHICS** | | | | | | | | | | | | | | | | | |
| **Type of Disability:**  Physical  Intellectual disability/  Developmental disability (ID/DD)  Mental Illness | | Traumatic Brain injury  Dementia | | | | | | | | | | **Ethnicity:**  Hispanic or Latino  Not Hispanic or Latino  Declined to state | | | | | |
| Other (*specify*): | | | | Enter Text | | | | | |
| None: | | | | | | | | | |
| **Race:**  Asian  Black/African American  Native Hawaiian or other Pacific Islander  American Indian or Alaskan Native  White  Declined to state  Other (*Specify)*: | | | **Relationship Status:**  Divorced  Domestic partner  Married  Separated  Single  Widowed  Declined to state | | | | **Language:**  English  American Indian (w/Eng)  American Indian (w/o Eng)  Spanish (w/Eng)  Spanish (w/o Eng) | | | | | | | | | | |
| Other (*Specify*): | | | | | | | | Enter Text | | |
| Declined to state | | | | | | | | | | |
| **English Fluency:**  Fluent  Limited  Needs translation  Declined to state | | | **Education:**  Grade school or less  Some high school  High school graduate | | | | | | Post high school  College degree  Declined to state | | | | | | | | |

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| **Client’s Name:** Enter Client’s Name | | | | | | | | | | | | | | **DAARS ID:** Enter DAARS ID | | | | |
| **Residence Type:**  Apartment  Assisted Living facility  Board and care  DD group home  Foster care  House | | Mobile  Nursing home  Declined to state | | | | | | | | | | | | **Living Arrangement:**  No pay  Owns  Rents  Subsidized  N/A  Declined to state | | | **Number in Household:**  Enter Text | |
| Other (specify): | | | | Enter Text | | | | | | | |
|  | | | | | | | | | | | |
| **Household Composition:**  Institutionalized  Lives alone  With domestic partner  With non-relative(s)  With other relative(s) | | | With parent(s)  With spouse  Declined to state  Other (*specify):* | | | | | | | | **Urban/Rural:**  Rural  Urban  Declined  to state | | | | **At or Below 100% FPL:**  Yes  No  Declined  to state | | | **Gender:**  Female  Male  Unknown |
| **Veteran:**  No  Child  Spouse  Veteran (*Veteran #):*  Declined to state | | | | | **Legal Status:**  Independent  Guardian  Child  LTC Payee | | | | | | | | Conservator  DP7 Payee  Declined to State  Other (Specify): | | | | | |
| **Emergency Contact** *(First, Last Name)****:*** | | | | Enter Emergency Contact’s Name | | | | | | | | | | | | | | |
| **Relationship:** | Enter Relationship | | | | | | | | **Phone #:** | | | Enter Phone # | | | | | | |
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| **PART II: NUTRITIONAL STATUS** | | | | | | | | | | | | | | | | | | |
| Does the client have a special diet? | | | | Yes | | | No | | | If yes, specify: Enter Text | | | | | | | | |
| Does the client have a food allergy? | | | | Yes | | | No | | | If yes, specify: Enter Text | | | | | | | | |
| **Nutritional Screening (*Check all that apply and total the score shown for each selected responses*):** | | | | | | | | | | | | | | | | | | |
| I have an illness or condition that changed the kind and/or amount of food I eat. (2) | | | | | | | | I don’t always have enough money to buy the food I need. (4) | | | | | | | | | | |
| I eat fewer than 2 meals per day. (3) | | | | | | | | I eat alone most of the time. (1) | | | | | | | | | | |
| I eat few fruits or vegetables or milk products. (2) | | | | | | | | I take 3 or more different prescribed or over-the-counter drugs a day. (1) | | | | | | | | | | |
| I have 3 or more drinks of beer, liquor or wine almost every day. (2) | | | | | | | | Without wanting to, I have lost or gained 10 pounds in the last 6 months. (2) | | | | | | | | | | |
| I have tooth or mouth problems that make it hard for me to eat. (2) | | | | | | | | I am not always physically able to shop, cook and/or feed myself. (2) | | | | | | | | | | |
| **Total Score**(*0-2 is good, 3-5 is moderate nutritional risk, 6 or greater is high nutritional risk*)**:** Enter Total Score | | | | | | | | **Height** (*optional):*  Enter Height | | | | | | | | **Weight** (*optional):*  Enter Weight | | |
| Comments: Enter Text | | | | | | | | | | | | | | | | | | |

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| **Client’s Name:** | | | | | | | | | | | | **DAARS ID:** | | | | | |
| **PART III: SERVICE ENROLLMENTS** | | | | | | | | | | | | | | | | | |
| Open  Change  Close  Continue | | | | | | | | | | Provider/Subcontractor: Select a Tribe | | | | | | | |
| Scope of Work: Enter Title III Service, i.e. CNG | | | | | | | | Enrollment Status:  Enrolled  Disenrolled  Waitlisted | | | | | | | | | |
| Units: Enter # | | Frequency Period:  One time  Daily  Weekly  Monthly Other: Enter Text | | | | | | | | | | | | | | | |
| Comments: Enter Text | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Open  Change  Close  Continue | | | | | | | | | | Provider/Subcontractor: Select a Tribe | | | | | | | |
| Scope of Work: Enter Title III Service, i.e. CNG | | | | | | | | Enrollment Status:  Enrolled  Disenrolled  Waitlisted | | | | | | | | | |
| Units: Enter # | | | Frequency Period:  One time  Daily  Weekly  Monthly Other: Enter Text | | | | | | | | | | | | | | |
| Comments: Enter Text | | | | | | | | | | | | | | | | | |
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| Open  Change  Close  Continue | | | | | | | | | | | Provider/Subcontractor:Select a Tribe | | | | | | |
| Scope of Work:Enter Title III Service, i.e. CNG | | | | | | | Enrollment Status:  Enrolled  Disenrolled  Waitlisted | | | | | | | | | | |
| Units:Enter # | | | | Frequency Period:  One time  Daily  Weekly  Monthly Other: : Enter Text | | | | | | | | | | | | | |
| Comments: : Enter Text | | | | | | | | | | | | | | | | | |
| **PART IV: AUTHORIZATION** | | | | | | | | | | | | | | | | | |
|  | I have received a copy of the Clients Rights and Responsibilities and I certify by my signature or mark that I understand my rights and responsibilities, and that the information provided on this form, as it relates to my request and eligibility, is true and correct. | | | | | | | | | | | | | | | | |
|  | The service plan has been discussed with me and I agree with the described services. I have received a copy of the grievance and appeals procedure, and I understand that if I disagree with any action taken in my case, I have the right to present a verbal or written request for a fair hearing. | | | | | | | | | | | | | | | | |
|  | I was provided the opportunity to contribute voluntarily to the cost of services. | | | | | | | | | | | | | | | | |
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| Client’s Signature or Mark | | | | | | | | | | | | | Date | | |
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| Responsible Party’s Signature | | | | | |  | | | Relationship | | | | | | | Date | |
|  | | | | | | | | | | | | | | | | | |
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| Worker’s Name | | | | | |  | | Worker’s Signature | | | | | |  | | Date | |
|  | | | | | |  | |  | | | | | |  | |  | |