Village of Pleasantville, Clinton Street Center

Home Delivered Meals Assessment

Date of Intake: _____

Name: _____ Phone: _____

Address: _____

DOB: _____ Gender: _____ Marital Status: _____

Living Arrangement: ___ALONE ____W/ Spouse _____W/ Children ____Other (_____)

Housing: _____Single Family Home _____Multi Family Home --- Own or Rent --_____# in Household

EMERGENCY CONTACT:

#1 Contact Name: _____ Relation: _____

Address: _____

Cell: _____Home:_____Work:_____

#2 Contact Name: _____Relation: _____

Address: _____

Cell: _____Home:_____Work:_____

Physician:

Name:_____Phone:_____FAX_____

Address:_____

Medical/Health Conditions: _____Dementia _____Arthritis _____Cancer _____COPD

_____Chronic Pain_____ Congestive Heart Failure _____Dental Issues _____Dialysis _____ Diabetic

_____ Insulation dependent _____ Hearing Impairment_____ High Blood Pressure _____Legally Blind

_____Parkinson _____ Visual Impairment Other: _____

Prescribed and OTC Medication:

ALLERGIES:

_____

Mental Status: ___ Adequate ____ Alert/Oriented _____ Limited

Durable Equipment: _____ Cane _____Dentures _____Glasses _____Hearing Aid _____ Walker/Rollator

Do you Receive: Social Security: _____ Medicare _____ Medicaid _____

Do you have a DNR? _____ Do you Final arrangements in Place: _____

Nutrition:

Are you on a special diet? _____

Any Food Allergies? _____

Nutrition Risk Assessment:

1. Do you have an illness or condition that makes you change the kind or amount of food eaten?
2. (i.e. diabetes, high blood pressure, or kidney disease) No Yes if yes 2 pts.
3. Do you eat fewer than 2 meals per day? No Yes if yes 3 pts.
4. Do you eat few fruits or vegetables or milk products per day? No Yes If yes 2 pts answer yes if you drink less that 2 cups of milk or other dairy daily, or eat Less than 5 serving of fruit/vegetables per day
5. Do you have trouble eating due to problems with teeth/mouth? No Yes if yes, 2 pts
6. Do you sometimes have problems buying food due to income? No Yes if yes 4 pts
7. Do you eat alone most of the time? No Yes if yes 1pt
8. Do you take 3 or more prescribed or OTC medications daily? No Yes if yes 1 pt
9. Without wanting to, have you gained or lost 10 pounds in the last 6 months? No Yes if yes 2pts
10. Are you not always physically able to shop, cook for yourself? No Yes if yes 2pts
11. Do you have 3 or more drinks of beer, wine or alcohol daily? No Yes if yes 2 pts

Total points _____

0-2 points Good Nutritional Health (re check at 6 month mark)
3 – 5 points Moderate Risk (share info with family/caregivers with suggestions for nutritional improvement)
5+ points High Nutritional Risk (Share info with family and physician)

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I _____ am requesting that I receive Home Delivered Meals. I understand that the information here is confidential and it will be used for purposes related to providing these services to me. I also understand that the meals cost $5 each and I will be billed at the end of each month. I release the Village of Pleasantville, its Board of Trustees, Employees and Volunteers of any liability whatsoever in relation to the delivering of these meals.

Signature/ Date: _____

Service provider signature/Date: _____

_____To be completed by Clinton Street Center Personnel_____

Approved for Services: _____Yes ____No

Days to receive meals: Mon. Tues. Wed. Thurs. Fri. Receive Hot Meal or Cold Meal

Date of Service Started: _____ Date Ended: _____