|  |  |  |
| --- | --- | --- |
| [ ]  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 # |
| MailingAddress: 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 # |
|  |
| **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 |
|  |
| [ ]  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.  |
|   |
|  |  |  |
| Client’s Signature or Mark | Date |
|  |
|   |  |  |  |  |
| Responsible Party’s Signature |  | Relationship | Date |
|  |
|  |  |  |  |  |
| Worker’s Name |  | Worker’s Signature |  | Date |
|  |  |  |  |  |