COMMUNITY SERVICES
Senior Services

☐ C-2 HOME-DELIVERED MEALS
☐ CASE MANAGEMENT ☐ PERSONAL CARE
☐ HOMEMAKER ☐ CHORE CLIENT REGISTRATION

TERMINATION DATE:	***TERMINATION REASON:***

CLIENT INFORMATION

NAME*			***DATE OF BIRTH***
LAST	FIRST	MI	
ADDRESS*			MARITAL STATUS
			☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED
CITY	STATE	***ZIP***	PHONE*
EMERGENCY CONTACT NAME*	RELATIONSHIP		EMERGENCY CONTACT PHONE*

RACE/ETHNICITY

RACE (Select all that apply)**:**

☐ WHITE
☐ BLACK
☐ AMERICAN INDIAN/ ALASKA NATIVE
☐ DECLINED/NOT STATED

Asian:
☐ ASIAN INDIAN
☐ CHINESE
☐ JAPANESE
☐ LAOTIAN
☐ OTHER ASIAN
☐ CAMBODIAN
☐ FILIPINO
☐ KOREAN
☐ VIETNAMESE

Hawaiian/Pacific Islander:
☐ GUAMANIAN
☐ HAWAIIAN
☐ SAMOAN
☐ OTHER PACIFIC ISLANDER

ETHNICITY:
☐ NOT HISPANIC/LATINO
☐ HISPANIC/LATINO
☐ DECLINED/NOT STATED

DEMOGRAPHICS

WHAT IS YOUR GENDER? ☐ DECLINED/NOT STATED
☐ MALE ☐ TRANSGENDER; FEMALE TO MALE
☐ FEMALE ☐ TRANSGENDER; MALE TO FEMALE
☐ GENDERQUEER/GENDER NON-BINARY
☐ NOT LISTED; SPECIFY: _____

HOW DO YOU DESCRIBE YOUR SEXUAL ORIENTATION OR SEXUAL IDENTITY? ☐ DECLINED/NOT STATED
☐ STRAIGHT/HETEROSEXUAL
☐ BISEXUAL
☐ GAY/LESBIAN/SAME-GENDER LOVING
☐ QUESTIONING/UNSURE
☐ NOT LISTED; SPECIFY: _____

WHAT WAS YOUR SEX AT BIRTH?
☐ MALE ☐ FEMALE ☐ DECLINED/NOT STATED

RURAL:
☐ YES ☐ NO ☐ DECLINED/NOT STATED

LIVING ARRANGEMENT:
☐ ALONE ☐ WITH OTHERS ☐ DECLINED/NOT STATED

NUMBER IN HOUSEHOLD:
_____ ☐ DECLINED/NOT STATED

FEMALE HEAD OF HOUSEHOLD:
☐ YES ☐ NO

CLIENT ASSESSMENT

REGISTRATION/ASSESSMENT DATE	TYPE OF COMMUNICATION	LANGUAGE SPOKEN
	☐ HOME VISIT (Blue)	

HOUSEHOLD INCOME ☐ DECLINED TO STATE ☐ NO CHANGES VERIFIED BY _____

FPL INCOME LESS THAN $12,880 (1 person) PER YEAR OR $17,420 (2 people) PER YEAR? ☐ YES ☐ NO

1 PERSON: ☐ $12,880 - $16,099 ☐ $16,100 - $17,129 ☐ $17,130 - $17,387 ☐ $17,388 - $17,773 ☐ $17,774+

2 PEOPLE: ☐ $17,420 - $21,774 ☐ $21,775 - $23,168 ☐ $23,169 - $23,516 ☐ $23,517 - $24,039 ☐ $24,040+

REASON FOR HOME DELIVERED MEALS/CARE MANAGEMENT SERVICES/PRESENTING PROBLEM	DAYS OF SERVICE REQUESTED
☐ 60+ ☐ DISABLED ☐ CAREGIVER ☐ INABILITY TO SHOP ☐ POOR EATING HABITS ☐ INABILITY TO COOK MEALS ☐ OTHER _____	☐ MON ☐ TUE ☐ WED ☐ THU ☐ FRI

HAS A CAREGIVER	HOURS/WEEK	ASSISTIVE DEVICES	DRIVES
☐ YES ☐ NO		☐ CANE ☐ WALKER ☐ WHEELCHAIR	☐ YES ☐ NO

TRANSPORTATION USED	OWNS A PET
☐ SELF ☐ ACCESS/OCTA ☐ TRIPS ☐ OTHER _____	☐ YES ☐ NO

DIETARY RESTRICTIONS (If YES, please list)	DIABETIC
☐ YES ☐ NO _____	☐ YES ☐ NO

PRESENTING PROBLEMS (Check all that apply)

☐ BREATHING/O2 ☐ LANGUAGE BARRIERS ☐ COGNITIVE LOSS ☐ MILD ☐ MODERATE ☐ SEVERE
☐ CARE GIVING ☐ LOW VISION ☐ EMOTIONAL
☐ DENTAL ☐ MOBILITY ☐ AGITATED ☐ ANXIOUS ☐ HOMICIDAL ☐ LONELY ☐ PARANOID
☐ FINANCIAL ☐ PHYSICAL ☐ ANGRY ☐ CONFUSED ☐ LETHARGIC ☐ SAD ☐ SUICIDAL
☐ HOH ☐ SLEEP ☐ SMOKES ☐ HOUSEHOLD SAFETY _____
☐ LEGAL ☐ TRANSPORTATION ☐ SMOKE ALARM ☐ OTHER _____

SIGNIFICANT CHANGES (In the last 3 months)

☐ ER/HOSPITALIZED ☐ FALLEN ☐ OTHER _____ WHEN _____ LENGTH OF TIME _____

SUGGESTED SERVICES (Mark all that apply - RECOMMENDED [+]; IN PLACE [O])

APS	CARE MGMT	EMERG. RESPONSE	FRIENDLY VISITOR/ CALLER	HANDY MAN	HOME MAKER/ CHORE	IADHS	IMOW	MENTAL HEALTH/ OAS	PERSONAL CARE	SENIOR CENTER	SHOPPING	TRANS-PORTATION	VETERANS AFFAIRS	MEDICAL	LEGAL

☐ OTHER / UNMET NEEDS _____

ACTIVITIES OF DAILY LIVING (ADL) / INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

Rate the following activities:

1=Independent
2=Verbal Assistance
3=Some Human Help
4=Lots of Human Help
5=Dependent
6=Declined to State

ACTIVITIES OF DAILY LIVING:

EATING		TRANSFER (CHAIR/BED)	
BATHING		WALKING	
TOILETING		DRESSING	
		TOTAL ADL#	

INSTRUMENTAL ACTIVITIES OF DAILY LIVING:

MEAL PREP		USE OF PHONE	
SHOPPING		HEAVY HOUSEWORK	
MEDICATION MGMT		LIGHT HOUSEWORK	
MONEY MGMT		TRANSPORTATION	
		TOTAL IADL#	

NUTRITIONAL RISK ASSESSMENT ☐ DECLINED TO STATE			POINTS
1. I have an illness or condition that made me change the kind and/or amount of food I eat.	☐ YES	☐ NO	2
2. I eat fewer than 2 meals per day.	☐ YES	☐ NO	3
3. I eat few fruits or vegetables, or milk products	☐ YES	☐ NO	2
4. I have 3 or more drinks of beer, liquor or wine almost every day.	☐ YES	☐ NO	2
5. I have tooth or mouth problems that make it hard for me to eat.	☐ YES	☐ NO	2
6. I do not always have enough money to buy the food I need.	☐ YES	☐ NO	4
7. I eat alone most of the time.	☐ YES	☐ NO	1
8. I take 3 or more different prescribed or over-the-counter drugs a day.	☐ YES	☐ NO	1
9. Without wanting to, I have lost or gained 10 pounds in the last 6 months.	☐ YES	☐ NO	2
10. I am not always physically able to shop, cook and/or feed myself.	☐ YES	☐ NO	2
11. Do you have less than 5 cups (8 oz. per cup) of fluids per day?* *Question is not part of the Nutrition Risk scoring.	☐ YES	☐ NO	
		TOTAL	

HIGH NUTRITIONAL RISK? *(High nutritional risk is a score of 6 or more points)* ☐ YES ☐ NO

REFRIGERATOR: TEMPERATURE _____ DATE _____

C-2 CLIENT REGISTRATION

FOR C-2 CLIENTS		
1. Does the client have any dietary restrictions?	☐ YES	☐ NO
2. Does the client have a working refrigerator?	☐ YES	☐ NO
3. Does the client have a working microwave?	☐ YES	☐ NO
4. Is the client physically/mentally able to open the food containers?	☐ YES	☐ NO
5. Is the client physically/mentally able to reheat a meal?	☐ YES	☐ NO

COMMENTS / RECOMMENDATIONS

I CERTIFY THE ABOVE INFORMATION IS CORRECT. _____ _____

SIGNATURE* (REQUIRED) DATE

FOR OFFICE USE ONLY

COMPLETED BY: _____

PARTICIPANT ID#: _____ DATE: _____