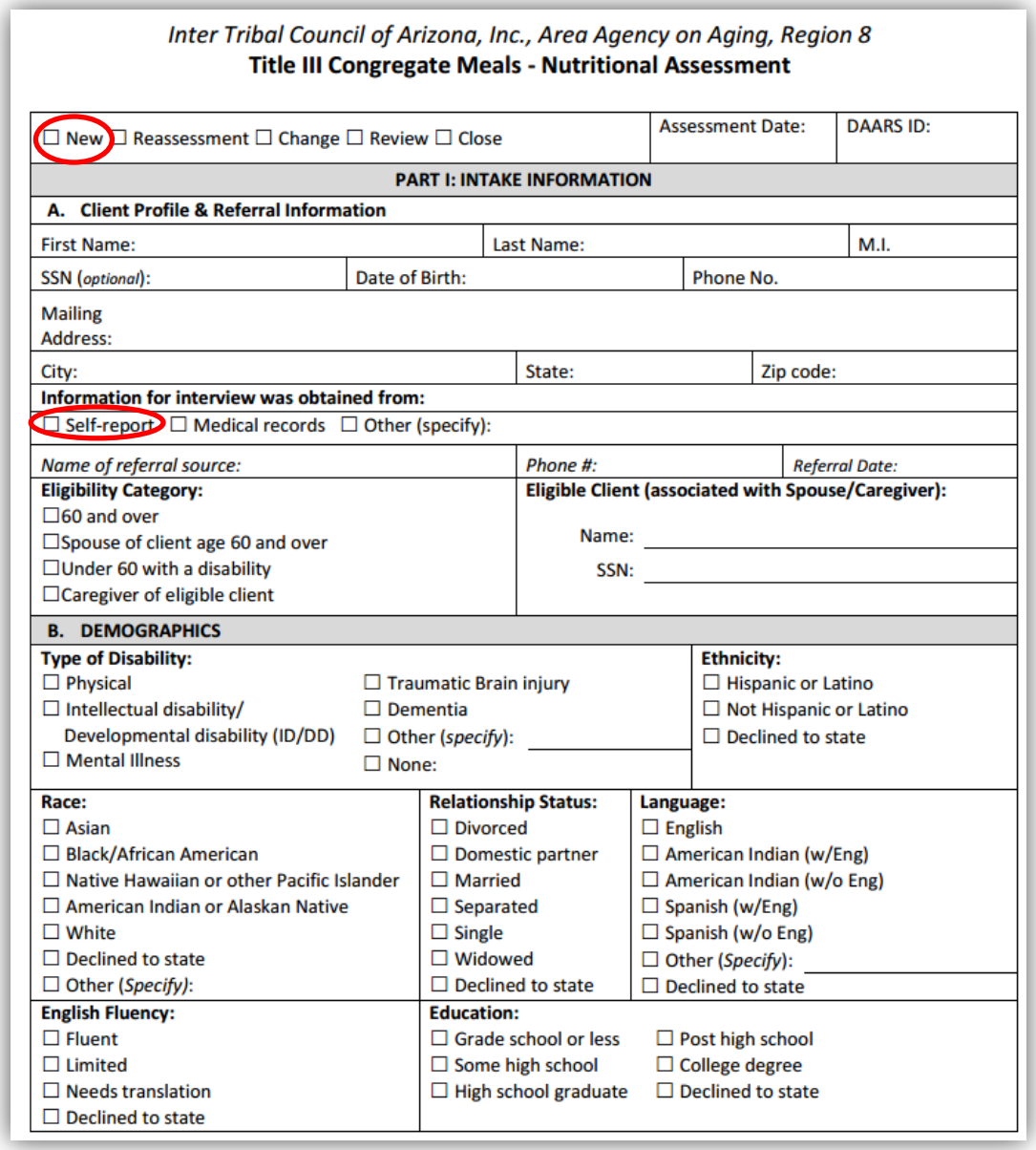
Title III Nutritional Assessment: Congregate Meals

ITCA-AAA, Region 8

DAARS Reporting Overview

Page 1: Intake Information



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:	**Eligible Client (associated with Spouse/Caregiver):**
☐60 and over ☐Spouse of client age 60 and over ☐Under 60 with a disability ☐Caregiver of eligible client	Name: _____ SSN: _____

B. DEMOGRAPHICS

Type of Disability:		**Ethnicity:**
☐ Physical	☐ Traumatic Brain injury	☐ Hispanic or Latino
☐ Intellectual disability/ Developmental disability (ID/DD)	☐ Dementia	☐ Not Hispanic or Latino
	☐ Other (*specify*): _____	☐ Declined to state
☐ Mental Illness	☐ None:	

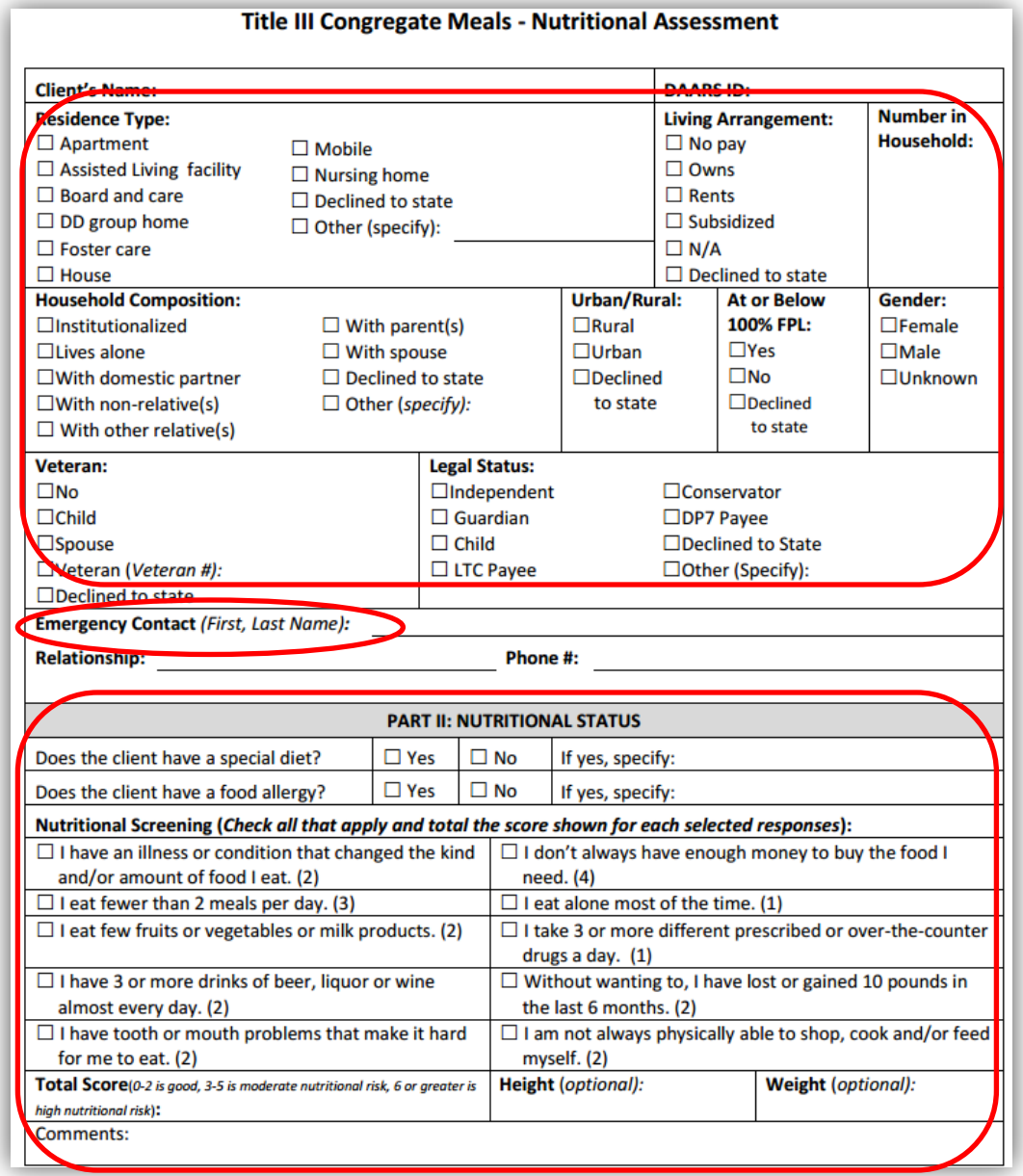
Race:	**Relationship Status:**	**Language:**
☐ Asian	☐ Divorced	☐ English
☐ Black/African American	☐ Domestic partner	☐ American Indian (w/Eng)
☐ Native Hawaiian or other Pacific Islander	☐ Married	☐ American Indian (w/o Eng)
☐ American Indian or Alaskan Native	☐ Separated	☐ Spanish (w/Eng)
☐ White	☐ Single	☐ Spanish (w/o Eng)
☐ Declined to state	☐ Widowed	☐ Other (*Specify*): _____
☐ Other (*Specify*):	☐ Declined to state	☐ Declined to state

English Fluency:	**Education:**	
☐ Fluent	☐ Grade school or less	☐ Post high school
☐ Limited	☐ Some high school	☐ College degree
☐ Needs translation	☐ High school graduate	☐ Declined to state
☐ Declined to state		

Please complete all sections on this page:

- Assessment Date is date form is completed
  - "New" if client is being added for first time
- DAARS ID is issued once client's information is entered in DAARS
- Client Profile & Contact Information
  - Name (First, Last)
  - Date of Birth
  - SSN – Optional
  - Self Report is if the client is providing information
- Demographics
  - Please review each box and select those that apply

Page 2: Nutritional Status



Title III Congregate Meals - Nutritional Assessment

Client's Name: | **DAARS ID:**

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

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

Number in Household:

Household Composition:
☐ Institutionalized ☐ With parent(s)
☐ Lives alone ☐ With spouse
☐ With domestic partner ☐ Declined to state
☐ With non-relative(s) ☐ Other (*specify):*
☐ With other relative(s)

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 ☐ Conservator
☐ Guardian ☐ DP7 Payee
☐ Child ☐ Declined to State
☐ LTC Payee ☐ Other (Specify):

Emergency Contact *(First, Last Name):* _____

Relationship: _____ **Phone #:** _____

PART II: NUTRITIONAL STATUS

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:

Please complete all sections on this page:

- **Demographic Questions:**
  - Residence Type
  - Living Arrangement
  - Number in Household
  - Household Composition
  - Urban/Rural
  - At/Below 100% Federal Poverty Level (FPL)
  - Gender
  - Veteran
  - Legal Status
- **Emergency Contact**
  - Provide a name and phone number
- **Nutritional Status**
  - Complete all questions, if none apply to client, please note in comments

Page 3: Service Enrollment

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

Title III Congregate Meals - Nutritional Assessment

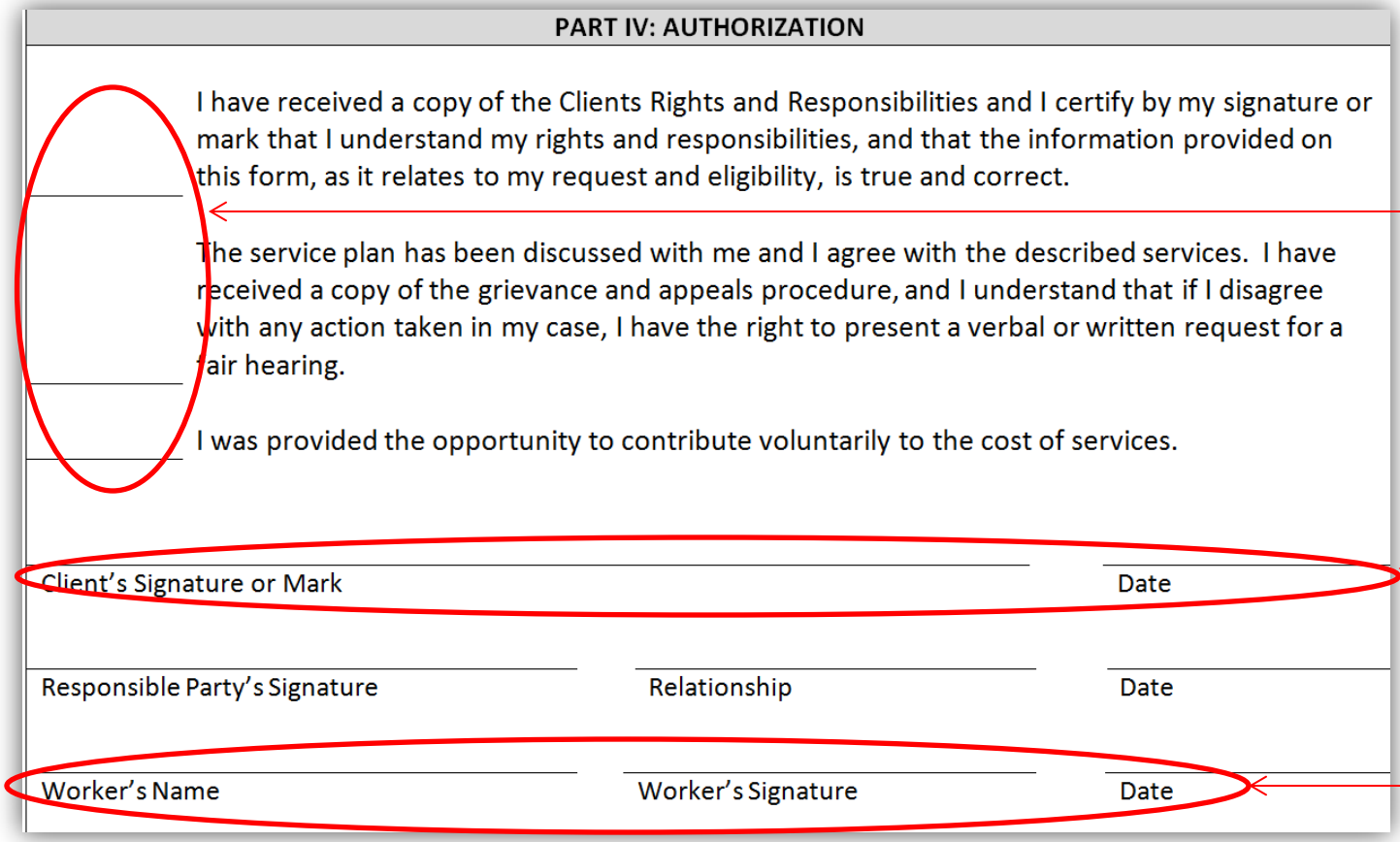
Client's Name:	**DAARS ID:**
PART III: SERVICE ENROLLMENTS	
☒ Open ☐ Change ☐ Close ☐ Continue	Provider/Subcontractor: **Kaibab Band of Paiute Indians**
Scope of Work: **Title III Congregate Meals**	Enrollment Status: ☒ Enrolled ☐ Disenrolled ☐ Waitlisted
Units: **23**	Frequency Period: ☐ One time ☐ Daily ☐ Weekly ☒ Monthly ☐ Other:
Comments:	

Please complete the following:

- Select "Open" if the client is new
- Input the name of the tribe (subcontractor)
- Scope of Work – Please type "Title III Congregate Meals"
- Enrollment status – Select "Enrolled" if client is new
- Units – Input "23" as the total amount, if more units then adjust according to meals provided to client on daily basis per month
- Frequency Period – Select "Monthly"
- Comments – Enter any comments regarding client's service enrollment status

Page 3: Authorization

Please have client initial in the following areas:



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

Client initials on three lines

Client signature and date

Worker's Name, Signature & date

Contact Information

Cynthia Freeman

AAA Program Coordinator

Cynthia.Freeman@itcaonline.com

ITCA Area Agency on Aging, Region 8

2214 N. Central Ave., Phoenix, AZ 85004

Phone: (602) 258-4822/Fax: (602) 258-4825