Home-Delivered Meal Program Assessment

Date of assessment:

First Name	Middle Initial	Last Name

Date of Birth	Gender:	Gender Identity:
/ /	☐ Female ☐ Male	☐ Female ☐ Male ☐ Non-Binary ☐ Non-Disclose ☐ Transgender-Female ☐ Transgender-Male ☐ Other

Residential Address:	Mailing Address:

City:	State	Zip Code	County

Phone number (include area code):	Emergency Contact Name & Phone Number:

Ethnicity:	Race:		Primary Language:
☐ Not Hispanic or Latino	☐ White	☐ American Indian/Alaskan	☐ English
☐ Hispanic or Latino	☐ Asian	☐ Black/African American	☐ Other
☐ Unknown	☐ White-Hispanic	☐ Native Hawaiian/Pacific Islander	

Lives Alone: ☐ Yes ☐ No | Income Below Poverty: ☐ Yes ☐ No

Is this individual a spouse or dependent disabled child of an eligible home-delivered consumer? ☐ No ☐ Yes

Client eligibility category: (If not homebound, spouse or disabled child; check any/all that apply)
- ☐ Congregate older individual requesting home-delivered meals due to short-term illness
- ☐ Older individual has limited physical mobility
- ☐Older individual is unable to tolerate a group situation due to physical or mental disability or substance abuse
- ☐ Older individual lives in a remote geographic location where no congregate meal site exists
- ☐ Older individual lives in a remote geographic location prohibits access due to transportation issues

Do you have ability to prepare frozen meals:	Do you have freezer space to store frozen meals:
☐ Yes ☐ No	☐ Yes ☐ No

Nutrition Screening Checklist

1.Do you have an illness and/or condition that made you change the kind and/or amount of food you eat? ☐ Yes ☐ No	2. Do you eat ***less*** than 2 meals a day? ☐ Yes ☐ No
3. The majority of days do you eat ***less*** than 1 ½ to 3 cups of fruits and/or vegetables? ☐ Yes ☐ No	4. The majority of days do you eat and/or drink ***less*** than 3 - 8 oz cups of dairy products (such as milk, yogurt, cheese)? ☐ Yes ☐ No
5. Do you have 3 or more drinks of alcohol almost every day? ☐ Yes ☐ No	6. Do you have any tooth and/or mouth problems that make it hard for you to eat? ☐ Yes ☐ No
7. Sometimes do you not have enough money to buy enough food? ☐ Yes ☐ No	8. Do you eat alone most of the time? ☐ Yes ☐ No
9. Do you take 3 or more different prescribe and/or over-the-counter medications per day? ☐ Yes ☐ No	10. Without wanting to, have you lost and/or gained 10 pounds in the last 6 months? ☐ Yes ☐ No

11. Are you sometimes ***not*** physically able to shop, cook, and/or feed yourself? ☐ Yes ☐ No

12. Are you interested in being referred for Nutrition Counseling (only if the score is eight (8) or higher? ☐ Yes ☐ No	
Activities of Daily Living	
1. What is your ability to bathe/shower yourself? ☐ Independent ☐ Requires Assistance	2. What is your ability to dress yourself? ☐ Independent ☐ Requires Assistance
3. What is your ability use the restroom facilities on your own? ☐ Independent ☐ Requires Assistance	4. What is your ability to physically transfer on your own? ☐ Independent ☐ Requires Assistance
5. Do you have any bowel and bladder (incontinence) issues? ☐ Independent ☐ Requires Assistance	6. Are you able to feed yourself? ☐ Independent ☐ Requires Assistance
Instrumental Activities of Daily Living	
1. Can you use the telephone on your own? ☐ Independent ☐ Requires Assistance	2. Can you do your own shopping? ☐ Independent ☐ Requires Assistance
3. Are you able to prepare meals? ☐ Independent ☐ Requires Assistance	4. Can you do your own housework? ☐ Independent ☐ Requires Assistance
5. Can you do your own laundry? ☐ Independent ☐ Requires Assistance	6. Can you arrange your own transportation? ☐ Independent ☐ Requires Assistance
7. Can you manage your own medications? ☐ Independent ☐ Requires Assistance	8. Can you manage your money? ☐ Independent ☐ Requires Assistance
Use of Information	
The information that is provided on this form is for home-delivered meal assessments only. The information is used by the ND Department of Health & Human Services – Aging Services Section to create reports for the Federal Government and to help identify other services that may be beneficial such as the Nutrition Counseling. This information will ***not*** be released/shared with anyone other than the above-mentioned parties unless I sign a separate consent (Release of Information).	

(Revised 5/16/2023)

Name of Meal Site: ____