CHIPPEWA COUNTY HOME DELIVERED MEALS REFERRAL AND ASSESSMENT

PROGRAM REQUIREMENTS
AGE 60+, HOMEBOUND, AND RESIDES OUTSIDE THE CHIPPEWA FALLS CITY LIMITS

Agency:_____ Name:_____

Date: _____ _____ Phone:_____

Has this person received HDM's in the past? ◯YES ◯NO If yes, why? _____

_____

Managed Care Organization: ◯YES ◯NO MCO Name: ◯ContinuUs ◯IRIS ◯Care WI ◯None

Are meals authorized by the MCO? ◯YES ◯NO Explain: _____

Do you/they drive? ◯YES ◯NO Explain: _____

Reason(s) for requesting Home Delivered Meals: _____

_____

Participant's Information: Name: _____

Date of Birth: _____ **Age:** _____ ◯**M** ◯**F** **Phone:** _____

Address: _____ **City:** _____ **Zip**: _____

Emergency Contact Name: _____

Phone(s): _____ **Relationship:** _____

Additional Emergency Contact Name: _____

Phone(s): _____ **Relationship:** _____

Status:
◯ Single
◯ Married
◯ Widowed
◯ Divorced

Living Arrangements:
◯ lives alone
◯ lives w/spouse
◯ lives w/others

Race/Ethnicity:
◯ Non-Minority (White)
◯ Hispanic
◯ African American
◯ Other

Health & Well Being:
☐ Visually Impaired
☐ Hearing Impaired
☐ Memory Impaired
☐ Balance issues
☐ Memory Loss
☐ History of falls
☐ Uses a walker or cane
☐ Weakness or fatigue
☐ History of Depression

Monthly Income:
1 person- $990.00/month Above ◯ Below ◯ 2 people- $1335.00/month Above ◯ Below ◯

Delivery Instructions:

Is this request ◯TEMPORARY ◯PERMANENT Explain: _____

_____

Days requested: ☐M ☐TU ☐W ☐TH ☐F Explain: _____

Directions/Special Delivery Instructions: _____

_____

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NUTRITION ASSESSMENT

What's Your Nutrition Risk? Check mark which ones apply to you	✓	Score
1. I have an illness or condition that made me change the kind and/or amount of food I eat.		2
2. I eat fewer than 2 meals per day.		3
3. I eat few fruits or vegetables, or milk products		2
4. I have 3 or more drinks of beer, liquor or wine almost every day		2
5. I have tooth or mouth problems that make it hard for me to eat.		2
6. I don't always have enough money to buy the food I need.		4
7. I eat alone most of the time.		1
8. I take 3 or more different prescribed or over-the-counter drugs a day.		1
9. Without wanting to, I have lost or gained 10 pounds in the last 6-months.		2
10. I am not always physically able to shop, cook, and or feed myself.		2
(0 – 2 **Good!)** (3 – 5 **Moderate nutritional risk.) (**6 +**High nutritional risk.)**	TOTAL	

Check activities of Daily Living (ADLs) with which you need assistance ☐ **None**

- ☐ Using utensils and eating without help
- ☐ Getting in and out of bed or a chair
- ☐ Dressing and undressing
- ☐ Bathing & personal hygeine
- ☐ Completing toilet activities
- ☐ Walking without getting tired

Check <u>Instrumental Activities of Daily Living</u> (IADLs) that you need help with: ☐ **None**

- ☐ Meal preparation
- ☐ Light housekeeping
- ☐ Shopping
- ☐ Traveling in a van, taxi, bus, or car
- ☐ Answering the phone or calling others
- ☐ Handling bill paying, banking, etc.
- ☐ Doing the laundry/outside chores
- ☐ Medication Management

FOR MORE INFORMATION PLEASE CONTACT:
Chippewa County Nutrition Program
Kelly Zimmerman, Program Assistant
711 N. Bridge Street, Room 118
Chippewa Falls, WI 54729 715-738-2590
FAX FORM TO: 715-738-2589
Or email: ADRC@co.chippewa.wi.us

ADRC OFFICE ONLY
APPROVED: ◯ NOT APPROVED: ◯
REASON: _____
_____
_____
Initial Assessment_____Date_____
Reassessment_____Date_____

The information you are being asked to provide is needed to determine if you are eligible to receive Older Americans Act Services and to comply with federal reporting requirements. This information will be stored in a secure electronic database and will not be used for any other purpose. Your information will not be shared with another agency without your permission. This information will not be sold to anyone. You have the right to review your electronic record and request changes to assure accuracy. You will not be denied most services if you refuse to provide this information. If you have questions regarding this, please ask the aging unit staff.