Inter Tribal Council of Arizona, Inc., Area Agency on Aging, Region 8

Title III Congregate Meals - Nutritional Assessment

☐ New ☐ Reassessment ☐ Change ☐ Review ☐ Close	Assessment Date:	DAARS ID:

PART I: INTAKE INFORMATION

A. Client Profile & Referral Information

First Name:	Last Name:	M.I.
SSN (*optional*):	Date of Birth:	Phone No.

Mailing Address:

City:	State:	Zip code:

Information for interview was obtained from:

☐ Self-report ☐ Medical records ☐ Other (specify):

Name of referral source:	*Phone #:*	*Referral 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: ______

SSN: ______

B. DEMOGRAPHICS

Type of Disability:
- ☐ Physical
- ☐ Intellectual disability/ Developmental disability (ID/DD)
- ☐ Mental Illness
- ☐ Traumatic Brain injury
- ☐ Dementia
- ☐ Other (*specify*): ______
- ☐ None:

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Declined to state

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*): ______
- ☐ 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:

DAARS ID:

Residence Type:
☐ Apartment
☐ Assisted Living facility
☐ Board and care
☐ DD group home
☐ Foster care
☐ House
☐ Mobile
☐ Nursing home
☐ Declined to state
☐ Other (specify): ____________

Living Arrangement:
☐ No pay
☐ Owns
☐ Rents
☐ Subsidized
☐ N/A
☐ Declined to state

Number in Household:

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):* ____________

Relationship: ____________ **Phone #:** ____________

PART II: NUTRITIONAL STATUS

Question			
Does the client have a special diet?	☐ Yes	☐ No	If yes, specify:
Does the client have a food allergy?	☐ Yes	☐ No	If yes, specify:

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)***:**	**Height** *(optional):*	**Weight** *(optional):*

Comments:

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Client's Name:	**DAARS ID:**
PART III: SERVICE ENROLLMENTS	
☐ Open ☐ Change ☐ Close ☐ Continue	Provider/Subcontractor:
Scope of Work:	Enrollment Status: ☐ Enrolled ☐ Disenrolled ☐ Waitlisted
Units:	Frequency Period: ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐Other:
Comments:	
☐ Open ☐ Change ☐ Close ☐ Continue	Provider/Subcontractor:
Scope of Work:	Enrollment Status: ☐ Enrolled ☐ Disenrolled ☐ Waitlisted
Units:	Frequency Period: ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐Other:
Comments:	
☐ Open ☐ Change ☐ Close ☐ Continue	Provider/Subcontractor:
Scope of Work:	Enrollment Status: ☐ Enrolled ☐ Disenrolled ☐ Waitlisted
Units:	Frequency Period: ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐Other:
Comments:	

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

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