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

MEALS ON WHEELS 2020 Consumer In-Home Services Assessment Form

Updated 8/5/19

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 ☐Other		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?		Phone Number:	
*Are you Hispanic or Latino? ☐Yes ☐No		Would you like 1% milk with your meal? ☐Yes ☐No	
*Are you visually impaired? ☐Yes ☐No Do you wear glasses/contacts? ☐Yes ☐No		What do you do for weekend meals?	
Are you receiving Medicaid? ☐Yes ☐No Do you have hearing problems? ☐Yes ☐No		Would you like to speak with a Registered Dietitian? (There is no charge). ☐Yes ☐No	
*Lives: ☐Alone ☐With Others How many?_____		Are you a previous Meals on Wheels customer? ☐Yes ☐No	
Marital status? ☐Married/Domestic partner ☐Single ☐Widow		***Emergency Contact Name:***	
*What is your individual monthly income?		***Phone Number:***	
*What is your household monthly income?		***Relation:***	
		Location City:	
What is your individual monthly income range? ☐ $1,063 or less ☐ $1,064 to $1,327 ☐ $1,328 to $1,965 ☐ $1,966 or more		What is you and your spouse's combined monthly income range? ☐ $1,437 or less ☐ $1,438 to $1,796 ☐ $1,797 to $2,658 ☐ $2,659 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 any safety concerns: _____

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 or condition that made me change 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 can bathe myself without help.			*I can manage money without help.		
*I can dress myself without help.			*I can take care of shopping without help.		
*I can get around inside my home w/o help.			*I can take my medication without help.		
*I can use the toilet without help.			*I can prepare meals without help.		
*I can eat without help.			*I can do ordinary housework without help.		
*I can get in/out of bed/chairs without help.			*I can use the telephone without help.		
Total 'No' Score: _____			*I can use transportation without help.		
			Total 'No' Score: _____		

Is anyone assisting you with the above activities?

Other Eligibility Criteria	Yes	No
*Does the client require Home Health Aide based on orders from a physician?		
*Is the client homebound or in a geographically isolated location to justify home delivered meals?		
*Can the client perform chore activities without help?		
*Does the client have cognitive impairment? ☐None ☐Mild ☐Moderate ☐Severe (requires assistance in routine situations due to lack of cognition functioning)		

Other Information: Comment on client's inability to perform daily living and/or chore activities, chronic medical conditions, where to send statements; special instructions for home.

_____

_____

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, Meals on Wheels 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. 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 Meals on Wheels may order a wellness check with the police department. ***Repeated absences and/or cancellations may result in service suspension.***

Pet Policy
I understand that pets are to be restrained and are not allowed to greet delivery drivers. ***Failure to comply can cause service to be suspended and/or terminated.***

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

Signature_____ Date_____ Contact Phone_____

☐ **Check here if information provided by someone other than client.**
Completed by_____ Phone _____Relation_____

For office use only:

☐ Frozen/milk	☐ Pets	☐ ADRC	☐ SHIP
☐ Delivery time	☐ No service days	☐ Senior Companion	☐ Handyman
☐ Receiving delivery	☐ Donation	☐ Dietitian	☐ Other
☐ Cancellations	☐ Releases	☐ 211	

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KEEP THIS FORM FOR YOUR RECORDS

Please read the following information concerning the 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 to do 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).

How to file a grievance:

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

Region 11 Area
Agency on Aging office
(970) 248-2717
(970) 248-2883 (Fax)
Attn: Heather Jones

Office of Community Access and Independence
Aging and Adult Services
1575 Sherman Street, 10th Floor
Denver, CO 80203
(303) 866-2800 (Main Line)
(303) 866-2977 (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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