OFFICE USE	Rec'd:	Assessment Date:	Start Date:	Harmony #_____	Route #_____

GRAY GOURMET **2017 Consumer In-Home Services Assessment Form**

Updated 7/12/2017

Basic Client Information		**Date of Assessment: / /**	
First Name:	Last Name:	Middle Initial:	"Common Name" if Applicable
Date of Birth: / /	Age:	Residential Street Address:	
Gender: ☐Male ☐Female		Apartment or Unit #:	
Are you a veteran? ☐Yes ☐No		Residential City or Town:	
What is your primary language?		Residential State, Zip Code:	
What is your race?		County of Residence:	
Are you Hispanic or Latino? ☐Yes ☐No		Phone Number:	
Are you visually impaired? ☐Yes ☐No (cannot be corrected with glasses)		Would you like 1% milk with your meal? ☐Yes ☐No	
Are you eligible for Medicaid? ☐Yes ☐No		Would you like weekend frozen meals (delivered on Fridays)? ☐Yes ☐No	
Do you have hearing problems? ☐Yes ☐No		Would you like to speak with a Registered Dietitian? (There is no charge). ☐Yes ☐No	
Do you live alone? ☐Yes ☐No		Are you a previous Gray Gourmet customer? ☐Yes ☐No	
What is your individual monthly income? What is your household monthly income?		***Emergency Contact Name:*** ***Phone Number:*** ***Relation:*** ***Location City:***	
What is your individual monthly income range? ☐ $1,005 or less ☐ $1,006 to $1,256 ☐ $1,257 to $1,859 ☐ $1,860 or more		What is you and your spouse's combined monthly income range? ☐ $1,353 or less ☐ $1,354 to $1,691 ☐ $1,692 to $2,503 ☐ $2,504 or more	

Client's Mobility and Health Conditions

Does the client use any mobility devices? ☐None ☐Cane ☐Crutches ☐Electric Scooter ☐Walker ☐ Wheelchair ☐Other: _____

Is the client memory impaired? ☐Yes ☐No

Has the client been diagnosed as being diabetic? ☐Yes ☐No

Does the client use oxygen? ☐Yes ☐No

Does the client need supervision? ☐Yes ☐No

Client's Home Condition and Pets

Is the home in need of repair? ☐Yes ☐No

If so, list what kind (especially if safety concern): _____

Are there any pets in the household? ☐Yes ☐No

If so, what pets does the client have? _____

Any vicious pets (threat to in-home help)? ☐Yes ☐No

Nutrition Checklist	Yes	No	Yes Score
*I have an illness/condition that changes the kind and/or amount of food I eat.			2
*I eat fewer than 2 meals per day.			3
*I eat few fruits or vegetables or milk products.			2
*I have 3 or more drinks of beer, liquor, or wine almost every day.			2
*I have tooth or mouth problems that make it hard for me to eat.			2
*I don't always have enough money to buy the food I need.			4
*I eat alone most of the time.			1
*I take 3 or more different prescribed or over the counter drugs a day.			1
*Without wanting to, I have lost or gained 10 pounds in the last 6 months.			2
*I am not always physically able to shop, cook and/or feed myself.			2

What is the consumer's nutritional risk score? *(0-2 = No Risk 3-5 = Moderate Risk 6 or more = High Risk)*

Total 'Yes' Score: _____

ADLs and IADSs Required to Determine Eligibility For Home Services

ADLs (Activities of Daily Living)	Yes	No	IADLs (Instrumental Activities of Daily Living)	Yes	No
I eat without help.			I manage money without help.		
I dress myself without help.			I take care of shopping without help.		
I bathe myself without help.			I take my medication without help.		
I use the toilet without help.			I prepare meals without help.		
I get in/out of bed/chairs without help.			I do ordinary housework without help.		
I get around inside my home without help.			I use the telephone without help.		
Total 'No' Score: _____			I use transportation without help.		
			Total 'No' Score: _____		

From whom are you receiving assistance with ADLs and or IADLs?

Other Eligibility Criteria	Yes	No
Does the client require Home Health Aide based on orders from a physician?		
Does the client reside in a rural area?		
Is the client homebound or in a geographically isolated location to justify home delivered meals?		
Can the client perform chore activities without help?		

Other Information: (For Example: Comment on client's inability to perform daily living and/or chore activities, chronic medical conditions, where to send statements; any special instructions to find house).

Contributions, Complaint & Appeals
I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service provider and I herewith give my consent to do so.

Photo & interview release
I authorize the Sisters of Charity of Leavenworth Health system, St. Mary's Hospital, Gray Gourmet and its agents to photograph or videotape my image and/or voice. I agree that photograph images, voice recordings and my name may be used for interview and publicity purposes. I agree to this without obligation to compensate me or others on my behalf for the use of such photographic, video or audio formats.

Delivery
I further understand that I need to be home to receive deliveries or make other arrangements with the office. I understand if I do not answer the door, Gray Gourmet representatives may try the door and place the meal inside if the door is unlocked. I may cancel occasionally for medical appointments, with 24hour notice. Food preference cancellations cannot be accommodated. If I am not home when deliveries are made, a notice will be placed on my door and I need to call the office to confirm I am ready for the next day delivery. If I do not confirm delivery for the next day Gray Gourmet may order a wellness check with the police department. ***Repeated absences and/or cancellations may result in service suspension.***

Reassessments
As a Gray Gourmet participant I will be reassessed approximately every 6 months to update my current circumstances. ***Failure to complete timely reassessments may result in service suspension.***

(If filled out by assessor or via phone, please have assessor check here and sign below ☐*).*
Signature_____ Date_____Contact Phone_____

For office use only:

☐ Frozen/milk	☐ Pets
☐ Delivery time	☐ No service days
☐ Receiving delivery	☐ Donation
☐ Cancellations	☐ Releases

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KEEP THIS FORM FOR YOUR RECORDS

Please read the following information concerning this Intake Form and Complaint/Grievance Procedure:

We are asking you to complete the attached form to the best of your knowledge so we understand how you would like to receive services. Some basic information, indicated with an * is needed to meet compliance with federal and state reporting requirements and to target consumers age 60 and older who have the greatest economic and social need, such as individuals who are low-income minority, frail, and rural. Requests for services are processed as funds allow.

Your income level is not used to qualify you to receive services, but rather as a means to gather demographic data to various entities to show the need for continued funding of services. Nobody will contact you, unless you choose so in order to receive information about services which might be available to you.

If there is not enough room on the application for any of your responses, please attach a separate sheet.

Complaint/Grievance/Appeal Procedure:

The purpose of the Complaint/Grievance/Appeal Procedure is

- To ensure fair and equitable treatment of all consumers, eliminate dissatisfaction, resolve problems and
- To establish complaint and appeals procedures that inform the consumers of their rights to complain and receive a written response at the provider level

Any OAA/OCA (Older Americans Act/Older Coloradans Act) eligible consumer who has a complaint/grievance with the organization asking you to fill out this assessment form has the right to file a complaint/grievance with said organization and, if not satisfied with the organization's decision, to appeal that decision with either the local AAA (Area Agency on Aging) or the SUA (State Unit on Aging).

The complete Complaint/Grievance/Appeal Procedure is available upon request by contacting your local AAA and/or the SUA as follows:

Office of Adult, Disability, and Rehabilitation Services
Aging and Adult Services
1575 Sherman Street, 10th Floor
Denver, CO 80203
(303) 866-2800 (Main Line)
(303) 866-2696 (Fax)
(888) 866-4243 (Toll Free)

Contributions:

Any person receiving services shall have the opportunity to contribute towards the cost of the service. No eligible person shall be denied a service because of their inability and/or choice not to contribute.

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